



Full Length Research Article

**AWARENESS OF THE EFFECT OF TRADITIONAL BIRTH ATTENDANCE AMONG WOMEN
OF CHILD BEARING AGE**

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ARTICLE INFO

Article History:

Received 21st October, 2015
Received in revised form
19th November, 2015
Accepted 08th December, 2015
Published online 31st January, 2016

Key Words:

Awareness, effect,
Traditional birth attendance,
Women, Childbearing age.

ABSTRACT

The study is awareness of the effect of traditional birth attendance practices among women of child bearing age. The main objective is to know the level of awareness of the effect of traditional birth attendant among women of child bearing age during pregnancy and delivery methods. A starter and purposive method was conducted where women are divided to starters and only women that have attend traditional birth attendant were selected among women of child bearing age to be interviewed. Data was collected using a structure questionnaire by the researcher. Data analysis: 200 respondent that delivered in traditional birth attendant was used. They all known the activities of traditional practices but 50% of respondents live far from health center were only engine boat was the mean for transportation. The main reason of people still patronizing the traditional birth attendant is ignorance lack of funds, transport, natural habit and unsatisfactory maternal health care. Conclusion: the proportion of women delivery at home in okoroma district in Nembe local government is high, thus reflecting an inevitable high maternal mobility and mortality rate. Deliberate imitative focusing on community maternal health education and improving the quality of maternal care in the community are needed.

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INTRODUCTION

Background of the study

Through out history, traditional birth attendance has been the main human resource for women during childbirth. Their roll varies across culture and at different times. However, even today, they attend the majority of deliveries in rural areas of developing countries. Bergsfrom, (2007). About 34% of women in developing countries receive no postpartum care during pregnancy. Almost 50% give birth without skilled attendance and receive postpartum care. Nembe Local Government of Bayelsa State in Nigeria among the developing countries with high maternal mortality. Of all deliveries, only 35% occur in the health facilities, the rest are attended by unskilled traditional birth attendance. Mulanakulya, (2009). The World Health Organization (WHO, 2011), define traditional birth attendant as a person who assist the mother

during child birth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendant. Traditional birth attendant are integrals members of their communities and provide an important window to local customs, traditions and perceptions regarding childbirth and newborn care. Although childbirth is a natural phenomenon, it is associated with risk and unforeseen complication, which may result to death. Traditional birth attendant may only be possible in uncomplicated labour, once there are complications, these mothers need to be referred immediately to a nearby health facilities, very unfortunately when complication arise it is too late or the mother is so weak that she cannot deliver safely. As a result, such mother dies before, during or after delivering or ending up stillbirth. Since it is difficult to predict the complication, which may arise during childbirth

Statement of the problem

Practices of traditional birth attendants have always being a problem in rural areas in developing countries. Traditional birth attendants have being the main human resources in rural

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communities especially in Okoroma District where there is no health facility in most of the communities though there are positive practices of traditional birth attendance but some of their negative practices has caused haemorrhage, obstructed labour, sepsis, eclampsia, puerperal infection etc. therefore, the aim of this study is to know the level of awareness of the effect of traditional birth attendant among women of childbearing age.

Purpose of the study

Objectives

- To determine the level of awareness of the negative practices of traditional birth attendant in pregnant women of Nembe Local Government Area.
- To determine the level of awareness of the positive practices of traditional birth attendant in pregnant women in Nembe Local Government Area.
- To determine the level of awareness of positive practices of traditional birth attendant during delivery in Nembe Local Government Area
- To determine the level of awareness of negative practices of traditional birth attendant during delivery in Nembe Local Government Area

Significant of the study

This research work will serve as baseline information to the researcher those harmful practices of traditional birth attendant that affects health.

It will also educate the women of child bearing age to safe guard their life from being a victim of these practices. It would also help to find out how best health education programmes could be developed to stop this practice at Nembe.

Research Questions

- What are the negative practices of traditional birth attendant that can affect pregnant women in Nembe Local Government Area?
- What are the positive practices of traditional birth attendant that can affect pregnant women in Nembe Local Government Area?
- What are the negative practices of traditional birth attendants that can affect the women of childbearing age during delivery?
- What are the positive practices of traditional birth attendant that can affect the women of childbearing age during delivery?

Delimitation

This study was focused on the level of awareness of the effect of traditional birth attendant practices among women of childbearing age.

Limitation

The main limitations have been time and money. The academic calendar did not allow much time for frequent visits and wider coverage of the Area. The respondents homes had to be searched for, for research team had problems gaining some respondents co-operation to assist in the data collection.

