

## Traditional Birth Attendants and Maternal Mortality

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**Abstract:** *The paper explored the consequences involved with the practice of traditional birth attendants and maternal mortality. In developing countries, most childbirth occurs at home and is not assisted by skilled attendants. This situation increases the risk of mortality for both mother and child with severe maternal and neonatal health complications. Maternal mortality is high in most African countries, particularly in rural areas where access to formal health care is limited. Physical distance and financial limitations are two major constraints that prevent community members from accessing, using trained attendants and institutional deliveries. Traditional Birth Attendants (TBAs) provide basic health care, support and advice during and after pregnancy/childbirth in rural communities. Traditional birth attendants are predominantly in rural, remote and other medically underserved areas. TBAs may not receive formal education and training in health care provision, and there are no specific professional requisites such as certification or licensing. Due to lack of education with some TBAs, the way they attend to delivery is risky for women and their babies, leading to poor health outcomes and even death. The paper suggests that since TBAs have made great impact in the rural communities, their roles cannot be abolished or overlooked therefore effective measures to train and improve their skills and define their roles is necessary. There should be integration and collaboration with the health sector to supervise and monitor their activities.*

**Keywords:** *Maternal mortality, Traditional birth attendants, rural communities, Pregnant women..*

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### I. Introduction

Each year about four million new-borns die in the first week of life worldwide and an estimated 358,000 mothers die due to pregnancy-related causes with maternal mortality rate of 260 per 100,000 live births and a life time risk of 1 in every 140 was recorded in 2008[1]. However Africa has a higher number of 190,000 maternal deaths with a maternal mortality rate of 620 per 100,000 live births and a life time risk of 1 in every 32[1]. In the same trend, 287,000 global maternal deaths were recorded in 2010 with Sub Saharan Africa having 56%, South Asia 26% both accounting for 85% global burden of maternal mortality with a global maternal mortality rate of 210 per 100,000 live births and life time risk of 1 in every 180[1]. The developed regions recorded a total maternal death of 2,200 with maternal mortality rate of 16 per 100,000 and a life time risk of 1 in every 3800[1]. In 2008 estimates of WHO, UNICEF, UNFPA and World Bank shows that 50,000 Nigerian women died of pregnancy and child birth related cases with a maternal mortality of 840 per 100,000 live births. In 2010 the estimate indicated a decline from 840 to 630 per 100,000 live births (United Nations Populations Fund [1].

Available data by the World Health Organisation [2] show that an estimated 289,000 global maternal deaths were recorded in 2013. The report also indicates that Nigeria is among top five countries with highest rates of maternal mortality with about 40,000 pregnant women dying in the country in 2013. Despite the efforts of the State Governments to provide quality health programmes with the establishment of Mother and Child Hospitals, safe motherhood, free medical services for pregnant women and other laudable systems, some pregnant women still patronize traditional birth attendants in Nigeria. However, the rate is higher in the Northern part of Nigeria as maternal deaths occur principally in areas where women have many babies in short time spans due to undernourishment, poor hygienic conditions and lack of access to quality medical treatment. Investigations showed that majority of the pregnant women, especially the illiterates still believed in the efficacy of local herbs and other concoctions given to them by traditional birth attendants despite the high risk associated with it [3].

According to Basavanthappa [4] in ancient time, it was in practice in India that untrained 'dais' (maids or traditional birth attendants) who belong to the lower community were mostly responsible for conducting deliveries. They were unclean in their habits even today a large percentage of deliveries are still conducted by them [4]. The care of women as well as practice of maternal and child health services were totally in their hands and majority of the deliveries in rural India were conducted by them. The indigenous 'dais' in India do not only help during childbirth but also act as consultants for any condition of the mother related to birth. This leads to various complications and increased maternal and infant mortality since they are unable to deal with difficult deliveries and pregnancies [4].

## **II. Traditional Birth Attendants**

Traditional birth attendants provide the majority of primary maternity care in many developing countries, and may function within specific communities in developed countries. They provide basic health care, support, advice during and after pregnancy and childbirth, based primarily on experience and knowledge acquired informally through the traditions and practices of the communities where they originated [5]. TBAs may not receive formal education and training in health care provision, and there are no specific professional requisites such as certification or licensure. They often learn their trade through apprenticeship or self-taught. In many communities one of the criteria for being accepted as a TBA by clients is experience as a mother. Many TBAs are also herbalists, or other traditional healers. Sometimes they serve as a bridge between the community and the formal health system. Traditional birth attendants are often older women, almost past or close to menopause, young adults and men who must have borne one or more children themselves and are respected in their communities. They consider themselves as private health care practitioners who respond to requests for service. The focus of their work is to assist women during delivery and post-partum [5].

