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THE TRADITIONAL BIRTH ATTENDANT AND THE HIGH NIGERIA'S MATERNAL MORTALITY

A. A. Salako
Department of Community Medicine & Primary Care, Olabisi Onabanjo University Teaching Hospital, Sagamu, Ogun State.

Despite the safe motherhood initiatives, maternal mortality rate continues to remain high in the country as high as 1000 maternal deaths per 100,000 live births and even higher in the rural areas. In 1999 alone, 70,000 women died from complications of childbirth, which meant that a woman dies every three minutes. These figures are incomparable with maternal mortality figures characteristic of a developed country where the maternal mortality rate is as low as 8/100,000 live births. The current contraceptive prevalence rate in the country is only seven percent, with many women using traditional methods of doubtful efficacy. Consequently despite a prevailing restrictive abortion laws, Nigeria has extremely high rate of abortion and abortion related morbidity and mortality. With maternal among the highest in Africa, Nigeria currently accounts for over 10 percent of the worlds' maternal mortality estimates. Nigeria also has high rates of infertility, sexually transmitted diseases (including HIV/AIDS) and female genital mutilation.

The traditional birth attendants (TBAS) are believed to be presently serving an interim function in reproductive health care in Nigeria, in the absence of the provision of a better affordable alternative to the people. The contention by many authorities is whether they should be regarded as a stop-gap providing health care until sufficient number of trained midwives become available to replace them, or as permanent community health workers.

However, the ever rising maternal mortality for example shows that the role of traditional birth attendant (TBA) in providing reproductive health care in Nigeria needs to be quickly reassessed and reviewed. For many decades, traditional birth attendants have been involved in providing maternity care and delivery services in both rural and urban Nigeria. Indeed, one of the recommended efforts to reduce the high rate of maternal mortality in Nigeria has been the retraining of TBAs. A recent appraisal of the determination of maternal mortality in the country suggested that unbooked emergencies still formed the predominant proportion of maternal deaths in the country, the very situation which TBA retraining sought to correct[1,2,3,4].

There are other issues of legal acceptability and recognition in case of ligitations and in defence of their practice and profession. Who is a traditional birth attendant? Is the WHO/ UNFPA/UNICEF statement's definition of 'a person who assists the mother during child birth and initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs' of global acceptability and recognition as a qualified and safe TBA? How has her ability been assessed without having gone through.a recognized traditional school of midwifery already accredited for that purpose especially in this new millennium?

Emuveyan (2000) listed the causes of maternal deaths in LUTH, Lagos (1986 - 1995) as Abortion related deaths (22.5%), Eclampsia (16.4%), puerperal sepsis (13.4%) obstetric haemorrhage (17%)' obstructed labour and Ruptured uterus (8.8%), Ectopic pregnancy (5.8%) among others. These deaths could have been avoided with early referral[5]. The most important question is whether TBAs should continue to be used in maternity services. If the answer to this question is yes, it would be necessary to identify a model for involving them in partnership with orthodox health care system in order to reduce the persisting high rate of maternal mortality and morbidity in the country. Other questions included whether TBAs should be involved in other aspect of reproductive health care such as provisions of family planning services and women health advocacy, and how this can be achieved.

As traditional birth attendants are continuously being trained for expanded roles in primary health care, the question of legal status and liability becomes more urgent. Who is liable should anything go wrong? The government, the supervising physician or paramedical, or the traditional birth attendant herself? What happens in case of death or injury as a result of negligence, incompetence, omission, or a plain breach of the criminal law as might arise when abortions and female circumcision have been performed. Is the position different, depending on whether the TBA has been trained or not? If the TBA is a government employee, what is the situation concerning employment protection? If she is to be private practitioner, will she be trained and authorized to practice by the government? And to what extent does authorization carry with it the right to prescribe and administer drugs? These are indications of some problems arising currently.

A global review of traditional birth attendant programmes in 1981 revealed a number of contrasting legal situation in different countries. For instance in Lebanon, Sudan, Turkey, TBAs are illegal, they have no right to practice under any circumstances and can be prosecuted and punished if they do so. In the Philipines, TBAs are prohibited by law from practicing in any locality where a trained midwife is available. In Nigeria, Rwanda, Congo Kinshasa, (formally Zaire) and Zambia, TBAs have no legal status but may practice in their respective communities. In

*Correspondence: A. A. Salako

Chad, Colombia, Costa Rica, Guatemala, the practice of TBAs is regulated by the health agency and a register is kept. They are recognized but not accorded full legal status. This arrangement is one increasingly adopted by many developing countries. In Liberia and Mexico, the TBA is accorded full legal status and granted legal authority to undertake specific functions under prescribed conditions[6].

Even though the prosecution of TBAs is uncommon either because such action would be culturally unacceptable or because of their large number, close monitoring of their activities will go a long way in reducing maternal mortality, as statistics showed that Nigeria's maternal mortality estimates is among the highest in Africa. Nigeria currently accounts for over 10 percent of the world's maternal mortality estimates. This is an eye sore that needs urgent attention.

Even though the federal and state Government and non-governmental organisations with the support of donor agencies have continued to organise training programmes to improve the performance of TBAs and to link them with the formal health care system, the effectiveness of TBAs in reproductive health care and safe motherhood is limited by several factors. These include inadequate system of referral, transportation difficulties, problems associated with data collection, record keeping as well as poor sustainability[7].

In a study Akenzua et al on the role of TBAs in the maternal and child care in a rural area in then Bendel State (Obadan village) TBAs were found to be managing prenancies of high risk that is beyond their scope, such as adolescent pregnancies, pregnancies with bad obstetric history, grandmultiparty, elderly primigravida, previous abdominal pregnancies, retained placenta with their own traditional remedies. Resuscitation of babies were done by sprinkling alligator pepper on babies, bathing baby with cold water and sand. These methods result in high maternal and neonatal mortality and morbidity. These acts ought to be discourages by stipulating penalties in the national TBA training and registration guidelines[8].

TBAs role in the management of complicated pregnancies should be limited to prompt referral as is in the national TBA training guidelines. The recommendation that TBAS could be used in family planning for motivation of clients and distribution of non-prescriptive contraceptive methods, as agents of the dissemination of reproductive health education at the grassroot level, for the promotion of childhood immunisation, and good nutritional practices, exclusive breastfeeding and neonatal care, the success of all these depends exclusively on their level of education, bearing in mind that most TBAs especially in the rural areas lacks the basic education. Basic facilities and human resources to ensure adequate supervision of TBAs should be provided. Ideally, all persons involved in maternity care should be adequately trained and government should endeavour to absorb all trained nurses/midwives within primary health care system to enable them to participate in improving maternal and child care most especially in the rural areas.

With the deplorable situation of reproductive health care in Nigeria most especially in the rural areas where 60 – 80% of Nigerians abound, the big question is for how long will the TBA continue to serve this interim function? Where trained midwives are unavailable, the role of Community Health Extension Workers can be expanded to include not only PHC activities but also aspects of reproductive health care, thereby facilitating the delivery of better services to the community. The present focus of primary health care in training of community Health Extension Workers (CHEWS) should highlight midwivery in its curriculum, to replace the TBA over time.

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