Chapter Two

Literature Review

Overview of traditional birth attendants

Traditional birth attendants were known to almost 90% of the community, 65% of respondent (women of child bearing age) had once delivered at home where 62% were assisted by traditional birth attendant Muanakulya, (2009). World Health Organization (WHO, 2011), define traditional birth attendant as a person who assist the mother during child birth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants. Traditional birth attendants are integral members of their community and provide an important window to local customer, Traditions and perception, regarding childbirth. Historically, traditional birth attendant have operate outside of the formal health care delivery structure.

Traditional birth attendant training has been used as a mean if extending health services to under serves communities in developing countries.⁴ United Nation Population Fund (2011). The traditional birth attendant role in the community should not be over looked; they are highly respected members and proven assets in addressing poor material out comes. Traditional birth attendant have been unsuccessful in handling obstetric complication but have contributed material neonatal and child health intervention. The key piece missing in traditional birth attendants training is an adequate referral system, which allows traditional birth attendant to use their close ties with the community to link pregnant women to skilled birth attendant's referrals to health care systems ability to support an increase in services provided and the supervision needed to support traditional birth attendant integration WHO, (2006).

Traditional Practices

Nancy A (2003) Throughout human history society has had particular perceptions of health and disease root in their own culture, which led to a plurality of practices for disease prevention, cure, pregnancy and delivery. It has found many traditional beliefs and practices prevalent in all the study communities. Examples are prolonged labour related to infidelity of husband during pregnancy. Trust on traditional medicine taken orally, rubbed over the abdomen, early marriage and dowry, female genital mutilation, food taboos during pregnancy, harmful traditional management of delivery complications, beliefs about with holding of colostrums, harmful traditional treatment of maternal and child illness, manipulation of birth carnal etc. on the other hand there are also traditional practices found in these communities that are positive and should be recognized and promoted, for example women benefit from warm and nutritious fluid administered during labour. It was founds that traditional practitioners have a vital role in these communities. They have been providing health care to community for generations and will continue to do so for the foreseeable future. Despite some harmful practices, traditional practitioners are important resources of health status. Traditional belief and attitude influence women's health seeking behavior. Even when women have access to appropriate facility bases care, they still

often prepare home / community based care. Women's reasons for non-utilization of health services include beliefs that antenatal care is not necessary for health women and superstitious about hospital delivery being unlucky for primigravides. Also superstitious about berried property leads to infertility and accessibility to maternal health services. (WHO 2004).

Harmful practices

Harmful traditional practices prevalent in that communities studied are harmful tradition management of delivery complication, early marriage and dowry, trust in traditional medicine taken orally, rubbed over abdomen, female genital mutilation, cutting of the uvula, education etc.

Female genital mutilation

Park (2007), it has been among these communities that female genital mutilation otherwise known as female circumcision is a universal practice among all the ethnic and religious groups found in the communities. The age at which mutilation is carried out varies from area to area. It is performed on infant as young as a few days old, on children 7-10yrs on adolescents. Adult women also undergo the operation at the time of marriage and immediately the delivery of the first baby. Genital mutilations are of 4 types. They are circumcision, excision or clitoripectomy, infibulations and unclassified. Hosken (1997).

Circumcision: This involves the removal of the prepuce and the tip of clitoris. This is the only operation, which mechanically can be likened to male circumcision.

Excision or Clitoridectomy: Price (2005) this involves the clitoris, and often the labiaminora; it is the most common operation and is practiced throughout Africa, Asia, the Middle East and the Arabian Peninsula.

Infibulations or pharaonic Circumcision: Gebreselassie, (1985) this is the most severe operation, involving excision plus the removal of the labiamajora and the sealing of the twosides, through stitching or natural fusion of scar tissue. What are left are a very smooth surface, and a small opening to permit urination and the passing of menstrual blood. The unclassified is another form of mutilation, which has been reported, is introcision, practiced specially by the pitter-patter aborigines or Australia.

