LEGAL FRAMEWORK FOR TRADITIONAL AND FAITH-BASED MATERNAL HEALTHCARE PRACTICES IN NIGERIA

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ABSTRACT

Reproductive health and reduction of maternal mortality are major components of the Sustainable Development Goals. Nigeria's Maternal Mortality Rate (MMR) estimate from 2000 to 2015 is 814 deaths per 100,000 live births. Traditional Birth Attendants (TBAs) and Faith-Based Birth Attendants (FBAs) play a significant role in the provision of maternal health care services, particularly where orthodox maternal healthcare services are inaccessible in Nigeria. Previous studies have attributed the causes and high incidence of MMR mortality in Nigeria to the frequent patronage of TBAs and FBAs by pregnant women with little focus on the legal framework guiding their practices. This study was, therefore conducted in order to examine the laws regulating traditional and faith-based maternal healthcare practices with a view majorly directed at ensuring the standardization of its practice.

Historical and Sociological theories of law were adopted. Qualitative research method was adopted. Study location was two urban (Abadina and Agbowo) and two rural (Akufo and Ologuneru) communities in Ibadan. In-depth interviews were conducted with 48 pregnant women ages 18 to 29, key informant interviews with 12 TBAs, 12 FBAs and 24 orthodox maternal healthcare practitioners including doctors, midwives and nurses; four focus group discussions were held with 32 couples ages 30 and above over a period of six months. Primary sources of law included the Constitution of the Federal Republic of Nigeria, 1999 (as amended), Traditional Medicine Policy 2007, National Health Policy 2016 and National Reproductive Health Policy 2017. Legislations from Tanzania, South Africa and Malaysia were examined for comparative purposes. Secondary sources included books, journal articles and internet materials. Data gathered were subjected to jurisprudential and comparative discourse.

Maternal healthcare practices of TBAs and FBAs were inadequately regulated under a specific national law to address the incidence of maternal mortality in Nigeria. There was a proliferation of unregulated maternity homes by both TBAs and FBAs. Women patronising TBAs and FBAs were exposed to risks and subjected to unorthodox practices in the hands

of quacks and incompetent personnel. The existing policies on health and traditional medicine lacked provisions regulating TBAs and FBAs. The Traditional Medicine Council Bill fell short of provisions stipulating standards, training, professionalism, referral and other practice guidelines in comparison with Malaysia, Tanzania and South Africa that have lower incidence of maternal mortality. Tanzania's Traditional and Alternative Medicines Act 2002, South Africa's Traditional Health Practitioners Act 2007 and Malaysia's Traditional and Complementary Medicine Act 2016 had provisions on professionalism and specialisation of traditional and complementary medicine practices, apprenticeship, training and the duty to refer patients.

Nigeria's current legal framework for addressing traditional and faith based maternal practices is weak and requires a review. There is a need for an all-embracing legislation to ensure more effective maternal health care services in Nigeria.

Keywords: Traditional birth attendants, Faith-based birth attendants, Reproductive health law, Maternal health care practices in Nigeria

Word count: 487

DEDICATION

To the Eternal one, Omnipotent, Almighty God, my beginning and my end, who saw me through it all

To the love of my life, my husband and father, John Eshiogheme Kess Tafita

To my seven wonderful children

To the memory of my Late father Rtd. Major Samson Abayomi Ashiru (Oloko) who believed so much in education and empowerment of the girl child.

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The staff of Odeku Library UCH, Simeon Adebo Library, National Archives, University of Ibadan, Ibadan.

CERTIFICATION

I certify that this thesis was undertaken by Folake Morenike Tafita in the Faculty of Law, University of Ibadan

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National Health Act 2014

Nigerian Medical and Dental Practitioners Act Cap M8 LFN, 2004

Dangerous Drugs Act Cap D1 LFN, 2004.

Lagos State Health Sector Reforms Law 2006

Oyo State Advisory Board on Traditional Medicine Edict, 1996,(now

Hospitals (Private) Registration Law Oyo State.

INTERNATIONAL CONVENTIONS

International Labour Organization Convention 169

United Nations Declaration on the Rights of Indigenous Peoples

Convention on the Elimination of all Forms of Discrimination Against Women. (CEDAW)

FOREIGN STATUTES

Traditional and Complementary Medicine Act, 2016, Laws of Malaysia Act

Health Professions Act 56 of 1974 South Africa

Traditional Health Practitioners Act 2014 No. 22 of 2007 South Africa

Traditional and Alternative Medicines Act, 2002 Tanzania.

TABLE OF CASE

R v. Morgentaler (1988), 44 Dominion Law Reports (4th) 385 (Supreme Court of Canada)

ABBREVIATIONS

AC	Appeal Cases
All ER	All England Report
All FWLR	All Federation Weekly Law Report
CA	Court of Appeal
CAP	Chapter
FBA	Faith Birth Attendant
FWLR	Federation Weekly law report
ICESC	Intentional Covenant on Economic, Social and Cultural Right
JCA	Justice of the Court Of Appeal
JSC	Justice of the Supreme Court
LFN	Laws of the Federation
NASEM	National Academies of Sciences Engineering and Medicine
NAFDAC	National Agency for Food and Drugs Administration Commission
NBS	National Bureau of Statistics
NIALS	Nigerian Institute of Advance Legal Studies
NPCN	National Population Commission Nigeria
NHMIS	National Health Management Information System
NMLF	Nigeria Monthly Law Report
SC	Judgment of the Supreme Court of Nigeria
TBA	Traditional Birth Attendant
UNICEF	United Nations Children Emergency Fund
UDHR	Universal Declaration of Human Rights
WHO	World Health Organisation

CHAPTER ONE

GENERAL INTRODUCTION

1.0 INTRODUCTION

Health is very precious in any society, hence the saying that health is wealth.[1] The right to health in all ramifications including reproductive maternal health is a fundamental part of human rights and of our understanding of a woman's right to life and safe motherhood.[2] In many developing countries, sexual and reproductive health related problems continue to contribute majorly to the issue of poor health and maternal mortality for women of childbearing age, unfortunately Nigeria is not an exception.

The obligation of governments is to protect the rights to life and health of everyone in the society, according to Cook et al, maternal mortality however seems to be the "neglected tragedy".[3] Child and maternal healthcare is a sector of the health system in Nigeria which has remained poor despite the efforts of government at improvement. Maternal mortality is unacceptably high in Nigeria. According to United Nations Children Emergency Fund (UNICEF), every day, Nigeria loses about 145 women of childbearing age, as one woman dies every 30minutes. This statistic puts Nigeria as the second largest contributor to the maternal mortality rate in the world.[4] While it is clear that a large percentage of these deaths are avertible, there remains a decline in the scope and quality of both orthodox and traditional maternal health care services in Nigeria, despite the National Reproductive Health Policy[5] objective to cut maternal mortality rates by half within ten years.[6] Presently, less than 20 per cent of the nation's health facilities are able to provide emergency obstetric services, of which only 35 per cent of the deliveries involve skilled birth attendants. Isaac

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[1] Malthus, T. R. 1978. *An Essay on the Principle of Population*. London: J. Johnson in St Paul's Church-Yard.

[2] Cook, R. J.et al 2003. Reproductive health and human rights: Integrating medicine, ethics, and law. New York: Clarendon Press. 32

[3] Ibid.

[4] Owoseni, J. S. et al. 2014. Pregnancy care and maternal mortality in Ilesa, Osun State Nigeria. *Standard Research Journal of Medicine and Medical Sciences* July 2.1: 044-056, Retrieved Nov. 20 2015, from http://www.standresjournals.org/journals/SRJMMS

[5] Federal Ministry of Health. May 2001. *National Reproductive Health Policy and Strategy*. Abuja

[6] Cited in Owoseni, J. S. et al. 2014. Pregnancy Care and Maternal Mortality in Ilesa, Osun State Nigeria.

