Childbirth in Nigeria

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Nigeria is a huge African country, home to 20% of Africans, with a population of about 140 million people (National Population Commission 2006). It also has a high fertility rate, although the 2003 Nigerian Demographic and Health Survey (NDHS 2001) shows a slight decline in the total fertility rate. Fertility also varies by region. In the South women have 4.1 children on average, compared to 7.0 children in the Northeast and 6.7 in the Northwest (NDHS 2003). In spite of this high premium given to childbirth in Nigeria, it is still a challenge for the majority of our women, with an unacceptably high maternal and neonatal mortality rate. The maternal mortality rate is estimated to be 800/100,000 live births (NDHS 2001). While this is lower than the sub-Saharan Africa average of 910/100,000, wide variation exists across the geopolitical zones. The North East Zone has almost ten times the maternal mortality rate than the South West Zone. There is also marked urban-rural variation 351/100,000 (urban) to 828/100,000 (rural) in maternal mortality rate (NDHS 2001), An estimated 52,900 Nigerian women die annually from pregnancy-related complications. A woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 18 (Women of our World 2005).The tragedy of maternal death is multiplied by the consequences to the offspring; the chance of death for children whose mother has died while they were under the age of 5 is as high as 50% in developing countries (Tinker and Koblinsky 2002).

The neonatal mortality rate (deaths of infants within the first 28 days of life) is 48 per 1000 live births (NDHS 2003); most newborn deaths in Nigeria occur within the first week of life.

Causes of Maternal Death During Childbirth

An individual maternal death is seldom due to one direct cause. Usually there are two or more causes, so that allocation of cause of death becomes problematic. The main causes of maternal mortality in Nigeria are: haemorrhage

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(23%), infection (17%), unsafe abortion (11%), obstructed labour (11%), and toxaemia/eclampsia/hypertension (11%). Malaria (11%), anaemia (11%) and others, including HIV/AIDS, contribute to about 5% of maternal deaths. It is also estimated that for every maternal death, at least 30 women suffer short to long-term disabilities such as vesico-vaginal fistula (VVF). VVF is a condition that arises from prolonged labour and complicated childbirth resulting in continuous dribbling of urine.

Process of Childbirth in Nigeria

Care in Pregnancy

Approximately half of our women attend antenatal care (ANC) at least once during their pregnancy (NDHS 2003). Only half of those attend at least 4 times, which administrators agree is the minimum frequency for good care. The other half attends the clinic once in order to obtain a ticket (maternity card) that can be used in the eventuality of having a complication during delivery and therefore the need to go to the hospital.

Two-thirds of the women present for the first antenatal clinic during their second trimester of pregnancy. Government Primary Health Centres are the main sources of ANC utilized by 51.4% of women (Galadanci et al. 2007). Other sources are government general hospitals and private clinics. In addition to attendance at antenatal clinics, the quality of care received in the clinics is another major determinant of pregnancy outcome. Only a third of women that attended antenatal clinics receive quality antenatal care (Galadanci et al. 2007). As reported in the 2003 NDHS, only 58% of pregnant women received iron supplements and 39% received drugs to prevent malaria as part of their antenatal care. The low quality of care offered in our antenatal clinics contributes to the low utilization of the service.

Care During Delivery

The WHO estimates that 60% of births in the developing world still occur outside a health facility, with 47% either unassisted or assisted only by Traditional Birth Attendants (TBA) (WHO 1997). Galadanci et al. (2007) reported that 85.3% women deliver at home in Northern Nigeria, whilst health facilities took 14.1% of deliveries with 0.6% of deliveries occurring in spiritual homes, farms, vehicles and other locations. This figure is higher than the national figure of 58% of women delivering at home (NDHS 2003). This is also true of other African countries, as in South Africa where women prefer to stay away from formal care structures for their deliveries (Fonn et al. 1998).

Attendant at Delivery

Childbirth is considered a natural process that does not need interference, so it can be conducted in the privacy of the parturient home. In fact the delivery attendant

is only called to cut the cord after delivery, clean the baby and bury the placenta in communities where that is practiced. The process of the labour is not interfered with, nor is any complication anticipated. Therefore when any complication occurs such as obstructed labour, eclampsia or bleeding, time is wasted before care is sorted.