Management of delivery complication

Management of complicated delivery is one of the things that make our people to deliver the home and sometimes cause maternal mortality. Traditional birth attendants are supposed to deliver only uncomplicated labours and are to refer immediately there is complication. Early pregnancy, nutritional taboos and practices related to child delivery: Early pregnancy can have harmful cause quenches for both young mothers and their babies. According to UNICEF (2002), no girl should become pregnant before the age of 18 because she is not yet physically ready to bear children. Babies of mothers younger than 18yrs tend to be born premature and have low baby weight, such babies are more likely to die in the first year of life. The risk of the young mothers own health is also

greater. Poor health is common among indigent and lactating women. In many parts of the developing world, especially in the rural area, girls marry shortly after puberty and are expected to start having children immediately. Although the situation has improved since the early 1980's in many areas the majority of girls under 20yrs of age are already married and having children. Although many countries have raised the legal for marriage, this has had little impact to traditional societies where marriage and child bearing "confer" on a woman.

Nutritional Taboos

Generally, throughout the developing world, the average food intake of pregnant and lactating mother's is far below that of the average male. Culturally practice, including nutritional taboos, ensures that pregnant women are deprived of essential nutriment, and as a result, they tend to suffer from iron and protein deficiencies. The reasons for such taboos are many, but all are steeped in superstition: man taboos are upheld because it is believed, that the consumption of a particular animal, plant or fish will bring harm to the individual or child.

Effect of the harmful practices

Three quarters of maternal death in developing countries are attributable to direct obstetric cause such as post partum haemorrhage, post partum sepsis, eclampsia, obstructed labour and complication of unsafe abortion WHO (1996).

Post partum haemorrhage

Postpartum haemorrhage is bleeding from the genital tract during (ante partum) and after (postpartum) delivery. Although in developing countries antepartum haemorrhage is no longer a major cause of maternal mortality, it is still an important cause of maternal and parental morbidity. In contrast, postpartum haemorrhage continues to be a major cause of maternal death both in the developing as well as in the developed world WHO (2004).

Sepsis

Puerperal sepsis was a common pregnancy related condition, which could eventually lead to obstetric shock or even death. With the introduction of antibiotic, puerperal fever declined further in developed countries. Puerperal sepsis is nonetheless still prevalent in developing countries and continues to pose a significant risk of obstetric morbidity and mortality Goodman (1995). Puerperal infection is a general term used to describe any infection of the genital tract after delivery. Because most pyrexia in the puerperal is caused by pyrexia infection. The incidence of the fever after child birth may be a reliable index of their incidence, though fever may also be associated with other infection related to child birth such as mastitis. In the absence of antibiotic treatment or in more severe cases, puerperal infection may be complicated by pelvic chronic pain, pelvic inflammatory disease, bilateral tubal occlusion and infertility. Estimating the incidence of sepsis around the world is fraught with difficulty because the aetiology and epidemiology of sepsis vary enormously as a result of local conditions in particular with regard to hygiene during delivery but also as a

function of roles if reproductive tract infection, including sexually transmitted infections

Eclampsia

Hypertensive disorders of pregnancy (HDP) represent a group of condition associated with high blood pressure during pregnancy. Proteinuria and in some cases convulsion. The most serious consequences for the mother and baby result from pre-eclampsia and eclampsia. Eclampsia is usually a consequence of pre-eclampsia consisting of central nervous system seizures which often leave the patient unconscious, if untreated, it may lead to death. Formulating estimates of the global incidence of pre-eclampsia and eclampsia is difficult because of heterogeneity in definitions problems related to the measurement of blood pressure in pregnant women and the validity of ordinary protein measurement in diagnosis of pre-eclampsia WHO (2004)

Abortion

The term covers a variety of condition arising during early pregnancy from ectopic pregnancy and hydatiform mole, through to spontaneous and induced abortion. There are important differences in the dimensions and nature of death disabilities resulting from different kinds of abortion. The overwhelming majority of deaths and disabilities caused by pregnancies with abortion outcome arise from the complication of unsafe abortion defined as an abortion taking place with a health facility (or other place recognized by law) and (or provided by unskilled traditional birth attendant) person WHO (2004; 1993). Unsafe abortion may lead to haemorrhage, infection and death, particularly in settings where there is poor access to hospital and medical care. When infection spreads upwards through the genital tract, causing damage to the fallopian tube and ovaries, the pelvic inflammation disease will develop. The condition causes pain and discomfort and if left untreated, can result in chronic pelvic pain, bilateral tubal occlusion, (due to adhesions and scars formed around the uterus) and some secondary infertility. Secondary infertility is defined as failure to conceive again after an established pregnancy. Goodman; (1995).