Adewole reiterating the fact of Nigeria's poor maternal health describes maternal mortality as a national tragedy, stating that 40,000 women die annually from maternal mortality.[7] The effect of poor health goes far beyond physical pain and suffering, no country has attained a high level of economic development with a population crippled by maternal mortality and other pervasive illness.[8] Many of the half million women per year who die in childbirth in developing countries like Nigeria are attended to by traditional birth attendants (TBAs) and faith birth attendants(FBAs) because they lack access to skilled maternity care or are discontented with the orthodox pattern of healthcare practice.[9]

1.1 BACKGROUND OF STUDY

Maternal health care service in Nigeria is a major component of primary and tertiary healthcare institutions, hospitals and maternity centres both public and private owned. Women generally are not restricted to any particular choice of maternal health care service. Women, literate and non-literate patronize public and private maternal health care services, but many women still prefer to give birth at home, while many others seek the help of local midwives, in the community where they live. Churches, mosques and other religious places also have birth and maternal centres rendering child birth assistance[10]. Older women, men, and family members who by experience and practice are knowledgeable in child delivery also assist pregnant women in labour and child birth.

Traditional birth attendants (TBAs) and faith birth attendants (FBAs) often serve communities located in isolated and remote areas where they are consulted as a matter of necessity due to the unavailability of orthodox health care services. However, they also render their services in urban/semi-urban communities, which despite exposure to orthodox health care services still prefer these places and the services rendered due to cost

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[7]Live transmission of ministerial screening exercise on Channels Television 28th October 2015.
[8]World Bank. 1994. *Development in practice: better health in Africa, experiences and lessons learned*. Washington D.C: A World Bank Publication. ISBN 0-8213-2817-4. 24
[9]Jonas, S. and Kovner, A. 1990.*Health care delivery in the United States.* 4th ed. New York: Springer publishing company. 8
[10]Read, M. 1966.*Culture, health and diseases*, London, Tavistock publications
These people are known and well respected in their communities for the art of child delivery. They are referred to by different names in different countries and communities such as "*iyaagbebi","comadrona","ambuya","Shona""dayah", "Granny".*

and other factors. Many pregnant women in urban and semi-urban settings visit ante-natal clinics in orthodox health care but when it is time to give birth; they would rather solicit assistance from local midwives and FBAs in faith based homes or unskilled TBAs.[11]

In low-resources settings and rural areas, professionally trained staff is often in short supply and there is a tendency for expectant mothers to rely on TBAs and FBAs for delivery.[12] Many women living in low-resource and rural settings continue to seek the care from TBAs and FBAs, despite the knowledge that orthodox health facility delivery is often safer.[13] Poverty has been said to be one of the factors for this, as some persons are too poor to afford adequate medical care services. The reality in many African countries is that orthodox health care facilities are not providing cost effective services in a way that it would impact health.

According to Isaac Adewole, in Nigeria, there are private hospitals that charge as much as 25,000 naira for normal delivery, whereas if the delivery is in a faith mission house no fees would be charged, and the FBAs are usually more sympathetic towards the pregnant women. [14] This preference for TBAs and FBAs is not limited to Nigeria. An estimated 60 to 80% of the South African population are currently using the trado-medical sector as their first contact for advice and/or treatment of health concerns.[15] The general notion is that the services are holistic, and deal with both the physical and psychosocial aspects of health. According to Ojua, a large number of African rural dwellers seem to be suspicious of western healthcare partly because it does not tolerate local beliefs and behaviours related to health matters and this forms a major part of the reason why some 90% of the rural

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[11] Eseme, N. 2016 Why rural women in Nigeria prefer traditional birth attendants to hospital midwives

[12]Oshonwoh, F. et al 2014.Traditional birth attendants and women's health practices: A case study of Pataniin Southern Nigeria. *Journal of Public Health and Epidemiology* Vol. 6(8), pp. 252-261, DOI: 10.5897/JPHE2013.0634 ISSN 2006-9723 Retrieved May 17 2017 from http://www.academicjournals.org/JPHE

[13]Pyone, T. et al 2014.Changing the role of traditional birth attendants in Somaliland. *International Journal of Gynecology and Obstetrics* 127.1:41-46

[14]Speech made during live transmission of ministerial screening exercise on Channels Television, 28thOctober 2015.

[15]Munyaradzi, M. et al 2011.Ethical quandaries in spiritual healing and herbal medicine: A critical analysis of the morality of traditional medicine advertising in Southern African urban societies. *Pan African Medical Journal* 10.6

populations seek traditional health care.[16] Although information on the status of TBAs in Africa, specifically Nigeria is not readily available, they are part and parcel of the very large human resource component in the traditional health sector, and it can be safely deduced that this category of health providers continues to play an important role.[17]

Noting the important role of maternal healthcare service providers such as traditional birth attendants and other local unskilled midwives, the World Health Organization has strongly encouraged the formulation of regulatory structures, policies and legislation to standardize traditional medical practice being an alternative healthcare choice within member states.[18] The World Health Organization in its Alma-Ata Declaration of 1978 recommends that world nations look inwards towards using the ideals of their various traditional health cares for the benefits of mankind.[19] For more than three decades, the WHO has encouraged traditional health care, especially in the developing countries by promoting the incorporation of its useful elements into national healthcare systems.[20]

Traditional health care, particularly maternal healthcare has consequently come to the fore as a major alternative to orthodox maternal healthcare in Africa and Nigeria in particular. This conceptualizes clearly the present state of shifting paradigms within the health sector both at the National level and on the International scene. This position of the WHO regarding traditional healthcare practice was re-affirmed at the 40th World Health

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[16]Ojua, A et al 2013. African cultural practices and health implications for Nigeria rural development. *International Review of Management and Business Research* 2;1; 181

[17]Sandlana, N. and Mtetwa, *D.* 2008. African traditional and religious faith healing practices and the provision of psychological wellbeing Among Amaxhosa people .*Indilinga*: *African Journal of Indigenous Knowledge Systems* 7.2:119-131

The authors identify a strong relationship between African traditional and religious faith healing. Related practices among the Amaxhosa people of the Eastern Cape, South Africa are used to exemplify both healing effects and psychological wellbeing outcomes. The religious component is addressed using Christian based methods of attending to psychological wellbeing. They argued that although generally viewed with suspicion, misrepresented, and even rejected in some circles, traditional and religious faith health care should be considered as a proper part of mainstream forms of therapeutic intervention. They call for a recognition of African traditional and religious faith health care methods as complementary to the current taken-as-mainstream provisions for people's wellbeing.

[18] WHO, 2005, National policy on traditional medicine and regulation of herbal medicines: Report of a WHO global survey Retrieved Jan 10 2016 from www .http://apps.who.int/medicinedocs/pdf/s7916e/s7916e.pdf

[19]Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 Retrieved May 16 2017 fromwww.who.int/publications/almaata_declaration_en.pdf

[20]Ibid.

Assembly (WHA) held in May 1987. It has been argued that if the majority of rural populations in developing countries have to be reached by some form of official health care, then efforts have to be made to use local resources.

