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Unilateral collaboration: The practices and understandings of traditional birth attendants in southeastern Nigeria

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ABSTRACT

Background: Despite the promotion of hospital-based maternity care as the safest option, for less developed countries, many women particularly those in the rural areas continue to patronise indigenous midwives or traditional birth attendants. Little is known about traditional birth attendants' perspectives regarding their pregnancy and birth practices.
Aim: To explore traditional birth attendants' discourses of their pregnancy and birthing practices in southeast Nigeria.
Method: Hermeneutic phenomenology guided by poststructural feminism was the methodological approach. Individual face to face semi-structured interviews were conducted with five traditional birth attendants following consent.
Findings: Participants' narratives of their pregnancy and birth practices are organised into two main themes namely: 'knowing differently,' and 'making a difference.' Their responses demonstrate evidence of expertise in sustaining normal birth, safe practice including hygiene, identifying deviation from the normal, willingness to refer women to hospital when required, and appropriate use of both traditional and western medicines. Inexpensive, culturally sensitive, and compassionate care were the attributes that differentiate traditional birth attendants' services from hospital-based maternity care.
Conclusion: The participants provided a counter-narrative to the official position in Nigeria about the space they occupy. They responded in ways that depict them as committed champions of normal birth with ability to offer comprehensive care in accordance with the individual needs of women, and respect for cultural norms. Professional midwives are therefore challenged to review their ways of practice. Emphasis should be placed on what formal healthcare providers and traditional birth attendants can learn from each other.

Statement of significance:

Problem or issue

Little is known about traditional birth attendants' perception of their pregnancy and birth practices.

What is already known

Historically, women gave birth under the watchful care of indigenous midwives. Birthing in the presence of a skilled birth attendant is universally acknowledged as vital in improving birth outcomes. Many women in low-income countries continue to utilise the services of traditional birth attendants.

What this paper adds

Traditional birth attendants are champions of normal birth. Pregnancy and birth can be safe outside conventional maternity setting.

1. Introduction

Pregnancy and birth practices are shaped by socio-cultural values. Historically, women in Nigeria, as in many other countries, gave birth under the watchful care of indigenous midwives, most commonly designated as the traditional birth attendants (TBAs),

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while other women did so under the care of close female relatives.[1,2] A TBA as defined by the World Health Organization (WHO)[3] is a person who assists the mother during childbirth and who initially acquired her skills by conducting birth herself or through an apprenticeship to other TBAs. Birthing in the presence of a skilled birth attendant is universally acknowledged as vital in improving birth outcomes.[4–6] It was also recognised as one of the key strategies for achieving Millennium Development Goal 5 (MDG-5) which has been replaced by target 3.1 of Sustainable Development Goal 3 (SDG-3) post 2015.[7]

Nigeria, Africa's most populous country, has a plural healthcare system similar to other African countries, and as such diversified healthcare seeking options are used in the country, the two most popular being the modern (conventional) and traditional (indigenous) health systems. A dichotomy exists between the dominant state-backed conventional maternity care and indigenous practices around pregnancy and birth. However, many Nigerian women,[8–10] as in other low-income countries,[11–14] continue to birth their babies under the care of TBAs. The reasons given by women for their preference of TBAs' care include: accessibility, affordability,[9,10,15] provision of compassionate, and culturally competent and acceptable care.[8,10,16] These reasons were also reported by the TBAs in Kenya[12] as to why women prefer their services. It is not uncommon for individuals to use both systems simultaneously according to their health needs. That said, the traditional healthcare system is often the most accessible and affordable for people in rural parts of the country because most modern healthcare facilities are located in the urban areas.

