ISSN No:-2456-2165

An Observation of the Practices of Two Urhobo Traditional Birth Attendants

Paulina Saad Dariah*
Dept. of Obstetrics and gynecology
Mindaid Hospital
Port Harcourt, Rivers State, Nigeria

Queen Ngerem
Dept. of Obstetrics and Gynecology
University of Port Harcourt,
Port Harcourt, Rivers State, Nigeria

Abstract:- This qualitative study explores the practices of two Urhobo traditional birth attendants in Delta State of Nigeria. It utilizes interviews and observation over a one-year period to understand and document their practices. Interpretation of observations was through the perspective of an orthodox trained obstetrician with experience in emergency medicine.

Only 2 (4.35%) of the 46 women providing out-of-hospital care had a practice rooted within the Urhobo socio-cultural construct, most having had some exposure to orthodox medicine.

Findings include the practice of 'rubbing' which entails External Cephalic Version and the use of herbs in restricting growth of the baby and in the control of post-partum hemorrhage. The delivery of the baby and placenta as a unit for the purpose of resuscitation is particularly interesting and needs more rigorous research.

The Urhobo TBA should not be disregarded. They seem to have a knowledge base that could be of benefit to the modern medicine.

Further research is needed to document their ways and rigorously evaluate their practices. They can be partners and a valuable resource in the provision of maternal health care.

Keywords:- *Traditional Birth Attendant; Cultural Practices; Delivery of Placenta; Newborn Resuscitation; External Cephalic Version; Urhobo.*

I. INTRODUCTION

An estimated 41% of deliveries in Nigeria occur in orthodox health facilities[1]. A majority occur out-of-hospital. Individuals who provide such out -of -hospital services are referred to as the Traditional Birth Attendants (TBA). Defined as "persons who assist a mother during childbirth and who initially acquired their skills by delivering babies themselves or through apprenticeship to other traditional birth attendants [2]. The term 'TBA' is often used loosely to describe a widely varied group that can be arguably categorized into three subgroups: 1. Individuals who have worked in, and are largely influenced by orthodox institutions of maternal care like medical and nursing school drop-outs, auxiliary nurses, chemists, anesthetic technicians and even hospital cleaners and potters. 2. Individuals whose practice is primarily based on faith and spiritual healing. 3. Practitioners who base their practice of maternal healthcare on a cumulative knowledge rooted in culture and acquired over many generations of learnings. This third group of 'practitioners' are as diverse as there are cultures. Considerations of TBA as a homogenous group of practitioners is thus intrinsically flawed. The analysis of data which do not appropriately consider this diversity is prone to error and recommendations emanating from such studies may misguide policy formulation and thus negatively impact maternal and child wellbeing.

The development of orthodox medicine and obstetric care in its present form emanated from European traditional ways. Traditional medical knowledge of other cultures has offered present medical practice valuable and increasing utilized methods like acupuncture from China and Ayurevedic medicine of India. African cultures similarly have a knowledge base upon which their traditional medical practices are rooted. Variolation in the prevention of smallpox was believed to have been practiced in Africa, India and China long before its adoption in Europe [3]. Many however rely on oral communication and apprenticeship for the trans-generational transfer of knowledge. Documentation of such knowledge is sparing and often times when they exist, measurements are not recorded. Indeed, most Sub-Saharan culture-based healings are clouded in mystic and hardly ever open to study by the modern science [4]. This potentially valuable knowledge is thus threatened especially with the changing dynamics of modern societies.

II. AIM

This study aims to explore the practices of the Urhobo Traditional Birth Attendant towards developing a better understanding of their knowledge base and documenting their ways. This may perhaps better preserve such knowledge and contribute to modern medicine. It also offers an opportunity for a different perspective towards the development of a mutually respectful co-operation in the provision of maternal health care in the region.

III. METHODOLOGY

This is a qualitative study. It is done from an epistemological bases of empiricism. Sampling was purposeful seeking out the TBA whose practice is rooted in knowledge within the Urhobo socio-cultural construct in the in Warri, Effurun and Ogunu communities of Delta State, Nigeria.