Following the Safe motherhood Conference held in 1987, Nairobi, Kenya, many initiatives have been undertaken both internationally and by national governments to stem the scourge of maternal deaths. The third goal of the United Nations' Sustainable Development Goals (SDG 3) calls for a reduction in global maternal mortality ratio to less than 70% and providing universal access to reproductive health.[21] The global commitment is to reduce maternal mortality by 2030. Some of these commitments include the International Conference on Population and Development (ICPD). [22]

1.2. STATEMENT OF PROBLEM

Reproductive health problems account for more than one third of the burden of disease of women.[23] 'Maternal mortality is a major cause of death and disability among women of reproductive age in Nigeria'.[24] In the last Global Demographic Maternal Mortality Rate Statistics in 2015, Nigeria is on the number four. From the 50% of all maternal deaths globally, Nigeria's maternal mortality accounts for 14%. As there are no reliable statistics on maternal mortality in Nigeria, going by estimates, it was calculated that more than 515,000 women died from complications related to pregnancy and childbirth, a rate of over 1,400 maternal deaths each day, and a little short of one death every minute.[25] Many women suffer injury as a result of complications from childbirth. A comprehensive data on these deaths are lacking in Africa. Similarly, there are no readily available country-wide

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[21]Donelly, K. et al Oct 2013. A Qualitative Analysis of the Experience of Women Supported by the Integrated Family Health Project to Reach Fistula Repair Services: Their Experience of Repair Services and Re-integration. *Pathfinder Research Evaluation Working Paper*. Retrieved Nov. 18 2015, from www.pathfind.org/publications

[22]WHO The World Health Organisation Africa Region, implementation of the making pregnancy safer initiative (mps) within the context of the road map for accelerating the attainment of the millenium development goals (mdg's) related to maternal and newborn health(mnh) in Africawww.afro.who.int/index. Retrieved Jan. 10 2016

[23] Mbizo, M.T. 1996. *Reproductive and Sexual health. Central African Journal of Medicine*. 42.3:80-85. 1

[24] Akinrinola, B. et al 2015. The incidence of Abortion in Nigeria. *International prospect sex Reproductive health.* 41(4):170-181.

[25]Cook, R. J.et al 2003. Reproductive health and human rights: Integrating medicine, ethics, and law. New York: Clarendon Press. 23 ; WHO.2001.*Maternal Mortality in 1995*:estimates developed by WHO, UNICEF, UNFPA. *Reproductive Health and Research* WHO/RHR/01.9.

statistics on quality of maternal care, morbidity and deaths caused by substandard care. Qualitative evidence and individual hospital statistics suggests these are major issues. It is estimated however that over 75% of the rural population in Africa seeks health care among traditional healers, and about half million women per year who die in childbirth are attended by unprofessional TBAs[26] and FBAs. According to a 2015 study carried out by UNICEF, every day, Nigeria loses about 145 women of childbearing age, many of the half million women per year who die in childbirth are attended to by TBAs or FBAs. In 2015, 62% of all births in that year took place in the home in Nigeria, clearly suggesting a strong cause of Nigeria's high maternal mortality ratio.[27]

TBAs and FBAs have been found to sometimes assume the role of surgeons, and some even operate upon women in labour to speed delivery.[28] This practice which is said to be a form of traditional surgery has led to very serious gynaecological complications such as Post-Partum Haemorrhage (PPH), Vesico Vaginal Fistulae (VVF) and even death. The adverse effect of women dying during childbirth is borne by not only the immediate families affected but by the collective community. In addition, considering the high prevalence of maternal mortality and morbidity attributable to patronage of these unorthodox maternal healthcare providers in Nigeria, currently, there is no specific legal framework or regulation for the practice of Traditional Birth Attendants and Faith Based maternal health services in Nigeria. In addition, the common law regulatory regimes of negligence under torts law and criminal law have not effectively addressed deaths and injuries occurring as a result of these unorthodox maternal health care practices. There is therefore the need to contextualize traditional and other maternal health practices for designing and implementing effective intervention[29] through a specific legal framework for effective regulation of these maternal practices.

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[26] Global One 2015, Maternal health in Nigeria. Retrieved Oct. 8, 2015 from, www.globalone2015.org. Global One in its 2015's field experience in Delta State, Nigeria, reported massive use of traditional birth attendants by rural women. Global One 2015 stated in its discovery, that an estimated 90 per cent of women living in rural communities seek traditional birth attendants at some point during pregnancies.

[27] UNICEF. Dec., 2008. The state of the World's children 2009*: Maternal and New Born Health journal*.

[28] WHO, 2014.Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division Retrieved Jan. 10, 2016, from www.who.int

[29] Morris, J. et al 2014. Maternal health practices, beliefs and traditions in Southeast Madagascar. *African Journal of Reproductive Health,* Sept.18.3: 101

Finally, there is the need for comparative inquiry into the regulatory frameworks for traditional and faith maternal health practices in other jurisdictions. The overall aim of which is to proffer a regulatory framework to assist in the development of a contemporary structure well suited to ensure standardization of care in traditional and faith based maternal health care practices in Nigeria.

1.3 RESEARCH QUESTIONS

This research provides answers to the following questions:

i. What is the legal standard of practice for TBA's and FBA's in Nigeria?

ii. Is there a nexus between the high rate of maternal mortality and regulation or non-regulation of traditional, faith based and other maternal health care practices in Nigeria?

iii. Can a legal framework and other regulatory policies for traditional and faith based maternal homes and missions reduce maternal mortality, and ultimately improve women's reproductive maternal health and rights in Nigeria?

1.4 AIM AND OBJECTIVES

The aim of this research is to examine the existing laws on regulation of traditional and faith based maternal healthcare practices and the effect of regulation or non-regulation on maternal mortality in Nigeria.

The specific objectives of the research are as follows;

1) Examine and describe the factors responsible for the choice of maternal health service.

2) Examine and assess the regulatory structures or regulatory measures for the practice of traditional and faith based maternal healthcare services in Nigeria.

3) Investigate and document the historical development of regulatory structures and standards of practice for traditional and faith based maternal healthcare in Nigeria from pre-colonial to modern day.

4) Consider those factors influencing non-implementation and non-compliance with these regulatory standards for TBA's and FBA's.

5) Compare regulatory standards with that of other jurisdictions in order to propose draft model legislation for the regulation of traditional and other alternative maternal health care practices in Nigeria.

The research will further look into the questions, problems and prospects of integrating regulatory structures for traditional and faith based maternal healthcare delivery within the regulatory framework for orthodox maternal healthcare. By way of a comparative analysis, this research will examine the regulation of traditional/alternative maternal healthcare practices in some selected jurisdictions, the Nigerian situation, and based on these, proffer some recommendations.

1.5. METHODOLOGY

Introduction

This research is an exploratory study involving the collection of qualitative data from different sources including available literature, primary and secondary sources of data collection which involve analyses and synthesis of data such as principal legislation and supplementary legislations, rules and regulations, including regulations from other jurisdictions for comparative purposes. The reason for selecting this approach is because there is little research in the investigation of legal framework for traditional and faith birth attendants in Nigeria even till recent time

Study Design

It is therefore considered appropriate to adopt an exploratory research design where the theory developed can be grounded on the data obtained. The research is also a qualitative, descriptive and contextual study with its theories and processes carried out in the legal context.

Study Location

The study location is Ibadan, Oyo State Nigeria. Nigeria is the most populous country in Africa with an estimated population of about 170 million people. The major ethnic groups are the Hausas, Yorubas and Igbos. There are other minor ethnic groups across the country with over 300 languages. The country is divided into 36 states and the Federal capital-Abuja. There are seven most populous cities of which Ibadan (Oyo state) is one. The major religious practices of the people are Islam, Christianity and Traditional worship. Nigeria operates a plural legal system of English common law, Islamic law/Sharia (in the 12 northern states), and customary (traditional) law. Provision of health care which is mainly orthodox is a shared constitutional responsibility between the Federal government and its other arms, as provided by the 1999 Constitution on the Federal Republic of Nigeria. Other private health care services accessed by the people include orthodox, traditional and faith based.