Despite its oil wealth, Nigeria with only 2.5% of the world population, records one of the highest maternal mortality (MM) worldwide accounting for 19% of the world's maternal deaths. It is estimated that 58,000 Nigerian women died in 2015 due to pregnancy-related complications.[17] In 2013, the national demographic and health survey (NDHS) revealed that while 61% of women received antenatal care (ANC) from a formally trained skilled healthcare provider during pregnancy, only 38% gave birth in the presence of a skilled birth attendant.[18] The figures were 58% (ANC) with 39% of births assisted by a skilled birth attendant (formally trained) in 2008. Thus there is a slight 1% fall in the number of women who gave birth in the presence of a formally trained skilled birth attendant in 2013 from its 2008 figure. This suggests that informal maternity care remains popular in Nigeria, even though the country's official policies promote the use of modern/formal health facility.[8–10,15,16,19]

The TBAs in Nigeria are independent practitioners, well known and accepted in their communities because of their knowledge of the culture and tradition of the local people.[8,20] Some of the present day TBAs in Nigeria acquired their knowledge through apprenticeship in government-approved hospitals, while many acquired their skills through observation of other TBAs, while others gained practice experience through their own childbirth.[21] Most of them have private practices, commonly known as 'maternity homes', situated in the local communities where they live, separate to government-own primary health centres or hospitals. In some cases, TBAs are called upon to assist women during home birth. Their work extends beyond caring for pregnant and birthing women.[21]

Though they remain the backbone of maternal healthcare, particularly in rural areas, TBAs are often blamed for the high rates of poor maternal outcomes among women in Nigeria.[9,19] Conscious of the controversy surrounding their practices, more so because of the tension between them and the formal healthcare practitioners, the TBAs do their work under intense pressure. Worth noting is that most of the recent literature about the TBAs and their practices in Nigeria are mainly other peoples' perspectives, primarily women's accounts of their reasons for seeking pregnancy and childbirth care from TBAs.[2,9,15,16,19] There are few published papers that address what TBAs say about their knowledge and practices.[8,9,12] This paper attempts to close this gap by giving a space for the TBAs' discourses of their practices and knowledges around pregnancy and birth, and by extension un/safe motherhood in the context of southeast Nigeria.

2. Method

The paper is drawn from a study which explored the concept of safe motherhood as experienced and understood by women, midwives and TBAs in southeastern part of Nigeria. The exact number of TBAs practicing in Nigeria is not known. Ofili and Okojie[23] reported that only 16% of TBAs are registered with the local government in Edo state south-west of the country. Given that little is known about the TBAs' perspectives of their pregnancy and birthing practice and by extension un/safe motherhood, we employed a hermeneutic phenomenological approach,[24] guided by poststructural feminism.[25] Hermeneutic phenomenology is useful when exploring human experiences and understanding/knowledge of a phenomenon. In this study, the principle tenets of poststructural feminism facilitated close attention not only to the TBAs' articulation of their understanding and experiences but also to their perception of the power issues that characterised or influenced their practices.

2.1. Participants and data collection

The TBAs who took part in this study were recruited from a rural community in one of the Local Government Areas located in southeast Nigeria. All the five TBAs approached for the study agreed to take part in the study. They acquired their knowledge through two to three years of an apprenticeship style of training. While three of the TBAs obtained their training in a formal private healthcare facility, two learned the practice of care under other TBAs. As such they do not all fit the WHOs' definition of TBAs but for the purpose of clarity we have used the term TBAs in this study. Four of the five TBAs completed secondary education while one explained that she did not complete secondary school due to financial constraints. Their experience of independent practice ranges between four and sixteen years.

Data collection which was through semi-structured interviews took place in December 2012–January 2013. The interviews lasted approximate 30–60 min and were conducted primarily in Igbo language and later transcribed directly to English language using the ecological method of translation which places emphasis on the language context.[26] The interviews took place outside the TBA's maternity (birthing) homes so that they would feel reassured that the purpose was not to scrutinise their practice. Open-ended questions were used to elicit their pregnancy and birthing practices, the measures they take to prevent complications of pregnancy, and the actions they take if any woman under their care develops complications. After each interview, key points made by the TBA were reiterated for clarification. Interestingly all the TBAs shared their experiences with a sense of confidence and passion, facilitated by the openness and disposition of the interviewer. TBAs' narratives of their pregnancy and birth practices, and knowledges provided insight into their understanding of safe motherhood.

2.2. Data analysis

The interviews and transcription/translation were done by the lead author who is a Nigerian native and speaks the Igbo language fluently so that no translator was needed. The transcripts were thematically analysed using the process of the hermeneutic circle