As most deliveries take place outside the health system, most will be attended by unskilled personnel. Traditional birth attendants (TBA), trained or not, are excluded from the category of skilled health-care workers. Skilled personnel in Northern Nigeria attend only 19.5% of deliveries with 80.5% of the deliveries attended by personnel with no verifiable training in sanitary birthing techniques (Galadanci et al. 2007). These include TBAs and Village Health Workers (VHW), parents, in-laws, neighbours and other relations who happened by at the critical moment.

TBAs were valuable members of the birthing process long before the advent of modern medicine and its institutions. They still play a major role in childbirth in Nigeria, especially in rural areas, where access to modern medicine is far away or the cost is prohibitive for most people. This is unfortunate, given that greater use of services of a skilled attendant at birth is considered a key step in reducing the half million maternal deaths in developing countries each year (Nzama and Hofoney 2005).

Care After Childbirth

One of the least utilised maternity care services is postnatal care with less than a fifth of women returning to the clinic after childbirth for postnatal check-ups (Galadanci et al. 2007). This needs to be addressed as more than 60% of maternal deaths occur in the postnatal period (Fortney et al. 1996), and a survey of women delivering in rural homes identified a 43% rate of postpartum morbidity (Bang et al. 2004).

Traditional Home Delivery

Traditional Birth Attendants are women whose ages range from 45 to 70 years. They believe in traditional or local medicine. They supervise and attend pregnant women at their homes before, during and after labour. In multigravidas (those with more than one delivery) the TBAs are usually informed when the pregnancy reaches 9 months. However in cases of primigravidas (women with their first pregnancy), the TBAs are informed once the relatives notice the pregnancy. This is because certain local herbs and advice are usually given to such women by the TBAs. Some of the herbs are believed to clear off mucous discharge (show) towards the end of the pregnancy. There are two categories of TBAs – trained and untrained.

Process of Delivery by Untrained TBA

At the onset of labour, the TBA will be called and a side or corner of a room cleaned and prepared for the woman in labour. She is then given a stool to kneel on, because of the belief that a woman lying on her back with her face upwards, will definitely

give up the spirits. She will remain in this position until after the delivery of the placenta. By her side are usually containers with two or more different types of traditional medicines that she will take at each contraction.

The second stage of labour is only predicted when the woman in labour starts pushing, as no vaginal examination is done to assess the progress of labour. At this stage the TBA starts preparing the hot water to be used for bathing after the delivery. Half a drum of water containing different types of medicinal sticks is put to boil. The woman is instructed to continue pushing with all her strength until the baby is delivered.

Once the baby is delivered, the TBA cuts the cord with a special knife mainly used for that purpose, and then presses the cord between her fingers to control bleeding. The baby is then wrapped in a clean cloth and kept aside. The placenta is expected to be expelled naturally on its own. The TBA then assists the woman in bathing using the boiled water and bunches of leaves that are specifically provided for that purpose. Finally the placenta is washed seven times and wrapped in a clean material and buried.

In a situation where the placenta does not expel naturally, the TBA will vigorously shake the woman's abdomen or induce coughing by sprinkling red pepper on burning charcoal. These procedures aid the expulsion of the placenta. However, when all efforts have failed, the woman is taken to the hospital.

If delivery has been successful, the TBA washes all the soiled linens. She also cleans and dresses the baby using a traditional black soap. Before the nursing mother comes out of the toilet, a traditional pap made of potassium with spices is made ready for her, which is believed to aid in the production of breast milk.

Trained Traditional Birth Attendants

Some TBAs have been able to attend one form of training for providing safe motherhood. In Nigeria, there is training on identifying danger signs in a pregnant woman or woman in labour, how to treat minor elements at home, nutritional counselling, importance of personal hygiene, the use of universal precaution materials, referrals and record keeping. Training of these TBAs has not been shown to improve maternal health care in the country.

Delays That Can Occur During Child Birth

The remote causes of maternal death during childbirth are rooted in the sociocultural and economic circumstances of the woman as well as the overall level of development of the society in which she dwells. Three delays can occur during childbirth.

The first is the delay that occurs before a decision is made to seek medical attention for a woman with complication in childbirth. This may arise as a result of lack of

information and inadequate knowledge about danger signals during labour, cultural practices that restrict women from seeking health care, perception of the quality of care provided in the health facility and accessibility to the health facility. In some parts of Nigeria, this delay contributes to up to 30–40% of maternal deaths.

The second occurs from the decision to seek medical care for a woman in labour with complication to the arrival at the health facility. Failures in the transport and communication systems are the main contributors of this delay. Others are poor siting of health facilities and poor community support.

