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THE PAIN OF LABOUR: PERSPECTIVES OF TRADITIONAL BIRTH ATTENDANTS IN EDO STATE, NIGERIA
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C. O. IMARENGIAYE, G. U. OTOJAHI, T. N. OTENE and V. Y. ADAM

ABSTRACT

Objective: **To determine the concept of labour pain and its relief in a cultural setting using the perspectives of Traditional Birth Attendants (TBAs).**
Design: **Cross Sectional Comparative Study.**
Setting: **An urban area (Benin City) and a semi-urban town (Auchi) in Edo State, Nigeria.**
Subjects: **Traditional Birth Attendants in an urban area (Benin City) and a semi-urban town (Auchi) were identified using information from a local directory and a respondent driven sampling method.**
Results: **A total of 58 TBAs (37 in Benin and 21 in Auchi) were interviewed. Most TBAs, 36 (97.3%) in Benin and 21 (100.0%) in Auchi, agreed that there is pain during labour. Almost all the TBAs, 34 (94.4%) in Benin and 21 (100,0%) in Auchi, reported that labour pain could be severe. Most of the TBAs, 31(83.8%) in Benin and 20 (95.2%) in Auchi reported that their clients request for pain relief in labour. Use of oral herbs was the most common method of pain relief in labour amongst the TBAs, 12(32.2%) in Benin and 20(100.0%) in Auchi. Most of the TBAs in Benin, 19(61.3%) offer nothing for labour pain, when pain relief is sought by their clients.**
Conclusion: **Labour is considered painful in our culture and most women desire relief. TBAs in semi-urban setting used herbal remedies more readily than their urban counterparts. Efforts should be made at providing comfort to all women in labour irrespective of the location of delivery.**

INTRODUCTION

Labour and delivery is associated with pain and this could be severe in some women (1). Despite the widespread availability of pain interventions during childbirth, most women in Nigeria are still underserved in terms of pain relief in labour. The control of pain and prevention of suffering during labour, in particular, remain a significant concern for clinicians and their clients(2). The American College of Obstetricians and Gynaecologists declares that "Labour results in severe pain for many women. There is no other circumstance where it is considered acceptable for a person to experience untreated severe pain, amenable to safe intervention, while under a physician's care" (ACOG)(3). This is a kind reminder of the need to alleviate the pain of labour.

In hospital based birthing process, various methods exist for the amelioration of the pain of labour. These methods include parenteral analgesics, entonox inhalation, epidural analgesia, spinal block and the combined spinal epidural technique. Although these methods are underutilised, evidence exist that women giving birth in the hospital experience pain and would desire pain relief in labour(4). Across Nigeria, evidence suggests that most women would desire pain relief in labour(5,6). The interpretation and extrapolation of these findings should be with caution as most, if not all, came from modern health facilities.

In most developed countries, labour and delivery occur in the hospitals. However, some deliveries occur at home under the supervision of a Traditional Birth Attendant especially in developing countries including Nigeria. It is estimated that between 60-80% of all deliveries in developing countries occur outside modern health care facilities, with a significant proportion of this attended to by TBAs(7,8). Indeed, some have advocated the training of TBAs in health care delivery since they are involved in the rural setting. TBAs, provide services that are linked to the framework of social and cultural matrix to which they belong and their practices and beliefs reflect the needs of the local community(9). Opinions about the

relevance of TBAs in obstetric practice and reduction of maternal mortality rate may vary but there is a consensus on their proximity to the mothers. It is not clear if the labour pain that exists in women is considered significant problem in the setting of the TBAs and if yes, the options and modalities for management. The determination of the severity of labour pain in the cultural setting may provide insight into the expectations of our women in terms of comfort during labour. It is believed that such an effort would allow the assessment of the subset population who are not in the orthodox healthcare facility and offer an objective appraisal of the concept of the pain of labour from the cultural point of view. Thus, the study ascertained the perceptions of TBAs on the pain of labour and its management in their practice.

