Traditional Birth Attendants and the Pursuit of Maternal and Child Health in Nigeria

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Executive Summary

Nigeria has the greatest burden of maternal and under-5 mortality in sub-saharan Africa. The National Demographic and Health Survey (NDHS) report states that 545 women will die of pregnancy-related causes out of 100,000 every year. The health of mothers also has implications for the health of their babies. The current Under-5 mortality ratio is 157 for every 1,000 children per annum. These are very poor child survival and maternal health indicators. The main cause of maternal mortality is that pregnant women are not seeking health services from health facilities and are not attended to by skilled birth attendants, health workers and, specifically, midwives, who are trained in the science of managing pregnancies, identifying and referring cases of complications or potential complications to the appropriate health facility and personnel.

ANC attendance in Nigeria is poor and delivery at home is very pervasive, as high as 90% in some zones. Deliveries at home are usually taken by a traditional midwife, called the Traditional Birth Attendant (TBA). There is a strong social norm of pregnant women patronising the TBA. There are strong empirical and normative expectations for patronage of the TBA. While TBAs are not the sole causes of poor maternal mortality figures, their activities do not encourage health facility visits and therefore do not create an opportunity for a lot more pregnant women to receive proper management which will; reduce complications of pregnancy and save more lives. TBAs are highly respected, credible and their practice is highly accepted. This creates a social dilemma for TBAs who would want to encourage women to go for ante-natal care in health facilities and also have their deliveries taken by a skilled birth attendant.

Several interventions by Government and other stakeholders in Nigeria have included training of TBAs to mainstream them into the health system. This has failed and has led to Government publicly declaring that TBAs are not part of its health system. That pronouncement has not changed the social norm of patronage of TBAs.

This case study analyses the situation in the light of emerging theories and proposes a social norms approach to facilitating coordinated abandonment of patronage of TBAs, working within the context of coordination games. The paper believes that key players within the community need to be part of the process and that the TBA has to be redefined to a role that is honourable, prestigious and that creates a new set of incentives. Pluralistic ignorance also has to be cured, working within the traditional modes of tracking development progress with the use of a Community Information Board. Data from this board can break the silence on taboo issues and promote common knowledge in the process of deliberation, the community dialogue sessions. A network analysis that identified key influentials and opinion leaders is critical to understanding the sphere of influence and defining the process of organised diffusion. The goal is to create a new social norm of health-seeking in health facilities and delivery in health facilities, which hold great promise of drastically improving on Nigeria’s data on maternal mortality.
Maternal mortality rate in Nigeria has always been relatively high. The current Demographic and Health Survey report (2008) puts it at 545/100,000. The main causes of maternal mortality in Nigeria are identified as follows: haemorrhage, unbooked emergencies, infection, unsafe abortion, obstructed labour, toxaemia/eclampsia/hypertension, malaria, anaemia and others, including HIV/AIDS and meningitis. Underlying these are other issues that include poverty, access to care and early marriage, with its attendant medical and social complications. In a 17-year study in North Central Nigeria, Ujah, et al (2005), found that 79% of deaths were noted to have occurred within 24 hours of admission and that most of the deaths were preventable.

It is also estimated that for every maternal death, at least thirty women suffer short to long term disabilities such as vesico-vaginal fistula (VVF). Nigeria accounts for 40% of the global burden of Vesico-Vaginal fistula. This translates to an estimated 800,000 women suffering from the condition arising from prolonged labour and complicated deliveries. This phenomenon is also linked with some social practices, such as early marriage. Key determinants of the quality of health of mothers pre and post-partum include Ante-natal clinic attendance, delivery in a health facility and delivery by a skilled birth attendant. NDHS Report (2008) states that 58% of women received ante-natal care from a trained health professional at least once during their pregnancy (87% in the South West and South East, 31% in the North West). Only one percent of mothers with no education received ANC services from a health professional, compared with 97% of mothers with more than a secondary education. Thirty-nine percent were delivered by trained health professionals and only 36% had their babies in a health facility

Newborn Health:

Most newborn deaths in Nigeria occur within the first week of life, reflecting the intimate link of newborn survival to the quality of maternal care. This is reflected in the results of the survey of 289 neonatal deaths by DHS in Nigeria in 2003

