

---

# Characteristics of traditional birth attendants and their beliefs and practices in the Offot Clan, Nigeria

S.M. Itina<sup>1</sup>

*This article presents the findings of a survey of a group of 52 traditional birth attendants (TBAs) in a clan in south-eastern Nigeria. The purpose of the study was to develop a database from which to design an effective programme for TBAs in the safe delivery and early referral of women with complications to hospital. The study showed that the majority of TBAs were illiterate and had no previous experience or training, even informal training, when they took on the TBA role. Ignorance about maternal complications during childbirth and the appropriate treatment was evident for most of the group. A small number of the group relied solely on divine revelation for guidance in the management of child-bearing women. The results of the survey clearly showed that educational programmes for TBAs and better integration into the health care system are essential for lowering maternal mortality and morbidity rates in areas where most mothers are not open to nor have access to professional care in childbirth.*

## Introduction

It is important that all obstetricians in developing countries are familiar with the practices of traditional birth attendants (TBAs) in their locality in order to manage properly referrals from them and reduce the high maternal mortality and morbidity rates associated with TBA practice. Also, obstetricians must be involved with planning and implementing safe motherhood programmes which address the deficiencies in TBA training and practice.

This article presents the findings of a descriptive study of TBAs that was undertaken as a preliminary part of a safe motherhood campaign in Akwa Ibom State, Nigeria. In Nigeria, 70–75% of all deliveries are attended by the TBAs though this percentage is much higher in the rural areas (1). This is also the trend in other developing countries, where maternal mortality rates are about 100 times greater than that in developed countries. The traditional birth attendant, also called the traditional midwife, is defined by WHO as “a person — usually a woman — who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other TBAs” (2). Such individuals live in and are part of the local community, culture, and traditions, and have a high social standing in many

places, as well as exerting considerable influence on local health practices (1, 3).

The area in which the study was carried out is semiurban with an estimated population of 600 000 and comprises 21 villages; it is located within the rain forest belt in the south-eastern corner of Nigeria. St. Luke's Hospital, the base for the study, is the only government (public) hospital within the clan's area. It also serves as a referral hospital (especially for complicated obstetric conditions) for other hospitals within the state and from three neighbouring states. In 1990, a hospital-based 5-year survey reported a maternal mortality rate of 768 per 100 000 in Nigeria (4). A total of 72% of the maternal deaths occurred among patients who were either unregistered for hospital antenatal care or were registered but nevertheless attempted delivery with TBAs. These TBA referrals usually arrived moribund in hospital, most of them dying within 24 h of admission. It is noteworthy that the TBA-referred patients constituted only 5.4% of the total hospital maternity population. TBAs practising within the Offot Clan contributed 24% of the maternal deaths seen in the hospital. Any effort, therefore, to reduce maternal deaths in developing countries must critically assess the characteristics, beliefs and practices of the TBAs who provide the bulk of the maternity services.

The purpose of this study was to identify all the Offot Clan TBAs and describe their socio-demographic characteristics, beliefs and practices. The ultimate goal was to identify and correct risky practices by introducing a TBA training programme to reduce the maternal mortality rate in the community.

---

<sup>1</sup> Chief Consultant Obstetrician—Gynaecologist, St. Luke's Hospital, Anua, P.M.B. 3, Uyo, Akwa Ibom State, Nigeria. Requests for reprints should be sent to this address.

Reprint No. 5813

## Method

### *Procedure*

A safe motherhood campaign team consisting of an obstetrician, a senior practising midwife, and a nurse health educator was established. The team visited the Head (overall chief) of the Offot Clan and his subordinate village chiefs to inform them of the very high maternal mortality rate in the clan and the identified causes. It was emphasized that most of the deaths were preventable. The permission and cooperation of these chiefs was sought in order to identify all the practising TBAs in the clan with a view to recruiting the attendants into the study and establishing a data base on both their harmless and risky practices. The chiefs readily accepted the proposal and promised to help identify and register all practising TBAs in their villages.

An itinerary was drawn up for visiting each village where the team formally identified and registered the TBAs. The aim of the project was explained in detail to the TBAs who were assured that there was no intention to stop them practising their trade. Rather, it was hoped the interaction would improve the standard of their practice. An appointment was made with each TBA for a comprehensive interview at a later, mutually acceptable date.