MATERIALS AND METHODS

This was a cross-sectional comparative study carried out amongst Traditional Birth Attendants in Benin City (Urban) and Auchi (Semi-urban). The study population comprised all practicing TBAs who were living in the study area. All accessible TBAs in Egor, Ikpoba-Okha and Oredo Local Government Areas of Benin City and Auchi in Etsako West Local Government Area of Edo State were recruited for the study.

The sample size was determined using the formula for comparing proportions.[10] $\mathbf{N = n_1 + n_2 = 4(Z_{1-\alpha/2} + Z_{1-\beta})^2\{(P_1 + P_2/2)(1 - P_1 + P_2/2)\}/2.}$ Where $\mathbf{P_1 = 0.97}$[11] and $\mathbf{P_2 = 0.65}$[12] obtained from studies done in Kenya[11] and Nigeria[12] respectively. Calculated $\mathbf{N}$ = 47, adding 10% non response of the minimum sample size, the estimated sample size = 52. However, a total of 58 respondents (37 in Benin City and 21 in Auchi) participated in the study.

Traditional Birth Attendants in an urban area (Benin City) and a semi-urban town (Auchi) were identified using information from a local directory and a respondent driven sampling method(13-15). The objectives of the study were clearly discussed and participation was voluntary. Quantitative data collection method was applied. Structured interviewer administered questionnaire was used to determine the location and scope of practice and perspectives on labour pain and its management by TBAs. An experienced interpreter was used throughout the study. Data were analyzed using IBM SPSS version 20.0. Univariate analysis was done for all variables and data were presented as prose and frequency tables. Mean age was calculated and t-test carried out to determine the association between two means. The level of significance was set at $p< 0.05$.

Ethical approval was sought and obtained from the Research and Ethics Committee of The University of Benin Teaching Hospital, Benin City. Verbal informed consent was obtained from individual TBAs. The TBAs were given health education on features of normal and complicated labour and importance of prompt referral.

RESULTS

The TBAs in the semi-urban area were older than their urban counterparts, with mean ages of 62.8(±8.6) and 46(±16.3) years respectively, ($p < 0.001$, t-test). Almost all of the TBAs were predominantly women except for 1(2.7%) male in the urban area. Over two-thirds, 26(70.3%) of the TBAs in urban area had formal education unlike the semi-urban practitioners who were mainly without education, 20(95.2%). The major religion of the TBAs in the urban area was Christianity, 34(91.9%), with few African Traditional Religion practitioners, 3(8.1%), while Islam was the predominant religion in the semi-urban area, 13(61.9%) (Table 1).

The scope of practice by the TBAs shows that more than half, 22(59.4%) and 5(23.8%) of the urban and semi-urban practitioners, take about 4-12 deliveries per month respectively. Less than a tenth, 1(2.8%) and 2(9.5%) of TBAs in Benin and Auchi, had over 12 clients per month. Almost all the respondents in the urban area, 35(94.6%) believed labour may not always be normal and 9/21(42.9%) of the semi-urban counterparts hold similar view. Less than half, 9(42.9%) and 35(94.6%) of the TBAs in Auchi and Benin responded to questions on features of normal and complicated labour. Full cervical dilatation and normal lie were considered features of normal labour by 12(34.3%) of TBAs in Benin and {1(11.1%) and 5(55.6%)} of practitioners in Auchi respectively. Small proportion of the TBAs considered prolonged labour, abnormal lie and closed cervix as complicated labour: 20.0%, 34,3% and 34.3% in Benin; and 33.3%, 55.6% and 11.1% in Auchi. Almost all, 95% of TBAs in Auchi thought the duration of labour is between 6 – 12 hours while 24.3% in Benin hold same view (Table 2).