Providers of out-of-hospital delivery and maternity service in the communities were identified through gate-keepers of the communities. Their delivery homes were visited and introductions made explaining the purpose of the visit. They were interviewed using a short, closed-caption questionnaire. Individuals who had undergone some form of formal orthodox medical training or ever worked in an orthodox hospital were eliminated. Providers whose practice were founded on faith healing were eliminated. TBAs of other ethnicities were eliminated. A second visit was made to these two traditional birth attendants. The visit to the first TBA to be referred to as Mama "A", was facilitated by a pregnant woman who was receiving care in her center and a relative of one of the prominent community leaders. The visit to the other TBA hereafter referred to as Mama 'B' was facilitated by a pregnant nurse receiving orthodox healthcare where the researcher works and also receiving traditional maternity care at her home. This visit was followed by several other visits carried out with gifts of palm oil, rice, beans and kola. Both TBAs refused cash gifts and alcohol but accepted the food items. While initially hostile, both stating *that 'you doctors think you know everything',* after several visits over a three-month period, they allowed access to their practice and permitted observation upon the promise that their clients will not be dissuaded from seeing them.

An initial interview of each of the TBAs was done. Some questions were closed and some open-ended. This was to further establish that their practice was within the Urhobo socio-cultural construct as well as learn more about them. The TBA homes were thereafter visited every weekend either of a Friday or a Saturday and often times both over a one-year period. Observations were noted as a hand written notes, and photographs taken when permitted. The TBAs sometimes obliged when probed with explanations of what they were doing and their reasons for doing so. Findings are descriptive and interpretations are made through the analytical prism of orthodox training in obstetrics and experience in emergency medicine with over 13 years of medical practice in the region of study. Towards the end of the study, some conversations of how and why orthodox practitioners do things the way it was done, was held as initiated by the TBA. Some interventions albeit unplanned took place.

IV. FINDINGS

A. *General Findings:*

Forty-six (46) 'unskilled birth attendants' were identified. Forty-two (91.3%) had been exposed to orthodox medical practice. Two (4.35%) were faith healers of the CAC denomination and only two (4.35%) women were identified whose practice was rooted in traditional Urhobo culture and knowledge base.

Both traditional birth attendants were elderly mother-figures, soft spoken and gentle.

Mama 'A' was not sure of her age but seemed to be in her 60s. she had practiced for about forty years. She had no child of her own but her niece was being trained to take over her practice. She had trained with a TBA who was a distant relative. She said the knowledge she based her practice on had developed several generations ago among the Urhobo people and was acquired from observing nature and how animals behaved when they were pregnant, in labor, and upon delivery.

Fig. 1 Mama "A's home-The footwear at the door tell of the number of clients within

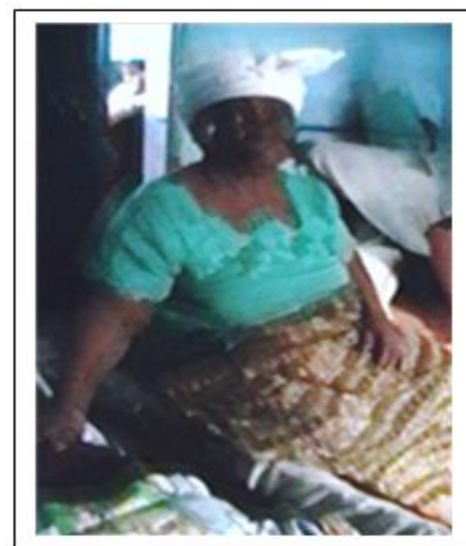

Fig. 2 Mama "A" at work

ISSN No:-2456-2165

Mama ‘B’ refused to have her photograph taken. She was not sure of her age but estimated it to be about 50 years. She had practiced for about thirty years. She said her knowledge was handed to her by her grandmother whom she had practiced with. She was not aware of how it had begun, but affirmed it was how Urhobo people had always done it

Both TBAs had very similar practices in the antenatal period, during delivery and in the immediate post-partum. They both preserved the dignity of their patients. They were respectful and kept them decently covered. The TBAs were compasionate and encouraged them through the pains of labour.

Fig. 3 Mama ‘B’s TBA home located deep within a swampy area. Cars had to park on a rough dirt road. Pregnant women walked on this ‘monkey bridge’, the only access to the home seen at the end of the bridge. Catfish and other swamp creatures inhabit the waters

Both Mamas where traditionalist but allowed their clients to pray in whatever way they wished, attending to Christians and Muslims alike.

Money did not seem to be the key motivator in the practice of the two TBAs observed. Both women did not charge any fees. They infact stated that it was wrong to demand a fee for their service as it was a god-given gift. They however accepted offerings of food and fabric and sometimes cash as was volunteered by the patients.