- 17% occurred on day 0;
- 44% on days 0 and 1; and
- 74% during the first week of life
According to NDHS 2008, Neonatal mortality rate is 40/1000 while Infant mortality rate is 75/1000 (MICS 2007 reported 91/1000). Most neonatal deaths occur at home, making record-keeping a huge challenge. NDHS 2003 showed that the highest neonatal death rates are observed in the North-east and North-west regions of the country while the lowest rates are seen in the South-east region (34 per 1,000 live births). Nigeria ranks highest in Africa in terms of neonatal deaths and the third highest worldwide, contributing about 8% of the world’s annual neonatal deaths (ACCESS, 2009)

**Child Health:** The survival of under-5 year old children, like that of newborn children, depends on the knowledge and practice of key household behaviours of parents and caregivers. There has been some improvement in the mortality rates of under-five children in Nigeria over the last six years, though emerging figures are still among the worst globally. Under-five rate is 157/1000 (NDHS, 2008). In 2003, Under-five mortality rate was 201/1000 (NDHS, 2003).

Easily preventable and/or treatable infectious diseases such as malaria (24%), pneumonia (20%), diarrhoea (16%), measles (6%) and HIV/AIDS (5%) accounted for 71% of the more than 1 million under-five deaths estimated in Nigeria in 2004. Yet, current data do not show a significant change in behaviours and practices that promote child health.

**Access to Health**

Access in its various dimensions, is a critical determinant of maternal mortality. These dimensions include physical access (distance of 5 kilometres to Primary Health Care services or one Emergency Obstetric Care centre per population of 500,000), cost, cultural factors, access to appropriate information etc.

**Financial Access:** Poverty has significant implications for health and development and poor people generally have poorer health status. Poorer women experience higher morbidity and mortality compared to those of higher socio-economic status. The incidence of poverty is higher in the rural areas, where maternal mortality rate is also higher. The NDHS (2008) results show a great gap in access to and use of health services between rural dwellers and urban dwellers. Specifically, for example, 85% of urban-dwelling women are likely to attend ANC compared to 46% rural-dwelling women (NDHS, 2008). Studies have further shown that, in the face of high poverty levels in Nigeria (52.6%), increasing health care cost resulted in substantial decrease in the utilization of maternal health services.
**Physical access:** Access to Emergency Obstetrics Care (EMOC) services has been shown to be clearly linked with the maternal mortality situation, as approximately 15% of pregnant women may develop life threatening conditions that would need such services for effective intervention. The availability and accessibility of EMOC services, thus, deserves particular focus in the review of the status of maternal mortality.

**Socio-cultural factors:** A number of socio-cultural beliefs and practices in Nigeria limit the ability of women to take autonomous decisions about their own lives, including the decision to seek appropriate health care. The decision-making power often lies with the husband or their male relatives, and studies have shown that many women have lost their lives in pregnancy-related conditions while awaiting a decision to be taken by such gatekeepers (SITAN, 2007). Socio-cultural issues are clearly discernible.

**Ante-natal Care**

NDHS (2008) reports that 58% of women attended ANC at least once during their pregnancy. However, delivery in a health facility is low nationwide. About 89% of childbirths in the North West and 82% in the North East take place at home (ACCESS, 2009). Many pregnant women believe that health workers do not provide client-friendly services when compared to Traditional Birth Attendants (TBAs) (PMTCT Formative Research, 2001; PMTCT Evaluation, 2005; IMNCH Document, 2007). Traditional Birth Attendants are believed to possess the experience, human feelings, skills and spiritual knowledge and composure to take deliveries under any circumstance and they have a long history of practice behind them, with skills passed from one generation of practitioners to another.

**Description of the Challenge**

Studies have shown that the key intervention to improving maternal health and, therefore, child health, is **ANC attendance** and Delivery by **skilled birth attendants**. The two interventions will jointly drastically reduce morbidity and mortality figures from pregnancy-related problems as well as post-partum care of infants. ANC attendance in Nigeria is poor, not meeting the minimum recommended by policy, which is four ANC visits per pregnancy. Most deliveries in Nigeria take place at home and are taken by a Traditional Birth Attendant (TBA), women endowed with native midwifery skills (62% national average, some zones as high as nearly 90%). 73% rural dwellers deliver at home and 36% urban dwellers. Two-thirds of Nigerians live in rural settings, are illiterate, poor and would usually consult a Traditional Birth Attendant (TBA), during pregnancy, labour and delivery. Most TBAs are illiterate, have no formal education and are unfamiliar with scientific midwifery methods but they have a
long history of managing pregnancies and taking deliveries in communities. Their practice has no link with orthodox medical approaches. It becomes a burden to manage several pregnancy-related issues that have been identified as main causes of the high mortality figures.