Almost all the TBAs in both areas agreed that there is pain during labour and that the pain could be severe. Most of the TBAs in Benin, 31(83.8%) reported that their clients request for pain relief in labour and 20(95.2%) of TBAs in Auchi had similar experience. On request for analgesia, less than a third, 10(32.2%) and 20(100.0%) of the respondents in Benin and Auchi respectively, offer herbal remedies and 61.3% do nothing to assist the clients (Table 3).

Table 1
Socio-demographic characteristics of the Traditional Birth Attendants

Variables	Benin Frequency (%)	Auchi Frequency (%)
Age group (years)		
≤ 30	8 (21.6)	0 (0.0)
31- 45	8 (21.6)	0 (0.0)
46-60	16 (43.3)	9 (42.9)
≥ 61	5 (13.5)	12 (57.1)
Mean age	46.5 (± 16.3)	62.8 (± 8.6)
Sex		
Female	36 (97.3)	21 (100.0)
Male	1 (2.7)	0 (0.0)
Level of education		
None	11 (29.7)	20 (95.2)
Primary	10 (27.1)	0 (0.0)
Secondary	11 (29.7)	1 (4.8)
Tertiary	5 (13.5)	0 (0.0)
Religion		
Christianity	34 (91.9)	8 (38.1)
Islam	0 (0.0)	13 (61.9)
ATR	3 (8.1)	0 (0.0)
TOTAL	37 (100.0)	21 (100.0)

ATR – African Traditional Religion; t = 25.19; df = 57; p < 0.001

Table 2
Scope of Practice, Knowledge and Perception of TBAs on Labour

Variables	Benin Frequency (%)	Auchi Frequency (%)
Number of deliveries per month	(n=37)	(n=37)
	(n=21)	
<4	14 (37.8)	14 (66.7)
4 – 12	22 (59.4)	5 (23.8)
> 12	1 (2.8)	2 (9.5)
Labour is always normal	(n=37)	(n=21)
normal		
Yes	2 (5.4)	12 (57.1)
No	35 (94.6)	9 (42.9)
Features of normal labour	(n=35)*	(n=9)*
Full cervical dilatation	12 (34.3)	1 (11.1)
Normal lie	12 (34.3)	5 (55.6)
Normal duration	5 (14.2)	3 (33.3)
Normal contraction	3 (8.6)	0 (0.0)
Labour at 9 month	3 (8.6)	0 (0.0)
Features of complicated labour	(n=35)*	(n=9)*
Prolonged labour	7 (20.0)	3 (33.3)
Abnormal lie	12 (34.3)	5 (55.6)
Closed cervix	12 (34.3)	1 (11.1)

Bleeding	2 (5.7)	0 (0.0)
Imminent operation	2 (5.7)	0 (0.0)
Duration of normal labour	(n=37)	(n=21)
<6 hours	26 (70.3)	0 (0.0)
6-12 hours	9 (24.3)	20 (95.2)
12-24 hour	2 (5.4)	1 (4.8)

*Multiple responses

Table 3
Methods of Pain Relief by TBAs

Variables	Benin Frequency (%)	Auchi Frequency (%)
Presence of pain during labour	(n=37)	(n=21)
Yes	36 (97.3)	21 (100.0)
No	1 (2.7)	0 (0.0)
Severity of labour pain	(n=36)	(n=21)
Severe	34 (94.4)	21 (100.0)
Moderate	2 (5.6)	0 (0.0)
Mild	0 (0.0)	0 (0.0)
Clients request for pain relief in labour	(n=37)	(n=21)
Yes	31 (83.8)	20 (95.2)
No	6 (16.2)	1 (4.8)
Methods of pain relief in labour	(n=31)	(n=20)
Oral herbs	10 (32.2)	20 (100.0)
Drugs	2 (6.5)	0(0.0)
Nothing	19 (61.3)	0 (0.0)

DISCUSSION

This study shows that women in labour under the care of TBAs in urban or semi-urban areas in Edo State report pain during labour. The TBAs believe pain accompanies labour and could be severe. In addition, a sizable proportion of the clients request analgesia in labour and often herbal remedies are offered in the semi-urban area while over half of the clients in the urban area receive no analgesia. The implication of this observation is that pain during labour is not limited only to women delivery in hospital setting.