### *Study sample*

A total of 52 TBAs were identified in the 21 villages of the clan, with an average of 2–3 TBAs per village (range, 1–5). Larger villages had more TBAs.

### *The instrument*

A questionnaire was developed and divided into two sections. Section one covered the TBAs' demographic characteristics, such as age, sex, number of pregnancies they had attended, number of live children they had delivered, marital status, and educational level. Section two covered the TBAs' beliefs and practices in pregnancy and labour, including ability to recognize risk factors in childbirth. The source and nature of their training, if any, and the fees paid to them were also examined. The items on the questionnaire had both open-ended and fixed-answer formats and were pre-tested on a group of TBAs to ensure there were no areas of ambiguity before it was administered within the community. The questionnaire was used by trained interviewers for in-depth interviews with each TBA in the villages. The interviewers were all qualified practising midwives and they were sent out in groups of two to interview TBAs in one village per day.

Data from the questionnaires were analysed manually, and the results transferred to large charts from which descriptive statistics (frequencies, percentages, etc.) were used to summarize the findings. The open-ended responses were sorted into categories, compiled, and ranked in order of frequency.

## Results

### *Sociodemographic characteristics*

The majority of TBAs (92.3%) were females, their age range was 28–70 years (mean, 45.3 years), and almost all were either married (46.2%) or widowed (46.2%). The educational level of the TBAs was very low: only 2 of 52 had graduated from secondary school and 67.3% were illiterate; and 34 (65.4%) had no TBA training before embarking on independent practice. Only two TBAs had any formal training, having attended a mission hospital which offered weekend courses over a 3-year period during the non-farming season. The majority of the TBAs who had pre-practice training were trained by close relatives. The training, in the form of apprenticeship, lasted 1–2 years under TBAs who were not relatives or 2–5 years under close relatives, many of whom were their mothers.

### *Training after establishing practice*

After starting independent practice, 10 of the 19 TBAs who had previously been trained and only seven (20.6%) of the 34 untrained TBAs undertook further training. This training was organized by the Ministry of Health (11 TBAs) or by other TBAs (6 TBAs), with the former training being carried out by qualified midwives. Of the seven untrained TBAs who attended, five received training from the Ministry of Health: one for 3 weeks, and four for 3 months. Two received apprenticeship training for 4 or 12 weeks from TBAs who were not relatives.

### *Attitude to training and monitoring of TBAs*

A total of 51 TBAs (98.1%) accepted that there is a need for training before commencing independent practice. Of these TBAs, 45 (88.2%) wanted the training conducted by government health workers (doctors and nurse-midwives), 3 (5.9%) by TBAs, and the remaining 3 (5.9%) by both. A total of 50 TBAs (96.2%) accepted the need for regular monitoring to ensure acceptable standards of practice; and 74% of these TBAs wanted a monitoring board consisting of conventional medical personnel, while 26% preferred one consisting of TBAs only.

### Traditional beliefs and practices

**In pregnancy.** None of the TBAs ran an organized antenatal care system, although they would advise or treat any patient who came to them with problems in pregnancy. The commonly prescribed treatment included fasting and prayers (20 TBAs), herbal medications either orally and/or by enema (12 TBAs), and referral to the hospital. A combination of herbal medication with fasting and prayers was usually prescribed by 10 TBAs. There was a significant degree of ignorance about the possible causes of bleeding in pregnancy — varying from “no idea” to “evil forces”. For example, the possible serious obstetric causes of antepartum haemorrhage in the third trimester were not recognized by any of the TBAs. Various features are used by the TBAs to diagnose pregnancy or intrauterine fetal death. The majority (61.5%) recognized absence of fetal movement as the primary sign of fetal death; however, 13.5% had no idea how to recognize it and two TBAs relied upon divine revelation.

The normal duration of pregnancy, counted by the TBAs in lunar months, was given as 9 months (14 TBAs), 10 months (34 TBAs), or over 10 months (2 TBAs); two TBAs had “no idea” of the duration. The management of prolonged pregnancy, when it was defined and recognized by the TBA, included referral to hospital and prayer and fasting (17 TBAs). In the case of prayer and fasting, referral to hospital was made if labour did not start within 3 days. Three TBAs reported they would offer sacrifices to appease the gods.