**Who are TBAs?**

According to the World Health Organisation (WHO), a skilled health worker is “an accredited health professional—such as a midwife, doctor, or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-partum period, and in the identification, management, and referral of complications in women and newborns” (WHO, 2008). WHO further states that traditional birth attendants (TBA), trained or untrained, are excluded from the category of skilled health workers. In this context, the term TBA refers to traditional, independent (of the health system), non-formally trained and community-based providers of care during pregnancy, childbirth, and the postnatal period. Antenatal care from a trained provider is important to monitor the pregnancy and reduce morbidity risks for the mother and child during pregnancy and delivery. Antenatal care provided by a skilled health worker enables: 1) early detection of complications and prompt treatment 2) prevention of diseases through immunisation and micronutrient supplementation; 3) birth preparedness and complication readiness; and 4) health promotion and disease prevention through health messages and counselling of pregnant women.

TBAs are middle-aged to older women, highly respected in communities that act as midwives in communities. Many inherited the practice from mothers, older female relations or other women in the community or other villages. Most community dwellers were born with the support of a TBA. TBAs are familiar with the culture, show friendliness and empathy, are highly credible (Bergstrom and Goodburn, 2001) and usually have the backing of the traditional and religious institutions. They are highly patronised for these and other reasons that include the perceived unfriendliness of health facility personnel, low cost of service (payment can be in cash or kind), trust, credibility and, sometimes, family ties. They are largely ignorant about maternal complications during childbirth and the appropriate treatment. Some rely on divine revelation for guidance in the management of childbearing women (Itina, 1997). Indeed, there is the emerging trend of interfacing traditional TBAs with faith-based midwives. Many cases of complications have led to deaths at home or unbooked emergencies in health facilities that have also resulted in deaths.
**Empirical and Normative Expectations**

**Empirical** expectations support strong patronage of TBAs. TBAs are usually the first point of call during pregnancy and at delivery and this is supported by DHS data. The TBA is very visible and her house is known by all. When a woman is pregnant or is in labour, her husband, mother-in-law or other influential relative invites the TBA or takes the pregnant relative to the TBA. Even in instances where an influential relative is not available, a known or related community member would take the pregnant woman to the TBA or invite the TBA, since that is the known practice in the family; that is how other children were born.

**Normative** Expectations also support strong patronage of TBAs. Families know that they are expected by other families, relatives and friends in the community to go to the TBA in case of pregnancy or delivery and they do exactly that. People tend to be cynical about suggestions of health seeking behaviour that promote visits to the health facility. Cynicism as a sanction is common in communities and it tends to question a person’s sense of judgement on what is the best place to go to seek maternity services.

**Legal and Social Norms**

This is a classic case of a conflict between the legal and the social norm. The **legal norm** prescribes that all pregnant women should have 4 ante-natal visits per pregnancy and deliver their babies under the supervision of skilled birth attendants, usually a Doctor, Nurse or Midwife. There are no clear sanctions to the legal norm here but unofficial sanction includes hostility to cases of obstetric emergencies (which is a weak negative incentive). Usually, when the TBA is unable to manage a case, the pregnant woman is rushed to the nearest health facility. They are not received well, even though they are attended to. As Ujah et al (2005) have shown, this category of health facility clients have a high mortality rate because of late report in a health facility. Clearly, the legal norm is disregarded.

The **social norm** is that TBAs are highly patronised and respected, attributable to long-term issues of access, availability, trust, credibility, low cost, gender (many service providers in clinics are male and cultural and religious barriers exist), family ties, friendliness and positive evaluation of services, which is a strong positive incentive.

**A Paradox of Social Dilemma**

**The Health Worker:** Health workers are trained on the critical importance of ANC attendance by pregnant women and delivery by skilled birth attendants as a way of reducing maternal and child mortality. They have the technical knowledge and skills to contribute to
this. Some health workers, however, respect, trust and even patronise TBAs when they or their relatives are pregnant, in line with the social norm in their communities and the desire to ‘fulfil others’ normative expectations’ (Bicchieri, 2006). Some health workers also align with TBAs in not promoting Exclusive Breastfeeding in the first 6 months of a baby’s life, which may also have implications for child health. The immediate dilemma for the health worker is selecting a reference group, whether it is the community or the community of practice (other health workers everywhere). In many cases, the reference group of the health worker is the community rather than the community of practice.