A previous report from an obstetric anaesthesia unit in Nigeria showed that women in the upper educational class, specifically healthcare providers and their spouses utilised labour analgesia services in that hospital(16). This may on the surface appear that women of lower social classes may not view labour pain as important during their intrapartum care. Our results argue against this simplistic approach to the utilisation of labour analgesia. Indeed, a sizable proportion of clients receiving care from TBAs indicated that labour pain exists and could be severe. Furthermore, the TBAs recognise also the painful nature of labour. Clients undergoing labour and delivery under the care of TBAs are mainly in the rural areas or lower social class in urban centres. Thus, the pain of labour cuts across different strata of educational or socio-economic class.

A study in South Africa explored the attitude and responses towards women in labour as well as the pain experienced during labour. The midwives' perception of women experiencing labour pain showed that labour pain is unique to the individual women, natural and bearable(17). A similar study in Swaziland investigated the management of labour pain by midwives and TBAs. The study sought the views of 50 midwives and 60 TBAs on the management of the pain of labour in a qualitative interview. The results indicate that the pain of labour was regarded as normal physiological response to labour and was given little attention. Although the midwives identified pharmacological and non-pharmacological approaches, the TBAs identified herbs, baths, adopting comfortable position and presence of the spouse(18). This attitude of accepting the pain of labour as a normal process in parturition may have informed the TBAs approach of not offering any form

of analgesic or herbal remedy to a high proportion of women in the urban setting.

The use of herbs appears to be a common practice among our TBAs in the semi-urban setting and the Swaziland group. In a focus-group-discussion with 17 TBAs in Dadu District in rural Pakistan, a local medication 'Butreeh' was used to control the pain of labour(19). The herbal remedies used by the TBAs in our study were not clearly stated as such practice is shrouded in secrecy. Identification of these herbal remedies may have provoked further studies on their analgesic efficacy.

Nearly all the TBAs interviewed were women except for one man in the urban centre. The practitioners in the semi-urban centre were significantly older and less educated than the practitioners in urban practice. These socio-demographic characteristics are in keeping with TBAs as no formal education or training in a health facility and no discrete professional requisites for practice. They often learn their trade through apprenticeship. Another worrisome characteristic is the number of deliveries per month, a finding similar to those obtained in Kenya and Atakumosa (Nigeria)(20,21). These figures are of concern given to the fact that an extrapolation of the number of women of reproductive age in these communities could be high. This may further reawaken the need for urgent action with respect to the provision of functional health facilities that are accessible and affordable in the various communities. The commencement of the Midwifery Service Scheme (MSS) by Nigerian government should be prioritised and further enlightenment of women of reproductive age on the need to utilise health facilities should be encouraged.

There are some limitations to the interpretation of our results. It is a quatitative study with clear concerns. Perhaps, a focused group discussion may have allowed the documentation of the TBAs comments.

These comments may have provided further insights for care providers and decision makers on the management of labour pain. Furthermore, it may have been necessary to determine the herbal remedies offered by the TBAs and their perceived efficacy. Nevertheless, the observation that pain of labour occurs and may be severe among women receiving care under TBAs is instructive. This adds value to the understanding that the pain of labour is not limited only to women receiving intra-partum care in health facilities, at least, in Nigeria.

In conclusion, the results show that the pain of labour is felt by women and could be severe in some and request for pain relief is common. The TBAs used herbal remedies particularly in the semi-urban setting while the counterparts in the urban setting did nothing in over 60% of their clients. It can be argued therefore, that the pain of labour also occurs among the low income group with low education. The concept that the pain of labour is normal may limit widespread application of labour analgesia in our cultural setting. Efforts should be made at providing comfort to all women in labour irrespective of the location of delivery.

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