Obstructed labour

Labour is considered obstructed when the presenting part of the fetus cannot progress into the birth canal, despite strong uterine contraction. The most frequent cause of obstructed labour is cephalopelvic disproportion. A mismatch between the fetal head and the mother's pelvic brim, such as the fetus may be large in relation to the maternal pelvic brim, such as the fetus of a diabetic woman, or the pelvis may be contracted, which is more common when malnutrition is prevalent. Other causes of obstructed labour may be malpresentation, normal position of the fetus (shoulder, brow or occipito-posterior position). In rare cases, locked twins or pelvic tumors can cause obstruction. Identifying these problems and referred to on time saves life but when these obstructed causes are neglected, both mother and unborn child is at high risk. The obstruction can only be alleviated by means of an operative delivery or other instrumental delivery (forceps, vacuum extraction or sym-

physiotomy). It is however, accepted that if obstruction cannot be overcome by manipulation immediate referral is needed especially in rural areas where health facilities are not available because caesarian section is needed based on extensive literature review and expert consensus, we estimate that obstructed labour occurs in around 4.6% of live births giving a total number of cases of obstructed labour of over 6 million. Over 40,000 women die following neglected obstructed labour and some 73,000 suffer the most serious debilitating non-fatal death outcome.

Plan of action for the elimination of harmful traditional practices

Knowing that the level of maternal mortality and neonatal mortality are unacceptably high, a key factor is care at delivery 65% of births taken place at home and 61% are attended by someone other than a skilled birth attendant. The leading cause of maternal death are postpartum haemorrhage, puerperal sepsis etc. for neonatal mortality, the leading cause are asphyxia, sepsis and prematurity substantially reduced by better home care or more prompt referral to hospital. Miller; (2012). Community outreach programs should be strengthened to serve communities, which are located far from health facilities. Many women have very limited access to health agents (CHEWS) or health workers during outreach programs and home visits. A thorough investigation should be carried out to document both beneficial and harmful practices, which can serve as a basis for training and health education. To raise community awareness of maternal and child health issues, specified traditional beliefs and practices have to be targeted and culturally appropriate material that deal comprehensively with the consequences of such practices and that present alternative options have to be prepared. For example: a food to be taken during pregnancy and location could be developed, Goodburn (2007).

MATERIALS AND METHODS

Research Design

The study design was a descriptive design

Area of study / promotion

The study area was Okoroma /Tereke in Nembe Local Government Area of Bayelsa State. Okoroma/Tereke is a district in Nembe Local Government with 20 communities. The population of study is all women of childbearing age that have had a traditional birth attendant for the past 5 years in these communities.

Sample /sampling technique

The technique was started and purposive where a community was divided into strata and the women that have attended traditional birth attendant for the past 5 years was selected. Sample size, 200 women of childbearing age was used in 10 communities of Okoroma district in Nembe Local Government Area.

Instrument for data collection

The instrument that was used is a structured questionnaire and schedule

Validity of Instrument

Copies of questionnaire were submitted to the project supervisor for vetting.

Procedure for data collection

Questionnaire were administered to the subjects before administration of questionnaire. The objective of the study was explained to the subject so as to remove fear and resistance. And to those that are illiterates a schedule was used.

Tool for data analysis

The tools used were a simple table and percentage.

Data Analysis

The table below shows the demographic characteristics of respondent were a total of 200 women participated in this study. 15(7.5%) were in the age of 15-19 years, 42(21%) in the age of 20-24 years, 50(25%) in the age of 25-29 years, 35(17.5%) were in the age of 30-34 year, 30(15%) were in the age of 35-39 years, 18(9%) in the age of 40-44 years and 10(5%) were in the age of 45-49. 110(55%) were illiterate and 90(45%) were literate. 40(20%) civil servant, 40(20%) traders, 5(2.5%) farmers and 7(3.5%) fishermen.

Demography characteristics of respondent

Age range	Frequency	Percentage
15-19	15	7.5%
20-24	42	21%
25-29	50	25%
30-34	35	17.5%
35-39	30	15%
40-44	18	9%
45-49	10	5%
TOTAL	200	100%

Occupation	Frequency	Percentage
Civil servant	40	20%
Trader	40	20%
Farmer	50	25%
Fisherman	70	35%
TOTAL	200	100%

Educational Background	Frequency	Percentage
Literate	90	45%
Illiterate	110	55%
TOTAL	200	100%