**The TBA:** The institution of the TBA has a long history of trust, respect and devotion. A TBA knows that she is highly regarded by members of the community and is strongly attached to the wellbeing of women and children. Community members do not link mortality figures to the inadequate knowledge of the TBA so the TBA enjoys her high influence on issues of maternal health. It becomes a big social dilemma to shift from her practice and promote health facility visits for the pregnant woman. She would lose her influence, revenue and also contend with the establishment that has had a long history of trust for the institution of the TBA.

**The Schema**

Communities in Nigeria rely greatly in alternative medicine and have poor health-seeking behaviour, using health facilities or seeking the services of a health worker. People consult the local *medicine man* for medication and in cases of pregnancy, pregnant women, by default, visit or are visited by the TBA. The TBA is a widely acceptable, respected and highly patronised traditional midwife. Everybody expects everybody else to visit a TBA when pregnant. There are social sanctions of cynicism. In the event that a woman loses her pregnancy or baby outside the hands of a TBA, there is blaming and, sometimes, a small fine which has to be paid by her family. On the whole, the script expects patronage of the TBA to be practiced by all and expected to be practiced by all.

**Current Intervention Strategies**

Government, development workers, professional groups, civil society and other stakeholders are aware of the negative effect of the wholesome patronage of TBAs on accelerating progress toward the Millennium Development Goals (MDGs) 4 and 5 that focus on improvement of maternal and child health. Several meetings have been held on the need to make TBAs useful within the formal health system, leveraging their credibility and wide
acceptance, while also ensuring that the overall goal of maternal and child health is pursued. The main strategy has been to embark on massive capacity development programmes for TBAs to make them support the regular health system. Studies have shown this to be ineffective (Bergstrom and Goodburn, 2001). Most TBAs have taken the training as a validation of their practice rather than a way to re-tool them, refine their operations and align their work to supporting the health sector goals. The unintended consequence of this is the weakening of the Legal Norm of health facility visits and the inadvertent validation of the centrality of TBAs to maternal and child health such that while nothing much has changed in their work, more people have confidence in them and their advertised additional skills (certificated trainings). This has led to some conclusions that TBAs are not trainable. Bergstrom and Goodburn (2001) observe that,

*recent analyses have come to the conclusion that the impact of training TBAs on maternal mortality is low. An emphasis on large scale TBA training efforts could also be counterproductive, by holding back the training of the necessary numbers of medium level providers, particularly midwives (p.85).*

The Federal Ministry of Health has, in its bid to de-emphasise the utility of patronising TBAs, publicly declared that TBAs are not part of the formal health sector, while also promoting programmes to increase access to skilled birth attendants. The regulatory mechanism of Government has not been able to question the pervasive demand for the services of TBAs in communities and the validation of their services by high-powered clients like the wives of traditional or religious leaders. Also, the health system does not have the structure and personnel to enforce regulations (legal norm), including number of ANC visits during pregnancy. Morbidity and mortality of women and children in communities are largely attributed to ‘the wish of the gods’ or the activity of negative forces and never to unskilled management of pregnant women by a TBA.

The existing strategies are not based on a social norms approach and do not show understanding of the sensitivities of communities that patronise TBAs. There has not been a systematic way of collecting data to understand the social norm; studies have focused on processes in the work of a TBA or done a mapping of TBAs as potential partners in community engagement. Some campaigns have been done across communities to promote health-seeking behaviour and patronage of health facilities but they are campaigns that do not understand the dynamics of community relations and the strength of the norm of patronising TBAs.
What needs to be Done?

The main problem identified is the high maternal and child morbidity and mortality and the main bottleneck is the social norm that encourages patronage of TBAs in health seeking and especially management of pregnancy, delivery and child care. TBAs are entrenched in the traditional institution and enjoy wide acclaim, recognition and even patronage by representatives of the social institution. There is a need to address the social dilemma of TBAs losing status, power, recognition and influence should they support patronage of health facilities.

There is need to support a coordinated abandonment of the negative social norm, in line with Social Convention Theory (Bicchieri, 2006) and following initiatives like TOSTAN. There is need to work with TBAs to promote ANC attendance and delivery in health facilities, work with Health Workers to openly declare support for ANC attendance and delivery in hospitals (eg, SALEEMA); there is need to explore the position of some literate members of the community that hospital visits and delivery is best. Educated members of the community present an opportunity as nodes and hubs in the community (opinion leaders/givers) (Muldoon, 2011). There is need to change the nature of incentives and explore cognitive dissonance, using trends in cities as a reference point. Pregnant women in cities maintain good ANC attendance and deliver in hospitals and they have strong links to rural communities because they have parents and other family members there.

