Training Workshop for Traditional Birth Attendants at Aliero, Kebbi State, Nigeria; A Community Development Service at Aliero, Kebbi State, Nigeria

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Citation

Y Buowari. *Training Workshop for Traditional Birth Attendants at Aliero, Kebbi State, Nigeria; A Community Development Service at Aliero, Kebbi State, Nigeria*. The Internet Journal of Tropical Medicine. 2010 Volume 7 Number 2.

Abstract

A significant proportion of births in Nigeria still occur in the homes of traditional birth attendants (TBA) [1]. Recent studies have revealed many complicated cases of obstructed labour from TBAs. TBAs are popular in developing countries. They lack formal education or medical training and some of their clients end up with obstetric complications, which may lead to severe maternal and perinatal morbidity and mortality. Women in the developing world are forty times more likely to die from pregnancy related complications than women living in the industrial world. More than 90% of maternal deaths occur in low income countries where others factors may contribute to the presence of severe postpartum haemorrhage. Most deliveries in Nigeria still occur in the homes of traditional birth attendants. Increased community awareness, promotion of appropriate technology, effective health care, planning starting from the grassroots levels to tertiary levels establishment of a streamlined and effective referral system will help reduce maternal mortality from obstetric emergencies reducing maternal morbidity and mortality are among the key international development goals.

INTRODUCTION

A significant proportion of births in Nigeria still occur in the homes of traditional birth attendants (TBA)[1]. Recent studies have revealed many complicated cases of obstructed labour from TBAs. TBAs are popular in developing countries. They lack formal education or medical training and some of their clients end up with obstetric complications, which may lead to severe maternal and perinatal morbidity and mortality. Women in the developing world are forty times more likely to die from pregnancy related complications than women living in the industrial world. More than 90% of maternal deaths occur in low income countries where others factors may contribute to the presence of severe postpartum haemorrhage. Most deliveries in Nigeria still occur in the homes of traditional birth attendants. Increased community awareness, promotion of appropriate technology, effective health care, planning starting from the grassroots levels to tertiary levels establishment of a streamlined and effective referral system will help reduce maternal mortality from obstetric emergencies reducing maternal morbidity and mortality are among the key international development goals.

A TBA also known as traditional midwife (TM) is a primary pregnancy childbirth care provider[2]. TBAs provide the majority of primary maternity care in developing countries and may function within specific communities in developed countries. They usually learn their trade through apprenticeship, although some may be wholly self-taught. They are not certified or licensed. The focus of their work is usually assisting women during childbirth delivery and in the immediate postpartum period.

There are an estimated 4 million neonatal deaths and 500,000 maternal deaths worldwide each year[3]. The vast majority of these deaths occur in developing countries where 43% of births are attended to by TBAs, the proportion generally being higher in rural areas with the most of these deliveries taking place at home[4,5]. TBAs are present at most home deliveries and training will avoid harmful delivery and postnatal practices. TBAs can be trained to recognize complications in the mother and newborn and make appropriate referrals, A major factor contributing to perinatal mortality arises from poor cord care[6,7,8]. Improvement in cord care practices will improve pregnancy outcome. Some of the practices of TBAs are harmful and contributes significantly to maternal and perinatal morbidity and mortality if untrained.

Rural dwellers prefer to use the services of TBAs as compared to their urban counterparts. Reasons for the preference include TBAs availability, accessibility, cheap services, and rural dwellers faith in the efficacy of their services[9]. Moreover, the fear of hospital (caesarean section), family with them, nearness to their locality and low charges. Inspite of the high patronage of TBAs, many of their practices during childbirth have been found to adversely affect the health of the mother[10]. There is need for improvement through a more holistic training programme including monitoring and supervision. Health education and other strategies aimed at changing the attitude of our TBAs towards utilization of sterile procedures, immunization services, and prompt referral of complicated obstetric cases to where modern health care facilities exist are recommended[11].

TBAs in many regions of the world have been trained in midwifery and basic hygiene as part of a safe motherhood initiative aimed at reducing maternal mortality[12]. TBAs speak the local languages, allow traditional birthing practices, and often have the trust and respect of the community[12, 13, 14]. Trained TBAs are more knowledgeable on danger signs during pregnancy and child health and are more likely to refer women with complications to a health facility compared to untrained TBAs[15]. TBAs should be trained on early identification of mothers with obstetrical complications on their prompt referral to health facilities that can provide emergency obstetrical care. Most TBAs are illiterate and this may be a major constraint in training them to provide high quality of care[16]. Continuing education and supervision of attendants are vital and should include training about infection control.