The table below shows the communities involved in the study and how far and near they are to the health facility. Owokiri community involve 20/10% women and is near to health center, OLogoama community involves 30/15% women near a health center, Ewoma community involves 25/12.5% women near health center, Eminahama community involves 10/5% women far from health center, Ekperiamacommunity involves 20/10% women near health center, Akakumama community involves 25/12.5% woman far from health center, AlagaoTereke community involves 10/5% women. This shows that 100% of my respondent are aware of the practices of traditional birth attendant but 77.5% are still using these practices. This is because most villagers are far from the health facilities of 200 respondents related to traditional practices in

pregnancies and deliveries, 75% is still taken traditional medicine by mouth and rub over abdomen during pregnancy while 25% is no longer doing it. 100% uses the form of massaging to know the conditions of the baby. 90% drunk nutritious fluid by mouth during labour while 10% did not because they could not take anything by mouth when in labour even though it is good. 80% still use traditional medicine by mouth to induce labour while 20% of respondent is no longer taking it again. 80% still apply pressure in abdomen to induce contraction feeling that, though they said is not good for her health but without is she cannot delivery while 20% is not using it again, 60% of respondent still believe in manipulation of birth canal for fear of under going operation while 40% did not do it again. 95% no longer delivery on bear floor while 10% still do it out of ignorant. 70% no longer beg husband during prolong labour while 30% still did it out of fear., 30% no longer induce vomiting to expel placenta but 7% still do it.

Relationship between level of awareness & usage of traditional practices

Traditional Practices	Negative Respondent	Positive Respondent	Percentage
Traditional Practices During pregnancies And deliveries	30	170	15%-85%
Rust on traditional Medicine taken by Mouth rub over Abdomen during pregnancy	50	150	25-75%
Massage and Knowing Condition of baby		200	100%
Drinking of Nutritious fluid by Mouth during Labour	20	180	10%-90%
Trust of taking Traditional Medicine by	40	160	20%-80%

Month to induce labour	Negative Respondent	Positive Respondent	Percentage
Applying pressure on Abdomen to induce Contraction during Canal	40	160	29%-80%
Manipulation of birth Canal	80	120	40%-60%
To deliver on bear floor	10	10	95%-5%
Begging husband during Long labour	140	60	70%-30%
Continual induction of Vomiting for expulsion Of placenta	60	140	30%-70%

DISCUSSION

Discussion of Findings

Childbirth taking place at home is still common in rural areas as observed in this study. This is because more than half of respondent live in communities where there is no health facilities. And even the rest that live close to where there is health facilities still deliver mostly at traditional birth attendant due to habit of delivering at respectively. This study's finding correlate with the study done by family health international in Tanzania which found that 80% of women live more than 5km from health facility and that walking is the

main means of transport even for pregnant women. The finding also correspond to the study done by Price in Tanzania which found that 84% of women who do so because of distance. And also in agreement with study done in Zambia in (2003), which pointed out people just do not have money to pay transport cost. The finding indicates that, although health facilities are available in some of the rural area, it is still difficult to utilize the services, most likely due to distance and cost of transport. So to avoid such cost and disturbances, women decide to give birth at home. These findings are in agreement with other previous studies done in Kongua district, (2009). Zambia (2003) and other African countries which describes clearly that, over 60% of rural women have strong adherence to traditional practices like drinking of herbs and inserting of stuff in the birth canal. The findings shows that ignorance is skill a problem of most pregnant women and emphasis should be directed towards community based maternal health education.

Recommendation

- Community health education should continue to focus on discouraging some of the non-beneficial traditional practices and promote modern evidence based practices.
- Practices traditional birth attendant should be trained for a appropriate care and referral so as to reduce the effect of their practices on women of child bearing age.
- Health facilities should be a functional unit for maternal health care, equipped with skilled and motivated staffs, essential drugs and supplies to provide basic and comprehensive obstetric care.
- First aid drugs should be provided by government to the traditional birth attendants and train them on how to use these drugs.
- These should be a study to find out those that have fall victim of the effect of traditional practices.

Government should train VHW/ traditional birth attendants in all community to be able to plant a mobile clinics in all communities so as to reduce maternal morbidity and mortality rate.

Limitation

The limitation encountered during this research include financial constraint, time constraint, difficulty in transportation to go round the villages, difficulty in gathering the women to pay attention to you in all issue, and difficulty in gathering information from books, journal and internet source, suggestions.

Conclusion

It has been understood that 100% of my respondent are aware of the practices of traditional birth attendants and the effect but still continue mainly on it because of their so much believes on tradition. Secondly, the cost of transportation from where they live to the health center other reasons is that it has becomes their habit delivery and some are not satisfied with the health services around or near.

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