According to WHO [6], traditional birth attendant is defined as a person who assists the mother during child birth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants. But in the contest of this paper and what is obtainable in Nigeria, a traditional birth attendant is a person (man or woman) who assists the mother or serves as an apprentice to other TBAs, during delivery, and must have acquired his or her knowledge and experience in delivery and is capable of delivering babies without assistance. They live in the community in which they practice and they are respected in that community. They operate mainly in a relatively restricted zones always limited to their own community and sometimes those close to them. Their roles include everything connected with the conduct of childbirth and this is where they hold most power and authority. Many of their beliefs and practices pertaining to the reproductive cycle are dependent upon religion or mystic sanctions. They are reinforced by rituals that are performed with traditional ceremonies which are intended to maintain the balance between the absence of ill health and state of ill health.

Due to the lack of education in some TBAs, the way many attended the delivery is risky for women and their babies, leading to poor health outcomes and even death [7]. There are various types of traditional birth attendants, they are, trained TBAs, untrained TBAs, family TBAs, Full-time TBAs, Part time TBAs, TBA/Herbalists and Spiritualists [7]. The traditional birth attendants make great impact in the rural community, they are very close to the people and the rural women believe and have trust on them so much that they cannot be easily abolished in the community [7]. To this effect, measures should be carried out to improve their skills for example health educating them, training, organising seminars and the need for referral of complicated cases and at risk mothers [7].

## **III. Perception Of Traditional Birth Attendants By Pregnant Women**

A TBA being a person who assists mothers and other TBAs during childbirth and acquired his or her skills by delivering babies themselves and through apprenticeship to other TBAs, born, bred and known in that community has a very high perception by the pregnant women. They are highly experienced and respected by all in that community. They have made great impact, trusted and believed by their people especially the pregnant women. Throughout history, TBAs have been the main human resource for women during childbirth in the rural areas. TBAs' profession has been handed over from one generation to another. They see them as the foundation pillars full of experience, and no programme should displace them.

Traditional birth attendants have been part of the community for a long time before the Safe Motherhood Initiative was endorsed. They are noted for their uninterrupted availability, accessibility and social distance; it was quite acceptable by the pregnant women that their services would be widely used [8]. Their expertise was valued due to their social and emotional closeness to the community, their long experience in providing services to mothers and infants and their intimacy with the people which created loyalty and understanding, particularly when other health care services were not accessible. This built the authoritative knowledge conferred on them by the community [8].

According to [9], the pregnant women opined that the services of a health professional can only be required by those experiencing obstetric complications or if the condition could not be handled by the TBA. A woman reported that the first assistance from which we seek care is the traditional birth attendant but if the delivery starts to be complicated or if the traditional birth attendant cannot manage the delivery we then call the midwives otherwise calling them is unnecessary. They have this perception that delivery is a natural rite of passage for women and thereby home delivery is preferably unless complications occur. They believe that the traditional birth attendants are more patient, tolerance, soft and can gently touch and examine them till they are delivered of the baby. TBAs are there for them even in the midnight.

The trust and tradition that TBAs engendered on them because they share the same culture, beliefs and customs as long serving members of the community. They believe in the efficacy of their local herbs, prayers and other concoctions given to them by the TBAs despite the high risk associated with it which they ignorantly refused to give attention to. Their role varies across cultures and times, but even today, they attend the majority of deliveries in rural areas of developing countries. There is no doubt that they have a significant role when it comes to cultural competence, consolation, empathy, and psychosocial support at birth, all of which are important benefits for the mother and also for the new-born child. The WHO observes that TBAs can potentially improve maternal and new-born health at community level while their role in caring for pregnant women and conducting deliveries is acknowledged, it is noted that they are generally not trained to deal with complications [10]. Despite all Government efforts to bring Safe Motherhood Programme and other free medical services for pregnant women, they still prefer deliveries conducted by the TBAs because of their perceptions towards them. For instance in Mexico, TBAs attend approximately 45% of all deliveries [11]. In Sierra Leone, TBAs conduct approximately 70% of deliveries, provide a significant amount of prenatal care, and are authorities in native methods of family planning [12].