They both complained that ‘quacks’ were claiming to be TBAs and spoiling their reputation.

There was significant resistance and antagonism encountered initially. This needed about three months to overcome. Both TBAs felt that orthodox doctors did not value their contributions to maternal health and looked down on them.

Both TBAs used herbs in their practice. Whilst the TBAs were open to being observed, they refused to reveal the name of the herbs they used or show the fresh plants/leaves. Mama ‘A’ categorically said the knowledge of being a TBA was divinely determined and they would know who to pass it down to. Both TBAs said the process was by apprenticeship over several years.

The two TBAs had a good understanding of the mechanism of labor and of clinical pelvimetry which they were observed to do. In one instance, a fifteen-year-old girl had been ‘admitted’ in the home of the Mama ‘A’. Upon enquiring why? Mama ‘A’ responded*:*

“Ah think say you be doctor? You no see say her hip small she no go fit bon””

Meaning: I thought you said you were a doctor? Is it not obvious to you that she cannot deliver on her own?

She then went on to describe in details the essentials of a clinical pelvimetry as is done by orthodox practitioners of obstetrics. She was admitting her till delivery so she could feed the young girl special vegetables to help her grow and make her “*biscuit bone”* (cartilage) soft and pliable so it can allow the baby to pass.

In both homes, hands were washed with soap before the conduct of delivery. No gloves were used for vaginal examination and the conduct of deliveries. No sanitizers, bleach or other antiseptics were observed to be used. Masks and special clothing were not used.

There was mutual impact towards the end of the one-year period. Whilst the TBAs were both initially not open to suggestions, they had become more receptive to co-operation and positively altered their practice;

- Using gloves rather than the naked hand to do vaginal examinations.
- Using an electronic Sphygmomanometer to check BP and referring women with abnormal readings to the central hospital in Warri.
- Mama’B’ permitted group health educational talks to their clients by the researcher in the last three months of visits. Similarly, there was better understanding of the TBA by the researcher, far less skepticism, and the development of genuine respect.

Fig. 4 Patients waiting for the herbs to dry after 'rubbing' at Mama 'B's home

B. Antenatal Practices:

The two TBAs practiced 'rubbing'. This entails the smearing of a paste of ground herbs on the gravid abdomen. It is started from the time the gravid uterus becomes palpable above the umbilicus. This in orthodox practice for a singleton practice would be about 22 to 24 weeks gestation. The paste was then left to air dry before the women cleaned it off. According to TBAs, 'rubbing' served two purposes:

- It ensured that *'the baby did not grow too big so it could pass through the birth canal'*
- Making sure the baby was '*well positioned for delivery'* and *'came with the head'.*

From an orthodox obstetrician's perspective, the TBAs were seen to be carrying out external cephalic version (ECV) as they rubbed the herbal paste on the anterior abdominal wall.

C. Post partum practices

Both women used fishing line to tie the cord and a new razor blade to cut the cord. They tied and cut the cord of the baby one to five minutes after delivery. The TBAs were not observed checking for cord pulsations. Of the deliveries observed, no cord was cut longer than 5 minutes. On all occasions, they babies had appeared stable before the cord was tied and cut. Upon asking why,

Mama 'A' said: *"That is how it had always been done. It is good for the baby."*

Mama 'B' said: "I*f you are lucky, you will see why*."

The researcher at a later time observed Mama 'B' take the delivery of a baby who did not spontaneously cry at birth. She dropped the still attached placenta in a cold bucket of water and in moments the baby took a breath and cried.

Mama 'A' was observed managing primary post-partum hemorrhage. This was in a multipara who started hemorrhaging after delivery of the baby and placenta. She chewed some dried herbs she had in her wooden case, molded it into a flat oval shape and placed it beneath the tongue of the woman. The observer was on the verge of breach of agreed terms when the bleeding ceased. Mama 'A' clearly stated that the dried leaves had to be chewed well for it to be effective. The plant used for rubbing and for management of primary post-partum hemorrhage seemed to be a vine or a creeper.