The third delay is in receiving medical care after arriving at the health facility. Factors contributing to this include inadequate skilled personnel, maldistribution of personnel, inadequate equipment and supplies, lack of blood, lack of motivation of staff and the consequent uncompassionate attitude of health workers. Power and water supply interruption also contribute to this delay.

Strategies for Improvement of Childbirth in Nigeria

Decades after launching the Safe Motherhood Initiatives in Nairobi 1978, childbirth in Nigeria continues to be a challenge. There is a need to advocate for at least 15% of our total annual budget for health, and at least 10% of that for maternal health care. There is need also for the cultivation of political priority for safe motherhood. The process of safe childbirth is greatly influenced by the level of education of the woman; hence education for the girl child is essential for improving maternal health statistics. Education raises the women's status and empowers them to take decisions regarding their health during childbirth. There is need to change the perception and the attitude of the women and the community as a whole on the importance of antenatal care during pregnancy. At the same time, there is the need to improve the quality of care offered at the ANC, so that the women can perceive the benefit of the care.

Skilled Attendant

Training of TBAs is a controversial issue with many training programmes being abandoned in the 1990s based on the advice of WHO. In regions with very high maternal mortality and very high coverage of delivery by TBAs, it is plausible that training of well-selected TBAs in a culturally appropriate approach in delivery hygiene and prompt referral for complications might have an impact on reducing maternal mortality. The generally accepted reason for lack of efficacy of TBA training programs is that it did not link the TBAs with functioning health care systems. The solution could be to establish a linkage between TBAs and the nearest Emergency Obstetric Care (EOC) facilities as well as establish a mechanism or system whereby the trained TBAs can call the skilled attendants for the delivery when the need arises and they can work as a team. Increasing the proportion of deliveries with skilled attendants is regarded as a crucial intervention strategy and is widely advocated by international agencies (Safe Motherhood Inter-Agency Group 2000).

Provision of family planning is another key strategy in improvement of childbirth in Nigeria. Spacing childbirths can have great impact on child survival. It protects both the woman's and infant's health by protecting the woman from high risk pregnancies and unwanted pregnancies. Spacing and timing childbirth can promote proper child development

Men play a critical role in women's reproductive health. They decide if and when a woman uses a child spacing method. They decide how and when to make resources available for care during pregnancy. Finally they decide when a woman during childbirth seeks emergency care when complication arises. There is therefore the need to involve them throughout the process of childbirth. When involved, they can communicate better with the women and take joint decisions on child spacing, use of antenatal care and care during delivery.

References

Bang, R. A., et al. "Maternal Morbidity During Labour and the Puerperium in Rural Homes and the Need for Medical Attention: A Prospective Observation Study in Gadchiroli India." *British Journal of Obstetrics and Gynaecology* 111 (2004): 231–38.

Fonn, S., et al. "Maternal Health Services in South Africa During the 10th Anniversary of the WHO 'Safe Motherhood Initiative." *South African Medical Journal* 88.6 (1998): 697–701.

Fortney, J. A., M. Kotelchuck, and L. H. Glover. "The Postpartum Period: The Key to Maternal Mortality." *International Journal of Gynaecology and Obstetrics* 54.1 (1996): 1–10.

Galadanci, H. S., et al. "Maternal Health in Northern Nigeria: A Far Cry from Ideal." *British Journal of Obstetrics and Gynaecology* 114 (2007): 448–52.

National Population Commission (Nigeria). *Nigerian Demographic and Health Survey: Policy and Programme Implications (Northeast Zone)*. 2001.

—. *National Census 2006*.

National Population Commission (Nigeria) and ORC Macro. *Nigerian Demographic and Health Survey 2003. Key Findings*. Calverton, Maryland USA: National Population Commission and ORC Macro, 2003.

Nzama, B., and J. Hofoney. "Improving the Experience of Birth in Poor Communities." *British Journal of Obstetrics and Gynaecology* 112.9 (2005): 1165–67.

Population Reference Bureau. *Women of Our World*. Washington, DC: Population Reference Bureau, 2005.

Safe Motherhood Interagency Group. *Skilled Attendance at Delivery*. A Review of the Evidence. New York, Family Care International, 2000.

Tinker, A., and M. A. Koblinsky. "Making Motherhood Safe" *World Bank Discussion Papers 2002*. Washington, DC: World Bank, 2002:143.

World Health Organization. Maternal and Newborn Health/Safe Motherhood Unit. *Coverage of Maternity Care. A Listing of Available Information*. Geneva, Switzerland: World Health Organization, 1997.