[13] estimated that between 60% and 80% of all deliveries in developing countries occur outside modern health care facilities, with a significant proportion of these attended by TBAs. TBAs attend to majority of women in Nigeria as in other developing countries. An eastern Nigerian study showed that although 93% of rural women registered for prenatal care, 49% delivered at home under the care of TBAs. In a study done in Edo State, south Nigeria, to assess the role of TBAs in health care delivery, respondents believed that TBAs could play meaningful roles in family planning, screening for high-risk pregnant mothers, fertility/infertility treatment, and maternal and child care services. Rural dwellers prefer to use the services of TBAs as compared with their urban counterparts. Reasons for their preference included: the option of home delivery, TBAs' availability, accessibility, inexpensive services, and rural dwellers' faith in the efficacy of their services [14]. Having a positive attitude toward TBA services and satisfaction with services obtained from TBAs was also significantly associated with those who had ever used their services.

#### **IV. Preference Of Traditional Birth Attendants By Pregnant Women**

The use of traditional birth attendants and home delivery were preferable for some pregnant women in some communities, despite the availability of health facilities and other laudable free programmes. Some of their reasons are: economic and pragmatic reasons, as the charges of the TBAs are cheap and affordable unlike the charge of the midwives. In addition, the flexibility of their payment method to the TBAs is more convenient, they were even allowed to pay them in instalments to ease their stress and tension. They are not bothered about paying transport to the health facility to deliver; the TBA is already there for them. The inconvenience of leaving the house looking for who accompanies the person to the centre is no more there.

Low Educational level of women also affects their ability to seek the most appropriate health care services. A lot of Free Medical programmes have been provided for use still it is difficult to access them due to their level of exposure. Ignorance of the availability of the services provided for their use. Many do not know that the services at the health facilities are for them even when awareness is created they will be thinking it is a deceit. Some women think that childbirth is a normal event and work rather than an event requiring medical attention. Lack of knowledge about symptoms which require medical care and attention can lead to delays in recognition and treatment of severe complications contributing to maternal death [15].

Pregnant women still believe in the efficacy of the TBAs' local herbs, concoctions and prayers given to them before and during delivery despite the high risk associated with them. One of them said pregnant women should seek refuge with traditional birth attendants because of their zeal to pray for expectant mothers.

Socio-cultural trust has also been one of the reasons why pregnant women patronise traditional birth attendants. The TBAs are part of the community, speaking the local language, living in the same community and sharing the same belief and culture, that have made them to develop the feeling of trust in the community. TBAs are seen to be much closer to the community; they have been treated as respected persons by the community members. Psychologically they trust the TBAs more.

Socio-cultural tradition is another factor that influenced their use and the perception of the TBAs by the family members especially the older ones. Their older or elder ones will encourage the younger ones out of experience to go to the TBAs and it will be difficult for them to resist the pressure as it is a long time tradition in the community of using their services. They believe that delivery is a natural rite of passage for women and can be handled by a TBA; therefore home delivery is preferred except where complications occur.

Other reasons are related to the issues of accessibility to the health care services due to physical distance especially where the road is bad and the sitting is not adequate. Time constrains and the availability of the health care providers, at times they may be willing to go to health facility but considering the distance, cost of transportation and whether they will see any person on duty, they relax and change their mind towards the TBAs. The attitude and the social distance of health care providers and the community can scare them away but

in rural areas, they have better access to the TBAs. They are always there for them 24 hours of the day, very friendly, familiar and patient with them and are not easily upset but poor attitude of the service providers are nothing to write home about.

### **V. Limitations Of Traditional Birth Attendants**

Some of the problems of TBAs are that they are not skilled attendants and so they are not adequately trained or equipped to handle complicated cases. They only attend to normal delivery. Their real ability to refer in emergencies is questionable. They do not know the actual or appropriate places to refer cases to. They are not monitored or supervised and that make them to be lord of their own. They do not know their limits, and make every attempt whether they will succeed or not. TBAs are not hygienic in nature, as they sometimes neglect hand washing, non sterilization of instrument, environmental sanity not maintained and others which will cause more harm than good to them and their patients. They use herbs during delivery to facilitate dilatation which may lead to infecting the mother and the baby.

### **VI. Maternal Health**

Maternal and child health refers to the promotive, preventive, curative and rehabilitative health care of mother and children. It also includes the subareas of maternal health, child health, family planning etc. Pregnancy is the vital event in the life of a woman. It needs special attention from the time of conception to the postnatal stage. Safe motherhood programme aims to prevent pregnancy related deaths and disability. The period of pregnancy extend from the time of conception to 42days after delivery. During this period the progress is not the same therefore the total period of pregnancy is divided into three periods namely the antenatal, intra-natal and the postnatal periods. Each period has its own special features and specific risks.