There are still many countries where a large proportion of the population does not have access to health services therefore relying on TBAs to meet their healthcare needs. In these countries, TBAs who have been trained cam contribute to improving maternal and child health as they offer the only means by which women in rural communities have access to a clean delivery. The existence of TBAs is as old as humanity. TBAs have no record keeping. They gain the confidence of the families where they live and work. Trained TBAs posses a higher knowledge of immunization, sterile techniques for cord cutting and dressing of the stump of umbilical cord than the untrained group. They cannot be removed no matter how badly disliked.

WORKSHOP AREA

General hospital Aliero is located in Kebbi State, northern of Nigeria. At the time of the workshop, General Hospital Aliero is located in Aliero, which is the capital of Aliero Local Government Area.

MOBILIZATION OF THE TBAS

This one-day training workshop for TBAs took place at Aliero in Aliero Local Government Area of Kebbi State, Nigeria. It was carried out as a community development service, which was sponsored by the Aliero Local Government of Kebbi State, Nigeria. The venue of the workshop was General Hospital, Aliero. A trained midwife who works in the community mobilized the TBAs. The facilitator was not fluent in the local dialect which is Hausa hence a midwife voluntered to be an interpreter during the programme. This training workshop was conducted in 2006 during my national youth service corps. National youth service corps is programme in Nigeria where graduates in Nigeria are posted out of there place of abode to other states to serve there fatherland for one year.

OBJECTIVE OF THE WORKSHOP

The objectives of the workshop are to update and improve the knowledge and skills of TBAs, to strengthen effective and efficient delivery system, to introduce the holistic approach to maternal and child health care delivery and to promote the concept of improving maternal and child health through support to both household and communities and to reduce maternal and perinatal morbidity and mortality.

TRAINING

The workshop dealt on three major aspects of delivery namely hygiene, umbilical cord care, and referral to a health facility.

HYGIENE: Wherever labour and delivery are managed, cleanliness is the first and foremost requirement. Nails must be short as well as clean and hands must be carefully washed with soap and water. Attention should be paid to the personal hygiene of labouring women and TBAs. As well as to the cleanliness of the environment and all materials used during birth. Positive effect of three cleans – hands, perineal area, and umbilical area. The TBAs must make sure that there is clean water at hand. There is need for careful hand washing – clean hands, clean delivery surface, clean cord cutting and care prevents puerperal sepsis (infection after delivery). Some measures should be taken during all

deliveries to prevent possible infection of the woman and / or the TBAs. These measures include the avoidance of direct blood /direct contact with blood and other body fluids by the use of gloves during vaginal examination, during delivery of the infant and handling the placenta. Surgical gloves are latex gloves there are sizes to fit the hand. Sterile surgical gloves should be worn for each vagina examination.

UMBILICAL CORD CARE: Minimal handling of the umbilical cord should be done. The cord if not handled properly, can be the portal of entry of bacteria and other infective organisms. Therefore, ensure good cord care: Cut with clean new freshly opened razor blade, tie tightly to avoid bleeding. Ensure that the tie is sterile and keep clean and dry until it falls off.

REFERRAL TO A HEALTH FACILITY: TBAs should refer a woman to a higher level of care if complications arise which requires interventions, which are beyond the competence of the TBAs. Appropirate pregnancy management can prevent many obstetric complications[17, 18]. Some cases requiring referral to a health facility are prolonged labour, prolonged second stage of labour, retained placenta, cord presentation, cord prolapse, antepartum, and postpartum haemorrhage, scarred uterus such as a woman with previous caesarean section or previous myomectomy, eclampsia and obstructed labour[16, 18].

Prolonged Labour: Prolonged labour is active labour with regular uterine contractions and progressive cervical dilatation for more than twelve hours. Refer urgently all women with prolonged labour having severe abdominal pain or weakness to the hospital as they may have ruptured uterus. A labouring woman should not be labouring from sunrise to sunset.

Prolonged Second Stage of Labour: This occurs if after full cervical dilatation, the woman has not delivered after one hour.

Retained Placenta: This occurs when the placenta is not delivered after thirty minutes to one hour of delivery of the baby.

Cord presentation: The umbilical cord is coming before the after coming head of the baby.

Cord Prolapse: The umbilical cord has come out of the vagina. The baby is yet unborn.

Bleeding During Labour: A woman bleeding during labour should be referred to a health facility because she may require blood transfusion.

Scarred Uterus: A woman who has had any operation where the uterus (womb) was opened such as caesarean section for delivery and myomectomy for removal of fibroids should deliver in a health facility. This is because she stands the risk of tearing her uterus if she is not properly managed.

Bleeding During Pregnancy: This can be caused by premature separation of the placenta or when the placenta is covering the cervix (neck of the womb). A woman with the placenta covering the neck of the womb should not be allowed to deliver vaginally because she can bleed to death. She should be referred to a health facility where she will be managed properly. It can also result if the placenta is separated in the uterus.