The city of Ibadan, located in the south western part of Nigeria, is the capital of Oyo State, located about 110 km (about 70 miles) northeast of Lagos, with eleven (11) local government areas. Five (5) of these local government areas are urban centres while the remaining six (6) are semi-urban centre. The city is multi-ethnic particularly in the metropolis; however, the inhabitants are mainly the Yoruba people. Although fast growing, Ibadan still has rural settlements that lack basic amenities like transportation, housing and health care services.

The study was carried out in four selected communities, two of which are Urban, namely; Agbowo community and Abadina community, of Ibadan North local government area. The other two are rural communities, namely; Akufo, and Ologuneru community located in Ido

local government area of Oyo state. The reason for selecting these communities is because the three major ethnic groups in Nigeria are well represented in these selected urban and rural communities.

Study Population

Burns and Grove[30] described population as "the particular type of individual or element who were the focus of the research". In this study, there are five groups of people. The first population group studied comprises of pregnant women and mothers who have experienced health care from TBA and FBA as well as orthodox health care providers.

The second population group are married adult male and females within the above mentioned selected communities according to their experiences and likely information and knowledge that they may have about the services of TBAs and FBAs, including patronage of these maternal health care services in the community.

The third population group comprises of orthodox medical practitioners (doctors, nurses and midwives) as they are responsible for correcting complications mismanaged by TBAs and FBAs which sometimes results into maternal mortality.

The fourth population group comprises of the Traditional Birth Attendants and Faith Birth Attendants as they are responsible for carrying out birth deliveries and care of pregnant women and mothers in the community.

The final group of the study population are community and religious leaders because they are closer spiritually and culturally to the people and most often influence decisions.

Research Instruments

The instruments employed in this research are focus group discussions (FGD), in-depth interviews (IDI) and key informant interviews (KII). This study adopts the purposive sampling technique in selecting the different groups for the interviews. The process of

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[30] Burns, N. and Grove, S. K. 2009. *The practice of nursing research, appraisal, synthesis and generation of evidence*. 6th Ed. St Louis. Elsevier, Saunders 343

selecting a group of people, events, behaviours, or other element that represents the population been studied according to Burns and Grove[31] is known as sampling method.

Focus group discussion was conducted in each community with two selected groups; the first group are young married male and female community members, between the ages 18 and 29 years. The second group was for adult married male and female community members whose ages fall between 30 years and above. As described by Burns and Grove[32], focus group discussion is a carefully planned data collection approach designed to access rich information as regards the participant's opinions in a focus area and settings that is non-threating. The group discussions aided the partic0ipants to freely express themselves on their individual opinions and experiences regarding traditional and faith based maternal practices in the community.

Key informant interviews (KII) were conducted; these interviews were with three groups of people. The first group are traditional birth attendants (TBAs), faith birth attendants (FBAs) and other local midwives in each of the selected communities. In this research, these are collectively referred to as "untrained health practitioners". The next group are health care workers including nurses and medical directors of hospitals, primary health centres, and private hospitals in each of the selected communities, referred to as "trained health practitioners". The last group are community leaders, religious leaders of the various sects in the community. Key informant interview is another qualitative information data tool that was used to obtain information from participants who have deep knowledge about the issue of maternal mortality and maternal practices of traditional and faith birth attendants. Their perception on the subject matter provides an insight into the prospects and likely challenges in developing a legal framework for TBAs and FBAs maternal practice in Nigeria.

A set of open ended questions addressing the topic was designed by the researcher for each of the different groups of participants.

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[31] Burns, N. and Grove, S. 2009. The practice of nursing research, appraisal, synthesis and generation of evidence, ibid. 349

[32] Ibid, 513

For the in-depth interviews (IDI), pregnant women and mothers were interviewed on one on one basis in each of the four communities; the interview with pregnant women and mothers took place in maternity health care centres in each of the communities. The maternity centres are TBA maternal centres, FBA maternal centres and Orthodox maternal centres. The one on one interview with this group of women was useful as it provides the opportunity for insightful information, opinions and experiences with TBAs, FBAs and orthodox maternal health care practices.

The criteria for selection includes: familiarity and association with the services of TBAs and FBAs, age, duration of stay in the community, willingness to participate in the study and ability to provide answers to the research questions of the study.

Data Collection Technique

In order to ensure that we obtain the needed cooperation for the success of the study, a letter of invitation was first sent to the community leaders, health care centres and participants briefing them on the objective of the study, explaining the benefits in the study, inviting them to participate in the study and seeking their consent to participate. When participants are not available, appointments were made with the participants in each of the communities and Faith Based Organizations over the telephones in order to get them involved in the research. They were supplied with information regarding the study's objectives and their assistance was solicited.

The researcher also engaged research assistants for the purpose of interviews which were from location to location and community to community. A study guide was developed to guide the interviews and discussions. Questions were outlined to guide each group of participants. There was a tape recorder and a research assistant to record responses verbatim and long hand.

After gaining consent from the participants to record proceedings, the interviews and FGDs commenced at the chosen venue. Long hand and electronic documentation were utilized in the recording of the participants' response. All interviews and FGDs except those of participants who are not able to communicate in English Language were

conducted in the local dialect and Pidgin English. The FGD sessions were conducted in the local language of the community. At the end of each session, tapes of the focus group discussions were transcribed from the local language to English language for consistency and correctness.

Data Management

All data collected were carefully reviewed and kept. Electronic data information was saved in well-protected digital software and pass worded to ensure confidentiality of information obtained. Data collected manually or long hand is neatly kept safe in a well secured locked up file cabinet.

Data Analysis Technique

All information gathered during the interviews was subjected to qualitative analysis. Qualitative data analysis according to Polit and Beck is defined as: "The process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents, it is a process of conjecture and verification, of correction and modification, of suggestion and defence"[33].

In qualitative research, data analysis is not a separate phase but one that occurs concurrently with data collection. According to Babbie and Mouton, qualitative data analysis examines words rather than numbers.[34] In this research, only information obtained during interviews (key informant interviews and in-depth interviews) as well as focus group discussions on the opinions of the different trained medical personnel, TBAs and FBAs, pregnant women/ mothers as well as community members on the issues relating to traditional and faith maternal health care practices were analysed using Nvivo for coding and analysis.

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[33] Polit, D. F & Beck, C. T. 2008, *Generating and Assessing Evidence for Nursing Practice*. 8th Edition, Lippincot Williams and Wilkins, a Wolters Kluwer business 508

[34] Babbie, E. and Mouton, J. 2001. *The practice of social research*, South African Edition, Oxford, University press

Ethical Considerations

In this research, all ethical considerations were observed and these include seeking the informed consent of participants, ensuring and assuring the participants of their confidentiality and anonymity. No name was required except where participant themselves mentioned or permits the use or mention of name. Tape recorder or voice recorder used during the process of gathering data was with strict confidentiality, and adequate protection of the participants' identity. There was no exploitation, exposure to risk or harm. Participation was voluntary.

Participants were made to understand that they can withdraw from the research at any time. They were also informed that information obtained before choosing to withdraw and which may have been modified or used cannot be withdrawn.

1.6. SCOPE OF STUDY

The research focus is on Nigeria; albeit the research also considered the legal framework and regulation of traditional and faith maternal health care practices in other jurisdictions, namely: Tanzania, Malaysia and South Africa. The study is limited to traditional and faith based maternal health care practices, the regulation and or non-regulation of traditional and faith based maternal health care practices in Nigeria and how this has contributed significantly and negatively to the continuous increase in maternal mortality in Nigeria. This research did not focus on the medical aspect of the practice.