Antenatal provides care to the pregnant woman with the aim of ensuring maternal and foetal wellbeing. The safe motherhood programme aimed at achieving a maternal mortality rate of 2/1000 live births by 2000AD. On the other hand, Intra-natal care starts from starting of labour to delivery of the placenta. Its objectives are the conduct of aseptic delivery, watch for complications during labour, timely referral if complications arise and care of the baby at delivery. Personnel involved in intra natal care should be given under the watchful supervision of Doctors, Nurses, Midwives or trained Female health workers (Skilled Attendants). Postnatal care is the care of the mother and new born after delivery. Its components are to watch for complications in the post natal period that are likely to arise, Puerperal sepsis, thrombophlebitis, secondary haemorrhage due to retained placenta, urinary tract infections, breast abscess[16].

Skilled attendance is defined as the process by which a woman is provided with adequate care during labour, delivery and postpartum period and requires both a skilled attendant and an enabling environment. Skilled attendant refers exclusively to people with midwifery skills for example Doctors, Midwives and Nurses who have been trained to proficiency in the skills necessary to manage normal deliveries, diagnose, manage or refer complications. It is noted that the higher the proportion of deliveries attended by skilled attendants in a country the lower the country's maternal mortality ratio [17].

Therefore every pregnancy should culminate in healthy mother and healthy baby. We need to ensure that all women have access to high quality essential and emergency obstetric service along with provision for safe abortion and contraceptive services to reduce mortality due to unplanned pregnancies.

### **VII. Traditional Birth Attendants And Maternal Mortality**

Maternal mortality is an indicator of state of maternal health services, state of women, women's health and above all the development of nation. Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes while maternal mortality rate is defined internationally as the maternal death rate per 100,000 live births [18]. A late maternal death is the death of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of pregnancy. A pregnancy related death is death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the cause of death.

Maternal mortality is divided into two major groups' namely direct and indirect obstetric death. Direct Obstetric Deaths results from obstetric complications of the pregnant state that is during pregnancy, labour and purperium. Most maternal deaths are related to obstetric complications like haemorrhage, sepsis, eclampsia, prolonged or obstructed labour and complications of abortion. Indirect Obstetric Deaths result from previous existing disease(s) that developed during pregnancy which were not due to obstetric causes, but was aggravated by physiological effect of pregnancy, example anaemia, HIV/AIDS and cardiovascular diseases, malaria to mention but a few[19].

However, other predisposing factors to maternal mortality are ignorance, low socio-economic status, illiteracy, age and parity. Socio-economic and cultural factors had been documented to influence maternal mortality. This is dependent on the ability of the woman to command resources and make independent decision about her fertility. Where women are afforded a low status in the society, their health needs are often neglected and existing health facilities may not be accessed when in need. Illiteracy, social cultural barriers, to seek care at the time of emergency, acceptance of death as wish of God and concern that only female health care providers should attend to women's reproductive systems had also been implicated for maternal death [20,21]. The risk of dying in pregnancy also depends on the number of pregnancies a woman had in her life time. The higher the number of pregnancies, the greater the risk of pregnancy related death. Maternal mortality rate is higher among multi- gravida and women below the age of 15years and those above 35years as compared to other age groups [20,21].

### **VIII. Conclusion**

Despite the efforts of the Government to provide quality health programmes with the establishment of Mother and Child Hospitals, safe motherhood and other laudable systems, some pregnant women still patronize traditional birth attendants in the state. TBAs are readily economically and physically accessible in the communities but are not without limitations. They may not be very aware of danger signs and may not refer at risk mothers. This had led to increase in maternal mortality in our communities and nation.

### **IX. Suggestions**

The effort to increase access to trained birth attendants which was initiated by World Health Organization in 1987 in Nairobi, Kenya, through the launching of the Safe Motherhood Initiative, which aimed at ensuring women have a safe pregnancy and childbirth should be strengthened. Attention to maternal health which was demonstrated in 2000 when 147 heads of state and government and a total of 189 nations in total signed the Millennium Declaration, in which the proportion of births assisted by trained birth attendants became an important indicator to measure the progress of improving maternal health should be maintained[10].

A partnership initiative should be put in place by involving health professionals and traditional birth attendants through Improving Maternal Health Programme, under this scheme the midwives and traditional birth attendants were expected to work together. Different strategies have been carried out to improve community awareness and utilization of the health professionals in addition to the traditional birth attendant. Efforts to strengthen the partnership program would appear to be a beneficial intervention. Advocacy, dissemination, and monitoring of activities of the TBAs should be carried out regularly. Local stakeholders, such as community leaders and full community participation should be encouraged to develop this program.

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