Convulsion during Pregnancy: This is caused by increased blood pressure during pregnancy. It is commoner among primips that is women having their first baby, twin pregnancy, and pregnancy with a new spouse.

Obstructed Labour: Labour is said to be obstructed when there is no progress inspite of strong uterine contractions. Progress of labour is arrested by mechanical factors. Delivery requires caesarean section. Death of the baby is common if prompt treatment for obstructed labour is not taken. It can be cause by:

Abnormality in the relationship between the mother and baby

Abnormal lie or malpresentation

Abnormal lie: The baby is lying across in the womb such as transverse and oblique lie.

Malpresentation: This when the baby is not coming with head. The baby is coming with other parts of the body such buttocks, face, forehead, shoulder or legs.

Compound presentation: this occurs when the baby is coming with more than one part of the body such as hand and head.

Cephalopelvic Disproportion: Here, the baby is bigger than the mother's pelvis. The baby cannot pass through the mother's pelvis. Abnormal labour due to cephalopelvic disproportion can be suspected because of possible big baby or an arrest of labour. Continuing to attempt a vaginal

delivery in this setting increases the risk of bleeding and metabolic consequences from a uterine rupture, increases the chances of infection. There is risk injury to the mother and baby.

Abnormal mother's pelvis: such as contracted pelvis and narrow midpelvis.

Abnormality of the baby: such as hydrocephaly where the baby's head is bigger than normal.

Rare causes are vagina stenosis, locked twins (the twin babies are locked within each other) and pelvic tumour.

WHEN TO SUSPECT OBSTRUCTED LABOUR

The cervix does not dilate inspite of good uterine contractions.

Moulding and caput increased but the baby's head does not descend into the mother's pelvis.

The mother becomes anxious, restless and looks tired.

The mother develops hypertonic uterine contractions with poor relaxation between them.

Stretched out lower segment.

The quantity of urine diminishes. She may have bloody urine.

Tomato vulva - the vulva becomes swollen and dry.

Deterioration in clients' condition.

DANGERS OF OBSTRUCTED LABOUR

In obstructed labour, the woman's vagina, bladder, and rectum are trapped between the baby's head and her pelvis. If the obstruction is neglected this ischemia can lead to tissue death and formation of vesicovagina or rectovagina fistula when necrotic slough separates several days after delivery. The commonest fistulae formation is vesicovagina fistula (VVF). Women with VVF become incontinent of urine and may suffer from vagina stenosis, amenorrhoea, and infertility.

Pressure necrosis and sloughing of her inferior vagina wall.

Asphyxia (suffocation) of the baby due to prolonged uterine contractions reducing the placental blood flow.

Birth injury for example Erb's palsy where the arm is limp, grasp is present.

Uterine rupture in which the womb may tear. The tear can be partial or total. It is commoner in multigravida (woman that are not having there first baby) particularly if there is a previous caesarean section scar. Bleeding may occur into the peritoneal cavity or may track downwards between the bladder and upper vagina. Uterine contraction may expel the baby and placenta through the tear into the abdomen.

SIGNS OF UTERINE RUPTURE

Failure of labour to progress

Severe abdominal pain

Vagina bleeding may or may not be present

Distended bladder

Bandl's ring: palpable ring forms between the upper and lower segment.

Frequent strong uterine contraction with little or no pause between them.

Uterine rupture may lead to peritonis, infection of the abdomen and bleeding from the rupture into her vagina.

SIGNS OF ACTUAL UTERINE RUPTURE

Vagina bleeding

Abdominal pain but painless rupture is always possible and an intact caesarean section scar can be tender

Cessation of contractions

Ascent of the presenting part

Easily palpable fetal parts (baby) from the abdomen

Occasionally, the bladder ruptures especially if it has stuck to the scar of a previous caesarean section or myomectomy.

Thank you for listening.

CONCLUSION

Some of the TBAs had already received other forms of training. Although the TBAs were not followed up, it is hoped that the training will improve their practice. Trying to stop the practices of the TBAs is a difficult one because they are closer to the people. Regular training of TBAs will go a long way in the reduction of maternal and perinatal morbidity and mortality especially in developing countries like Nigeria and achieving the millennium development goals. The TBAs were advised to accompany their client to

the hospital and encourage them to do so when the need arises. They were taught on observing universal precautions.

Figure 1

Figure 1: The Facilitator and Traditional Birth Attendants at the End of the Training Workshop

ACKNOWLEDGEMENT

All staff of General Hospital, Aliero, Northern Nigeria is acknowledged for their efforts for ensuring that the training workshop was a success. I thank Aliero Local Government for sponsoring the training workshop. Hajia Amah who mobilised the TBAs and acted as an interpreter during the programme is acknowledged. I wish to thank all participating TBAs at the training workshop.

NOTE

Any one interested in organising training workshop, seminars and courses for traditional birth attendants in any country can use this material.

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