The research also discusses the role and importance of traditional, faith based and other maternal healthcare practices in fulfilling the right to maternal health care, and the right to one's choice of health care based on one's belief and cultural acceptability.

Finally, due to time constraint, it could not have been possible to cover the whole of Nigeria during the field study for the purpose of key informant interviews and focus group discussions. We however attempted a fair representation of the country by conducting the research in selected urban and rural communities that represent a mixed population of the major ethnic groups in Nigeria.

1.7. JUSTIFICATION FOR THE STUDY

Maternal mortality is a reproductive health issue and more importantly a development and human right issue;[35] it is ranked as the primary health problem in young adult women particularly in Africa. For a woman in Africa, the overall life time risk of a maternal death is 1 in 16 as compared to 1 in 2,500 for women in developed countries. "Reproduction is the survival of our species and motherhood a dream of every woman". Maternal mortality is an important health indicator for any country.[36] With 10% of the world's maternal death rate, Nigeria ranks as number 2, coming in second only to India in terms of the high count of global maternal mortality[37]. As at 2015, amongst 10 countries with the highest mortality ratios in sub-Saharan Africa, Nigeria ranks fourth with 814 maternal deaths per 100,000 live births.[38]

Maternal death is defined as the death of a woman while pregnant or within six weeks of the end of pregnancy irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by pregnancy and its management.[39] These deaths, which need not occur, are as a result of poorly managed pregnancies and deliveries particularly by FBAs and TBAs. There is the need to reassess the standards and quality of maternal healthcare services available and further re-appraise state obligation under international human rights treaties to take all measures including legislation to provide and ensure access to quality reproductive health care, particularly maternal healthcare through regulation.

Ensuring that government complies with its duties in accordance with the universal principles of human rights towards reducing preventable causes of maternal mortality, and the high rate of morbidity among women, would include taking all measures, for example, regulatory and legal mechanisms to guarantee protection of women's reproductive health rights and ultimately the right to life.

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[35]Cook, R.et al 2003. Reproductive health and human rights: Integrating medicine, ethics, and law. op cit. 13
[36] Ibid.
[37]Azuh D and Azuh A.E 2015Gender influence on health care utilization among antenatal care women in Nigeria *Case Studies Journal* May 4; 5. 1Retrieved Jan. 10, 2016 fromhttp://www.casestudiesjournal.com
[38]Based on estimate by the World Bank Group, United Nations, UNFPA, World Health Organization, and UNICEF.
[39]World Health Organization. Partnership for Maternal, Newborn and Child Health. 2015. http://www.who.int/topics/millennium_development_goals/maternal_health/en/ retrieved 4th Sept. 2019.

There have been many studies on antenatal care, maternal mortality, morbidity rates; causes, prevalence, and role of TBA's and FBA's in maternal health care and other issues relating to the maternal mortality and morbidity, but very little or no studies have been done on regulatory framework and specific legal mechanisms for TBA's and FBA's to reduce maternal mortality in Nigeria. Hitherto, the focus of intervention had been medically oriented and little has been done on the legal aspect. The right to health which includes maternal health as provided under international legal instruments is closely linked to the right to life. Thus maternal death ought to be reduced to the barest minimum via a specific legal framework for regulation of unorthodox maternal health care providers and the services rendered.

The study focuses on examining the legal framework for regulating traditional and faith based homes and delivery centres in Nigeria, (if there are) and the effectiveness of such regulatory structures. It seeks to provide an explanation and also establish the link between regulation or non-regulation of traditional, faith based and other maternal health care practices and the high incidence of maternal mortality in Nigeria.

The results of the study will be beneficial to the following: The general public, government, governmental agencies and establishments of healthcare, policy makers, practitioners and providers of maternal healthcare, academics and other researchers in fields relevant to the study.

1.8. LIMITATION OF STUDY

Traditional and faith maternal health care practices are based and rooted in strong religious beliefs and inclinations. Issues relating to faith and culture are highly spiritual and metaphysical. One major obstacle encountered in this research is breaking into the fold of traditional and faith based health care practitioners so as to glean useful information on some of their practices, which are usually shrouded in mystery. In order to overcome this, the researcher adopted an inclusive approach; informed the TBA's and FBA's interviewed about the study and the purpose of the study and the benefits of the research to their practice.

Another limitation is the dearth of local resource materials. Most of the materials are foreign with few publications on the area of research.

1.9. STRUCTURE OF THE STUDY

This work is divided into six chapters.

Chapter one provides the introduction and a brief background to the study, while also stating the statement of problem, aim and objectives of the study, justification for the study and scope of study. In addition, the chapter gives an insight into the methodology and research approach, terms and concepts, limitation of study and expected outcomes. Finally, the chapter raises questions that are pertinent to finding answers to the research problem.

Chapter two reviews the extant literature on the work, giving an insight to the existing gap in knowledge which the research seeks to fill. It discusses the theoretical and conceptual framework of the research, considers the jurisprudential/ legal theories from two major schools of legal theory to explain and analyse the narratives of the research. The chapter includes a summary and conclusion leading to the next chapter, that is, chapter three.

Chapter three discusses the different types of maternal health care practices, namely; orthodox, traditional and faith based maternal health care. This chapter exposes the historical evolution of the three types of maternal health practices and the laws regulating each of these practices from inception to present day. The chapter concludes with a summary and conclusion, opening the discussion into the next chapter.

Chapter four, flowing from chapter three, comparatively discusses and analyses model regulatory framework from three selected jurisdictions, namely; Tanzania, South Africa and Malaysia. These regulatory frameworks and the regulatory framework for orthodox medicine in Nigeria are used as model for the institutionalization and regulation of traditional and faith based maternal health care practice in Nigeria. This chapter also ends with a summary and conclusion.

Chapter five considers the limitations and defects observed in the `laws and regulatory mechanisms of traditional and faith based maternal health care practices under chapter

three. Finally, chapter six states the findings of the research, total summary and conclusion of the work. This final part accordingly proffer recommendations based on the findings and discussions in the preceding chapters. Draft model legislation for the regulation of TBAs and FBAs is presented.

1.10. DEFINITION OF TERMS

In every research, it is imperative to attempt a definition of key terms and concepts that feature prominently as terms and concepts relating to, familiar or peculiar to the area or specialty of the research. Terms and concepts that feature commonly in this research are defined below:

Maternal Mortality

Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, while maternal morbidity refers to sickness, illness, disease or incapacity associated with the reproductive process. Maternal Mortality Ratio (MMR) is the number of maternal deaths per a thousand births.

Traditional and Alternative Health Care

According to the WHO, Traditional Medicine is 'the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness'.[40]

The term complementary medicine or alternative medicine as used inter-changeably is the term adopted in this research. In the same vein, complementary medicine is defined as a wide spectrum of healthcare practices that are non-indigenous to a country and are not incorporated into the prevailing healthcare system.

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[40] Executive board and world health assembly resolutions on traditional medicine. www.who.int/traditional-complementary-integrative-medicine/about/en.

Traditional Birth Attendants and Faith Birth Attendants

A traditional birth attendant (TBA) is a person, usually a woman but sometimes a man who assists the mother at child birth and who initially acquired the skills of delivering babies by herself or through an apprenticeship to other TBAs. A faith birth attendant (FBA) on the other hand is a birth attendant who assists a woman in child delivery under a faith mission or religious based organization.