**In labour.** Most TBAs used several clinical features to diagnose onset of labour, good progress in labour, and imminent delivery; although, again, a small number relied on spiritual revelation. As with bleeding in the third trimester, the TBAs were generally ignorant about the possible obstetric causes of intrapartum haemorrhage associated with generalized abdominal pains. A total of 29 TBAs had never seen such a patient in their practice and would refer any to the hospital, while 14 TBAs would prescribe herbs and 9 TBAs use prayers in such instances. Referral to hospital was, however, a second option to the latter two groups.

The TBAs' management of postpartum haemorrhage included herbal medications (18 TBAs (34.6%)), prayer (16 TBAs (30.8%)), referral to hospital (12 TBAs (23.1%)), and rubbing up of uterine contractions (4 TBAs (7.7%)).

**The third stage.** All of the TBAs waited for the delivery of the placenta before cutting the umbilical cord. They all use the signs of lengthening of the cord with

a trickle of red blood to identify placental separation. Patients are then urged to bear down to encourage placental expulsion. Delay in separation and spontaneous delivery of the placenta were managed by administration of herbs (31 TBAs (59.6%)), induction of vomiting and manual compression of the uterus (24 TBAs (46.2%)), and manual removal of the placenta (7 TBAs (13.5%)).

### Discussion

The sociodemographic characteristics of the study TBAs were, broadly speaking, similar to those of TBAs in other areas of Nigeria (5) and in other developing countries (1, 6, 7). However, contrary to the experience in rural Bangladesh (3), and the popular belief that most TBAs had prolonged periods of apprenticeship before commencing independent practice (1, 7, 8), 65.4% of the TBAs in our study had no training whatsoever in traditional midwifery before embarking on independent practice. For this group of TBAs, the signal to start practising was a supernatural call through prophecy and/or dreams. The only “practical experience” they could lay claim on was what they gained individually through childbirth (almost all were parous, the only nulliparous TBA having been trained by her mother who was a TBA). All of them, however, insisted that they were supernaturally endowed to practise their given profession. This lack of training, in our opinion, is mainly responsible for the ignorance displayed by the TBAs in the study, especially in cases of complicated pregnancy and labour. Another contributory factor is that their practice is steeped in superstition, traditional religion, and suspicion — all of which breed secrecy and preclude open critical appraisal. The high illiteracy rate (67.3% in this study), which militates against record keeping in their practice, further compounds the problem.

Our TBAs, like those from other communities (7, 10), use herbal medications in pregnancy, labour and puerperium. The medicines are mostly made from leaves, roots and/or bark and contain potent medicaments given in unregulated dosages. These usually produce toxic effects which are difficult to manage as antidotes are unknown. Moreover, some herbs are also given to overcome obstructed labour, thus precipitating rupture of the uterus and posing anaesthetic risks when the patient eventually is referred to the hospital. Fundal pressure, also used by 27% of the TBAs to overcome obstructed labour, facilitates rupture of the uterus. Other forms of management included prayers, fasting, and sacrifices. These are usually prescribed when the TBAs are confronted with symptoms and signs they do not

understand and which they attribute to "evil forces", "attacks by wicked people", and/or infidelity; these all serve to waste valuable time during which the patient could have been referred to the hospital. Moreover, prolonged fasting is dangerous to the mother and the fetus. Another alarming feature, given that antepartum and postpartum haemorrhage are major causes of maternal mortality, is the ignorance about haemorrhage and the first-choice interventions chosen by the group of TBAs. Again, valuable time is wasted before transferring the mother to hospital.

The reality is, however, that TBAs continue to attract a large clientele because they live within and are easily accepted as part of the culture and tradition of their local communities. Such TBAs are familiar to their clients and easily accessible at any time of the day or night; do not insist on payment before delivery; and are prepared to accept payment in kind anytime after the delivery. Even when and where modern, trained care providers are available, many women prefer traditional care at delivery for economic and sociocultural reasons (2, 8-10). The only way of providing good maternity care to the clients of TBAs, now and in the near future, is to study their practice and thereafter design appropriate training programmes which will improve their standard of practice. Specifically, the aim should be to enlighten them on the early recognition of high-risk indicators in pregnancy, childbirth, and puerperium and encourage prompt referral to appropriate centres. Fortunately our TBAs, probably in recognition of their handicaps, have accepted the need to be properly trained and are also willing to submit themselves to regular monitoring and supervision; this was borne out during the 2 years during which the safe motherhood campaign was conducted. Over this period the TBAs cooperated maximally with us and usually accompanied their referrals to the hospital. It was thus easy to trace TBAs responsible for any neglected or mismanaged labour cases and who invariably accepted corrections. Our experience agrees with that of Brennan (1) and Matthews et al. (5), who have reported marked reduction in maternal mortality and morbidity following TBA training.