V. DISCUSSION

"All traditional medical systems share one important characteristic: when modern medical services intrude into their domain, their premises are questioned'. [5] This cannot be more exemplified than in the role of the traditional birth attendant. Whilst Initial animosity was encountered during this study over trust and mutual respect developed over time. Despite their role being highly contentious in orthodox medicine, the TBA remains highly respected by women in several cultures in Nigeria. As they continue to provide maternal health care for many who see value in their cumulative knowledge and services their impact ultimately extends to the newborn. They can therefore not be easily dismissed. An inadvertent fallout of this study was the adoption of the use of gloves, the openness to health talks and the use of an electronic sphygmomanometer with the referral of patients with abnormal reading to the government-run Central Hospital in Warri. This suggests that with the right approach, they are open to partnership and could be a useful resource. Some studies similarly suggest there is still a place for them in maternal and child health [6,7].

One of the practices observed is the delivery of the placenta with the baby as a unit. The cord being tied only after the baby cries. The advantages of delayed clamping of the fetal cord are well documented [8,9,10] and is increasingly replacing the practice of immediate cord clamping in many delivery rooms. Whilst the two TBAs in this study tied and cut the cord in a similar time range of 1 to 5 minutes, they in addition delivered the placenta still attached to the newborn and only cut the cord after the baby had cried. This practice differs from the Lotus method of delivering the placenta as traditionally practiced by many civilizations where the placenta is left attached for days and falls off on its own. Not severing the placenta is believed to be less traumatic spiritually for the baby[11]. The TBA observed in this study however seemed to have delivered the baby and placenta as a unit for more a more pragmatic and specific purpose of resuscitation of the baby in the event of what orthodox practitioners would term birth asphyxia. Whilst the TBA may not be able to explain the relevant physiology, from the perspective of an orthodox practitioner, it makes perfect physiologic sense. The placenta is a vascular organ. Putting it in cold water would cause vasoconstriction inducing a rush of cold blood from the placenta into the circulation of the fetus. This would theoretically have two impacts; the delivery of relatively oxygenated blood into the circulatory system of the newborn, and the induction of mild to moderate hypothermia.

Several studies have shown hypothermia to be of benefit to hypoxic brain in newborns [12-15].

The practice of rubbing seems to involve two components done in a bid to improve the odds for a successful vaginal delivery, the transdermal application of an herbal paste said to keep the baby small (not necessarily desirable in modern obstetrics) and what orthodox practitioners would refer to as external cephalic version. ECV is a valuable maneuver in obstetrics also undertaken to facilitate a successful vaginal delivery [16]. Mostly done at term, it is sometimes undertaken at 34 weeks [17], a gestational age much higher than what was observed during this study.

The nature of the herb used in the paste and applied trans-dermal was not revealed and its efficacy in inducing growth restriction needs to be verified. Traditional practices of other cultures like that of the Chinese has offered our increasingly globalizing world numerous botanical products of value in the treatment of many diseases [18]. Similarly, many plants in Nigeria have been shown to have some pharmacological potential [19]. It is therefore not farfetched to hypothesize that these herbs may have some active component of potential value to modern medicine. The placement of chewed herbs under the tongue for the management of post-partum hemorrhage was particularly interesting for many reasons. The TBA was particular about the fact that it had to be chewed for it to work. Whilst the exact purpose of chewing could not be deciphered, this act not only breaks down the dried herbs but moistens it and mixes it with saliva which is alkaline and also has enzymes like ptyalin. Any of these may have been required for activation of the 'oxytocic' molecule in them. Secondly, the molded herb-saliva mixture was place under the tongue, a route used in orthodox medicine for the administration of many drugs including oxytocic agents like misoprostol for the management of primary post-partum hemorrhage.

Whilst the study did not set out to change practices, at the end of the one-year period, the two TBAs had adopted some orthodox practices. The research also changed the principal researcher who started off as a skeptic and subsequently developed a better understanding and respect for the TBA. This is not unusual with empirical studies.

RECOMMENDATIONS

Knowledge in custody of the Urhobo TBA must not be disregarded. Albeit poorly understood, it appears to have much to offer modern medicine. More rigorous and research is required to document their practices, analyze the herbs used and isolate the active agents.

The practice of delivering the placenta with the baby and its value in resuscitation of the newborn requires further studies.

Not all TBAs function within the same socio-cultural context and a distinction is important.

The traditional birth attendants in this study are open to co-operation with orthodox medical care and the adoption of modern infection control methods. This must however be done recognizing their role within the socio-cultural milieu, and their value as relevant maternal healthcare providers and partners.

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