Reproductive Health Rights

Maternity and maternal health relates to reproductive and sexual health law and rights. In this work, the definition of sexual and reproductive health as contained in the definition of the 1994 International Conference on Population and Development (ICPD) Programme of Action, which took place in Cairo, Egypt, will be adopted. Some of the elements outlined in that definition which are pertinent to this work include:

- Pre-natal care, assisted childbirth from a trained attendant (e.g., a physician or midwife), safe motherhood services and comprehensive infant health care;
- Prevention and treatment of violence against women and girls, including torture;
- Safe and accessible post-abortion care and, where legal, access to safe abortion services;
- Sexual health information, education, and counselling, to enhance personal relationships and quality of life.

The basic rights of all couples and individuals to:

- Decide freely and responsibly the number, spacing and timing of their children;
- Have the information and means to do so;
- Attain the highest standard of sexual and reproductive health;
- Make decisions on reproduction free of discrimination, coercion and violence.

Legal Regulation and Legal Framework

Legal regulation is a rule of order having the force of law, prescribed by a superior or competent authority, relating to the actions of those under the authority's control. Legal framework is a broad system of rules that governs and regulates conduct, decision making, agreements, laws, etc.

CHAPTER TWO

THEORETICAL AND CONCEPTUAL CLARIFICATION AND LITERATURE REVIEW

2.1. INTRODUCTION

This chapter will establish the theoretical framework of this research, review existing literatures on the research topic and also attempt clarification of some concepts that are significant to the research, in order to de-limit the scope of the topic and issues pertaining to the research. This work is anchored on some schools of jurisprudence (Theories of Law) which are the historical and sociological law schools. These two schools with their own notion of what is the nature, origin and purpose of laws, will expose the evolution, history, function of traditional and faith based health (Maternal health) care and their significance to indigenous communities and cultures. These schools of jurisprudence will help locate the appropriate place, form and nature of law in these societies, explaining the major issues and concepts such as reproductive and sexual health rights which includes; right to safe motherhood, rights to life, maternity, and choice of healthcare that is culturally acceptable. These theories will also be employed to explain the obligation of government to ensure, promote and protect the right to life and safe motherhood by taking all appropriate measures.

Literature reviews are a means of denoting a researchers' understanding about a specific field of study, the history and extent of previous works of other researchers and research groups in that area or field of study.[41]Attempts will be made to clarify concepts such as traditional medicine, alternative and complementary medicine, faith based, faith homes, traditional birth attendants(TBAs) and faith birth attendants(FBAs), rights to health and self-determination, to mention but a few.

[41]Randolph, J. J. 2009. A guide to writing the dissertation literature review: practical assessment, research and evaluation, June 4.13:1ISSN 1531-7714. Originally cited from Le Compte et al, 2003. Editor's introduction. *Review of Educational Research.* 73.2:123-124.

2.2. LITERATURE REVIEW

Research, literature and case studies on maternal mortality, traditional birth attendants, regulation and legal framework on health care abounds, with many of the literature and researches paving way for more research on the various perspectives and focus of the different authors. Many of these works have established and discussed extensively, maternal mortality as a major health problem affecting women in developing countries, exposing the causes and prevalence. Many have also focused on selected aspects of the subjects only; yet it is observed that there is a dearth of specific literature or research on legal framework and regulation of traditional and faith based maternal practices as a scheme aimed towards the decrease of maternal mortality in Nigeria, hence the gap and the need to review existing works and literature on the focus issue of the research. It is the aim of this research to bridge some of the gaps in existing literature.

This research attempts to contribute to already existing literature by looking at legitimising and providing an institutional legal frame work for the regulation of traditional and faith based maternal health care practices. The research is centred on Nigeria resulting from the high prevalence and its unacceptable global rating on the maternal mortality scale.[42] The research also beam its search lights on literature from other jurisdictions and the model frameworks for regulation of traditional and other alternative health care practices aside orthodox healthcare practice.

Bergstrom S and Goodburn E in the article, 'The Role of Traditional Birth Attendants in the Reduction of Maternity'[43] reviews and evaluates the impact of TBA training. The article reiterates the importance and cultural role of TBA's as a human resource for women during child birth, particularly in rural communities of poor resource countries. The writers adjudged the skill of local TBA's in terms of their cultural competence, consolation, empathy and psychosocial support. Bergstrom and Goodburn hold the view that trained midwives unlike TBA's and FBA's have an unfriendly attitude to women during child

[42]Nwafor. P. 2018. Global worry over Nigeria's low rating in maternal health. According to recent World Bank estimates, Nigeria's maternal mortality rate is 821 per 100,000 live births. 58,000 Nigerian women died in the year 2015 due to birth related complications. Retrieved July 17, 2018, from www.vanguardngr.com

[43]Bergstrom, S. and Goodburn, E. 2001.The role of traditional birth attendants in the reduction of maternal mortality.

delivery. The position of the Bergstrom on the role of TBAs and FBAs is in consonance with the position of this research on the role and importance of TBAs and FBAs in maternal health care delivery in Nigeria, filling the inadequacy in terms of access to orthodox maternal health care. Other writers such as Walraven and Andrews in their work maintain that TBA's despite their weaknesses, remain an important resource to women in poor countries, and provide needed maternal health care service, agreeing with the position of Bergstrom on the role, importance, preference for, and local acceptance of TBAs and FBAs.

On the training of TBAs and FBAs, Bergstrom states that even as many countries have adopted training of TBA's as strategy to improve maternal and neonatal outcomes, recent analyses reveals that the impact of training TBA's on maternal mortality is low. The article maintains that training of a TBA does not affect the belief systems and practices, confirming the position of the historical school of law which we have engaged in this research to explain and argue that law is reflective of culture, folk and beliefs of the people. Another position of Bergstrom et al is that TBAs cannot replace the need for more skilled birth attendants (Midwives). The article concluded on the note that the only way to reduce maternal mortality is to make use of trained TBA's in the interim or short term, with a long term plan to replace TBA's with skilled midwives.

This research finds Bergstrom and Goodburn's article very pertinent to this discourse; however, disagrees with their conclusion that the only way to reduce maternal mortality is to have more skilled trained midwives and phase out or totally replaces TBA's with skilled midwives. This research contends this position, and contrary to the conclusion of Bergstrom et al, advocates and re-emphasize the continual need for TBAs and FBAs in ensuring access to affordable and available maternal health care particularly in rural and low income settings. This research supports the assertions of Turnbull and Lourdes Verderese M.[44] that traditional birth attendants have a role to play in reducing maternal mortality if their training is combined with other strategies such as standardization, legitimization and regulation within their system and practice. This research contends that

[44] Turnbull, L. and Lourdes Verderese, M. 1975. The traditional birth attendant in maternal and child health and family planning: a guide to her training and utilization. Geneva: WHO. Publication No.18(See note 51)

the idea of phasing out or replacing TBA's will not affect or change the belief systems of the people which make them to patronize TBAs and FBAs. What is needed rather is to improve and make safer the practice standards within these alternative healthcare systems so as to make erring practitioners culpable or liable as the case may be. Therefore, the general notion about training should not be to turn TBA's into orthodox skilled midwives, but rather that the two systems should exist as parallels according to Akerele in the article "The best of both worlds: Bringing traditional medicine up to date" [45]

Turnbull and Lourdes Verderese M.[46] in their report started by giving a definition of traditional birth attendants, stating their role, profile and practices. The writers documented the world wide survey of traditional birth attendants and their involvement in maternal and child health and family planning. Corroborating previous researchers and works, the authors opined that there is a strong dependency on the locally organized traditional health care system, of which TBA's is one of the principal elements. The authors discussed the possible constraints in the mobilization of TBA's for its involvement in maternal and child health and family planning programmes. Amongst other interesting issues in the work of the authors is the extensive discuss on the more pertinent issue to this thesis, which is legislation, regulation and registration of TBA's. The authors elucidate the report of the W.H.O survey[47] with regard to the legal status, identification, registration and the freedom to practice as TBA's from a data gleaned from 64 countries. The authors were particularly concerned and asked the question, how can the centrally organized system of health care regulate the practice of TBA's considering that the TBA's are sanctioned by customs, traditions and rituals? The authors stated that as much as it is the responsibility of every government to protect the health of the citizens, to have laws and regulation for the traditional maternal health care practitioners seems laudable but the snag is that it may be difficult to apply the force of law to regulate the practice of TBA's. The authors are of the

[45]Akerele, O. 1987. The best of both worlds: bringing traditional medicine up to date. *Social Science & Medicine Journal* 24.2:177-181

[46] Turnbull, L. and Lourdes Verderese, M. 1975. The traditional birth attendant in maternal and child health and family planning: a guide to her training and utilization. Geneva: WHO. Publication No.18

[47]Turnbull, L. and Lourdes Verderese, M. 1975. The traditional birth attendant in maternal and child health and family planning: a guide to her training and utilization.Ibid.

opinion that TBA's should be given required training to practice and legal recognition, and that the laws should guide their practice rather than restriction.