In conclusion, as a result of the study, the obstetricians and midwives in the area became familiar with TBA practices. Also, we have designed a follow-up educational programme to address the TBAs' deficiencies, with the ultimate aim of lowering the maternal and neonatal mortality and morbidity rates in the study area. We also have identified a need to register, re-train and monitor all practising TBAs if their harmful practices are to be changed; the TBAs in our study have accepted this. Reluctance to integrate TBAs into the health care system

lies with obstetricians and trained midwives who tend to view them as competitors and refuse to cooperate with them rather than offering leadership for the sake of maternal and infant health.

---

## Acknowledgements

Prof. Kay Mathews is thanked for her invaluable assistance in the preparation of this paper. Appreciation goes also to the members of the Safe Motherhood team, and especially to the interviewers.

This study was funded by the Ford Foundation, USA (grant no. 890-0987: Partial Support for a Reproductive and Maternal Health Programme in South-Eastern Nigeria).

---

## Résumé

### Caractéristiques des accoucheuses traditionnelles et croyances et pratiques de celles-ci dans le clan Offot, au Nigéria

Le présent article donne les résultats d'une enquête effectuée sur un groupe de 52 accoucheuses traditionnelles dans un clan du sud-est du Nigéria. L'étude avait pour but de mettre en place une base de données permettant de concevoir, à l'intention des accoucheuses traditionnelles, un programme efficace portant sur l'accouchement dans de bonnes conditions de sécurité et l'orientation rapide des femmes présentant des complications vers l'hôpital. L'étude a montré que la majorité des accoucheuses traditionnelles étaient analphabètes et n'avaient aucune expérience ou formation préalables, même informelles, lorsqu'elles décidaient d'assumer le rôle d'accoucheuse traditionnelle. L'ignorance pour ce qui était des complications maternelles durant l'accouchement et les traitements appropriés était patente pour la majeure partie du groupe. Un petit nombre d'entre elles s'appuyaient uniquement sur la révélation divine pour la prise en charge des parturientes. Les résultats de l'enquête ont clairement montré que les programmes éducatifs conçus à l'intention des accoucheuses traditionnelles et une meilleure intégration dans le système de soins de santé sont indispensables pour abaisser les taux de mortalité et de morbidité maternelles dans les régions où la plupart des mères n'ont pas l'intention de faire appel à des soins professionnels lors de leur accouchement ou n'ont pas accès à ceux-ci.

---

## References

1. Brennan M. Training traditional birth attendants. *Post-graduate doctor*, 1989, 11: 16.

2. *Primary health care: Report of the International Conference on Primary Health Care, Alma-Ata 1978*. Geneva, World Health Organization, 1978: 63 (Health for All Series No. 1).
3. **Amin R, Khan AH**. Characteristics of traditional midwives and their beliefs and practices in rural Bangladesh. *International journal of gynaecology and obstetrics*, 1989, **28**: 119–125.
4. **Itina SM**. Maternal mortality in St. Luke's Hospital, Anna-Uyo: a five-year review. *Medlink*, 1990, **1**: 4–22.
5. **Matthews MK et al**. Training traditional birth attendants in Nigeria: the pictorial method. *World health forum*, 1995, **16**: 409–414.
6. **Egulion C**. Training traditional midwives in Manica and Zimbabwe. *International journal of gynaecology and obstetrics*, 1985, **23**: 287.
7. **Leedam E**. Traditional birth attendants. *International journal of gynaecology and obstetrics*, 1985, **23**: 245.
8. **Mutambirwa J**. Pregnancy, childbirth, mother and child care among the indigenous people of Zimbabwe. *International journal of gynaecology and obstetrics*, 1985, **23**: 275–285.
9. Traditional midwives and family planning. *Population Reports*, 1980, Series I, No. 22.
10. Mothers' lives matter: maternal health in the community. *Population Reports*, 1988, Series L, No. 7.