Proposed Strategy to Change Social Norm

- The first task is data collection to identify the nature of the social norm, reference groups, conditional preferences, existing incentives and the strength of empirical and normative expectations, and establish the presence of mutual normative expectations, using counterfactual questions, among others. Evidence generated from this process will guide the intervention process
- Address pluralistic ignorance and denial, using the Community Information Board (CIB) to break the silence on status of maternal and child health
- Map networks that exist and study the hierarchy of influence as possible beginning points in evidence-based advocacy and as participant groups for systematic capacity development (special focus on traditional and religious leaders)
- Study networks of TBAs, using a Snowball Approach; who influences them or are their significant other? How wide is their network and how do they relate within or outside their communities?

- Organised diffusion, working with the core group of educated elite that access health facilities (following the Footbinding abandonment model) (Mackie, 2011); educated people largely feel convinced about and comfortable with ANC attendance and delivery in health facilities and present a big opportunity for catalyzing the diffusion process

- Deliberation, working within Community Dialogue sessions that are based on evidence from the Community Information Board. The CIB is a simple tool used in communities by community members to track key child survival and maternal health indicators. It has great potential to catalyze the process of questioning negative norms. Indicators 11-14 focus on maternal health/mortality as well as infant and under-5 mortality. Data from the Board feeds into community discussion as negative trends in mortality figures would lead to questions about causes, required action, timelines and feedback

### Community Information Board

#### Our Children, Our Future

- **Name of Community**
- **Year**
- **Total Population (Adult):** Male, Female
- **Total number of children under five years:**
- **Children (6-12 years):** Male, Female
- **Children (13-15 years):** Male, Female
- **Total enrolled in primary school at start of the school year:** Girls, Boys
- **No of Community Improved water sources**

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<th>Description</th>
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<th>Apr-Jun</th>
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<td>Number of children born</td>
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<td>Number of children registered at birth</td>
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<td>3</td>
<td>Number of children under one year who have received first dose OPV at birth</td>
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<td>Number of children not gaining weight</td>
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<td>6</td>
<td>Number of orphans</td>
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<td>7</td>
<td>Number of children attending primary school (boys and girls)</td>
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<td>8</td>
<td>Number of households with long lasting Insecticide Treated Nets (ITNs)</td>
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<td>Number of households with latrines</td>
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<td>Number of pregnant women attending antenatal clinic</td>
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<td>Number of Village Development Association meetings held</td>
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Explore a renewed partnership between TBAs and Government, where TBAs play roles of referrals, facilitate Birth Registration and act as facilitator of community health-seeking practice. Bergstrom and Goodburn (2001) observe that, *the main benefits from training TBAs appear to be improved referral and links with the formal health care system, but only where essential obstetric services are available. Some studies have observed that formal training is not a requirement for this function.*

This process would involve extensive consultation and dialogue with key influencers and gatekeepers in communities, including getting the buy-in of traditional and religious leaders, women leaders, community opinion leaders and elites, men’s unions and even youths. The process of deliberation ordinarily takes time. This should prioritise participation of key players within the community rather than reliance on external facilitators.

- Re-nominate TBAs by emphasising their importance in modern day health service delivery eg, as *Baby Champions* or *Community Mothers* and institute periodic awards that give visibility and validate their new role/status.

- Promote the notion of *Prestige* in use of health facilities. Educated people regard it as prestigious to seek health services in health facilities. It is regarded as unfashionable to patronise any traditional health practitioner. They have the potential of exerting social pressure on the adoption of a new norm of health-seeking.

### Conclusion

Maternal mortality is a serious issue in Nigeria and every step is being taken to address it, if Nigeria is to accelerate progress toward the MDGs. While it would be untrue and uncharitable to accuse TBAs of being solely responsible for the slow progress in reaching the goals, the fact that an overwhelming number of pregnant women deliver their babies at home points to TBAs as a critical group whose activities require some closer scrutiny. There is an established social norm of delivery at home, with the help of TBAs. There is need to change the social norm through a coordination game that is all inclusive and does not jeopardise the respect and recognition that TBAs presently enjoy. Central to this process would be a core group that includes educated people who already access health services, are trusted and consider it more prestigious and modern. A social norms approach is critical to understanding and intervening in the current dilemma, facilitating a coordinated abandonment of patronage of TBAs by pregnant women.
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