The position of the authors, Turnbull and Lourdes Verderese M. is quite in tandem with the focus of this research and issues relevant to the thesis. However, with some slight disagreement with the position of the authors on the need for legal restriction, our study canvasses that where there is recognition of a trade or art and its skills which the society have adjudged overtime as useful, that art or trade is entitled to be ascribed the status of a profession, following which there must be regulation in order to protect the people from abuse, exploitation and other forms of harm. The position of this research on the need for proper regulation draws authority from the works of J. Liberman.[48] Furthermore, it holds the view that, this work of Turnbull L and Lourdes Verderese M. and their suggestions, which is based on a 1972 survey, can no longer suffice for our contemporary time and current dispensation, going by the unacceptable rates of deaths attributed to maternal mortality, resulting from the unscrupulous practices of some TBA's, the entrants of charlatans[49] and other self-designated faith midwives[50] into the locally organized maternal health care systems.

Akerele O. in his article,[51] states that 'if there is to be any real improvement in the health of the underserved populations of the world, there will have to be full utilization of all available resources, human and material'. The author advocates that recognizing and utilizing alternative health care systems such as TBA's is fundamental to the primary health care approach. He further opined that traditional practitioners constitute the main, and in most cases, valuable health resources available in rural communities. He is of the opinion that TBA's and FBA's are of crucial and significant influence to their communities and should be considered in any initiative to develop health services at the local level. The author also attests to the fact that Member States are responding differently to a number of

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[48]Liberman, J. K. 1970. The Tyranny of experts: how professionals are closing the open society. New York:Walker.
[49]Turnbull, L. and Lourdes Verderese, M. 1975. The traditional birth attendant in maternal and child health and family planning: a guide to her training and utilization. op cit.
[50]Ibid
[51]Akerele, O.1987.The best of both worlds: bringing traditional medicine up to date. op.cit.

key WHO resolutions calling on governments to develop traditional medicine practices as a part of their health care system.

The position of Akerele in the foregoing article, calling for a parallel existence of traditional medicine alongside orthodox medicine is a view that this research also holds strongly and intends to canvass in this research. However, unlike the research focus which is regulation and standardization, the focus of Akerele's article is on primary health care and improving utilization. It is opined that if there is going to be a parallel existence of traditional health care practice alongside orthodox health care, traditional health care practitioners and their practices just as orthodox, must be standardized and regulated for safety, protection and improved utilization. Furthermore, Akerele emphasise only the importance and role of traditional practitioners, unlike Walraven and Andrews,[52] he failed to balance his position by not mentioning the weaknesses and negative roles of traditional practitioners and their practices on health, particularly maternal mortality and morbidity.

Similar to Akerele's foregoing article is Rajendra Kale's article[53] which discusses the significant role of traditional healers in South Africa. Like previous literature, she alludes that 'traditional healers are enshrined in the minds of the people and respected in their community'.[54] The article enumerates the different types of traditional healers and their scope of practice as herbalists, diviners and faith healers. One interesting thing to note is that the article categorizes faith healers under the types of traditional healers, stating that they are professed Christians of the African Churches. We tend to disagree with this categorization or grouping by Rajendra Kale and reiterate that though traditional health care practice and practitioners can be traced to religion, faith healing of the Christian faith is different from traditional medicine and cannot be said to be the same.

Rajendra's article also confirms other literature on the level of acceptability of traditional medical practice or health care among the African people, stating that the number of

[52] Walraven, G. and Andrews, W. 1999, The role of (traditional) birth attendants with midwifery skills in the reduction of maternal mortality. *Tropical Medicine and International Health*.4.8:527-529. See note 56.
[53]Rajendra, K. 1995. South Africa's health: traditional healers in South Africa: a parallel health care system. *BMJ*.310:1182
[54]Turnbull, L. and LourdesVerderese, M. 1975. The traditional birth attendant in maternal and child health and family planning: a guide to her training and utilization.op.cit.

traditional healers far out numbers orthodox medical practitioners. According to the writer, traditional healers are more caring; strive to satisfy the patient, offering holistic care. This caring feature of traditional health care practitioners which has been acknowledged in many of the literature on traditional health care and systems of health continue to make traditional health care a preferred choice particularly in maternal health. However, on the issue of recognition and regulation, the writer reveals that there is a statutory ban on traditional healers in South Africa.[55]The article mentioned the status of traditional healers in other African countries like Zimbabwe and Mozambique. Rajendra's article and information on statutory ban of traditional healers in South Africa is out of date and does not reflect the current status and importance of traditional healthcare practitioners to South Africa's health care system in the last decade.

Walraven G. and Andrews W. in their work[56] buttress the fact that TBA's despite their weaknesses, remain an important resource to women in poor resource countries in the provision of maternal health care and service. The article states that despite the many initiatives of the safe motherhood strategy, for example, the training of TBA's, there has been very little impact on the reduction of maternal deaths. Unlike the position taken by Bergstrom, the article discusses the implication of phasing out the TBA's and replacing them by training professional midwives. The author identifies some of the unexpected negative effects that may likely attend such policies. Some of the challenges identified include; huge cost of training, salaries and wages, non-acceptance, withdrawal of trust and respect by the community, alienation and cultural insensitivity to community's health care necessities. The article identifies with and buttresses the many literatures that have expressed the position that for a people to access health care, the type of health care must be culturally acceptable to the people. Where a healthcare is against the culture and religious beliefs of a community, intervention and strategies to improve and promote quality and standard of health care services rendered will be an exercise in futility.[57] The authors ask the question whether it would be a wise decision to abandon TBA's and not

[55]Health Professions Act 56 of 1974
[56]Walraven, G. and Andrews, W. 1999, The role of (traditional) birth attendants with midwifery skills in the reduction of maternal mortality.op cit
[57]Ibid

consider the good works that they sometimes do. They concluded by stating that though the training of professional midwives is a laudable policy, as an intermediate solution to reducing maternal mortality, TBA's practicing in their communities should be identified and supported with midwifery skills.

Nkundakozera A. in his own article[58] discusses the important role that trained traditional midwives can play in reducing the high rates of maternal and infant mortality in Rwanda. According to the writer "Rwanda suffers from all the ills common to developing countries, including high rates of stillbirth and infant mortality".[59] The article emphasized the need for training and continuing education of traditional midwives who are already recognized and chosen by their communities, stating further that trained traditional midwives have a role to play in providing maternal and infant health care at the primary level in Rwanda if equipped with the necessary 'scientific obstetrical knowledge', such as observing hygiene, diet, obstetrical care, the desirability of giving birth at a health centre, vaccination of pregnant women against tetanus, immunization of infants and referrals. The author suggests a training period of 4-weeks courses in proper procedures for prenatal visits, labour and delivery, postpartum, and for the new-born.[60] Finally, he recommends that traditional midwives after training be incorporated into the primary health care system and should receive continuing education on a regular basis. This position of this article on the role of traditional midwives and the need for formal training has been canvassed by other researchers, and also adopted by governments as a strategy towards reducing maternal mortality. However, the pertinent question to ask is whether such training have actually reduced maternal mortality in countries where this strategy had been undertaken going by the yet unacceptably high rates of maternal mortality and morbidity.[61]Bergstrom, Walraven and Andrews in their works[62] have maintained that despite the many initiatives of the strategy for safe motherhood, such as the training of TBA's, there has been insignificant impact on the reduction of maternal deaths.

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[58]Nkundakozera, A. 1985. The role of traditional midwives in the provision of primary health care in Rwanda. *Imbonezamuryango*. April, 2:8-11
[59]Ibid
[60]Ibid
[61]Ibid
[62]Walraven, G. and Andrews, W. 1999.The role of (traditional) birth attendants with midwifery skills in the reduction of maternal mortality. op.cit.

Of all the literature and works reviewed so far, the work of Stepan, Jan[63] specially touches on legislation and alternative systems of medicine. The article exposes the history and position of traditional medicine in health care systems of different countries which he enumerates and categorizes into four, namely; monopolistic, tolerant, inclusive and integrated. The article identifies the selected branches of alternative medicine as traditional birth attendants, manipulative therapy (Chiropractic and Osteopathy), acupuncturists, and homoeopathy.

The article exposes the problem of connecting health issues to supernatural forces and witchcraft. He expressed that there is a de-facto toleration of traditional healers even in developing countries despite the strict monopoly for orthodox medical professionals.

On legislation and regulation, the author, Stepan J. chronicles examples of countries with prohibiting, tolerant and legitimizing legislations. In his extensive discussion on legislation, the author states:

> *… It is self-evident that in States where the expensive and complicated structure of modern scientific medicine is unable to satisfy even the most basic needs of a small fraction of the population, and where people have always resorted to indigenous form of healing, it is entirely unrealistic to prohibit traditional medicine. The law is powerless to interfere with the daily practices of all sorts of traditional healers unless "something goes wrong". Mostly where a conspicuous death results from evident malpractice, such healers are unmolested and informally tolerated, although they are denied official recognition.*[64]

He further reiterates that in such developing countries, prohibitive legislation is minimal or non-existent. Some governments allow registration of associations of traditional healers,

[63]Stepan, J. 1985.Traditional and alternative systems of medicine: a comparative review of legislation. *International digest of health legislation* 36.2 : 281-341
[64]Stepan, J. 1985.Traditional and alternative systems of medicine: a comparative review of legislation. op.cit.

but are mostly in accordance with government laws for trade unions. Stepan in the article further opines that a health care decision rests on the right to self-determination and the right to privacy.

This discourse particularly finds the work of Stepan interesting and very relevant to this research. Most significant is the article's exposition on the inter-relatedness which identifies traditional birth attendants (Traditional medicine) as a part or branch of alternative medicine. The revelation may be important in determining whether traditional medicine and alternative medicine are the same or the question of whether alternative medicine stemmed from traditional medicine. This is an issue that is yet to be resolved amongst the practitioners of the 'two systems'. In the same confusion, many authors have used the terms interchangeably and to mean one and the same. Yakubu A. in his book[65] while discussing traditional health care used the terms 'alternative healing device or natural healing device', 'alternative medical practice'. Noting this confusion, this research prefers to differ in opinion on the term and meaning of 'alternative medical practice'. The position which this research holds strongly is that traditional or indigenous system of healthcare is the official medical system of the natives or indigenes. Referring to traditional healthcare as 'Alternative or complementary healthcare' is therefore erroneous. Rather, it is orthodox, Western medicine that came as an alternative medicine to our own indigenous system of healthcare and should appropriately be referred to as such.

Although Stepan's article unlike some of the works previously discussed did not delve into the role of traditional birth attendants and maternal mortality, the article gives room for more research into the appropriate nomenclature, current status and position of traditional/ alternative medicine practitioners in different countries.

Elujoba A. et al in the article[66] focuses on Traditional African Medicine (TAM). The article states that TAM is part and parcel of Africa's socio-economic and socio-cultural heritage, servicing over 80% of the populations in Africa. The authors, Elujoba et al note that

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[65] Yakubu A 2002. Medical Law in Nigeria, Demyaks law books, Ibadan. 71

[66]Elujoba, A. et al. 2005.Traditional medicine development for medical and dental primary health care delivery system in Africa. *African Journal of Traditional, Complementary and Alternative Medicines*. Dec, 2.1:46-61.

although TAM, has 'come a long way from the times of our ancestors, not much significant progress on its development and utilization had taken place due to colonial suppression on one hand, foreign religions in particular, absolute lack of patriotism and political will of our Governments',[67]confirming the position of other writers about African governments attitude to the development of TAM, and the fact that government merely tolerate traditional healthcare practices. The authors Elujoba et al further maintain that TAM exhibits far more merits than demerits and that its values can be exploited provided the Africans themselves can approach it with an open mind and scientific mentality. The article also reiterates the commitment and efforts by the World Health Organization (WHO) on encouraging African governments to develop TAM.

Elujoba et al article did not specifically focus on traditional maternal health care or the need for regulation or non-regulation; it however touches on traditional medicine which is the broad 'tree' of which traditional maternal health care is a branch. A discussion on traditional maternal healthcare will not be complete without reference to traditional medicine. In addition, the article's position is the same as Turnbull L and Lourdes Verderese M. that traditional health care practices in Africa are socio-culturally rooted, socially accepted, affordable, cultural compatible, relevant and allows for community participation. Elujoba et al position also buttress the opinion of other writers that the traditional healthcare provider is closer to the community, living with them and providing healthcare services in the same communities. This confirms the poor situation of health care in the Africa's developing nations and their rural communities, where traditional health care practices and its practitioners are the people's only available recourse for health care, due to western type of health institutions being unavailable or out of the reach of most people in terms of distance and costs. Elujoba et al advocate that traditional medicine be institutionalized not fused but parallel to 'orthodox medicine within the national health care scheme in order to move the health agenda forward'. Orthodox medicine alone cannot achieve an effective health agenda for the African continent unless the system is

[67]Elujoba, A. et al. 2005.Traditional medicine development for medical and dental primary health care delivery system in Africa.Ibid.

complemented by traditional medicine practice.[68] The focus of the Elujoba et al article is on traditional medicine and orthodox dentistry; however of interest to this thesis is the authors' suggestion and recommendation on the institutionalisation of traditional healthcare alongside orthodox healthcare.

Cook R.J et al in the renowned book on Reproductive Health[69] discussed maternal mortality and morbidity and the need to make motherhood safe for women. The authors maintained that though maternal deaths are now very rare in developed countries, the incidence is still common and high in developing countries, stating further that women who die are usually those in the prime of their lives. The book exposed also the prevalence of maternal morbidity, stating that maternal mortality is "only the tip of an iceberg of maternal morbidity" and that many women are going through acute or chronic suffering and some form of incapacity. Commenting on safe motherhood, the authors stated that skilled birth attendants are more in developed States than less developed States. The authors reiterated and canvassed like many other authors that trained midwives have an important role to play in making motherhood safe for all women. Finally, on maternal mortality, Cook R.J et al in the book states that maternal mortality in developing countries is a tragedy in terms of equity and social justice, re-emphasizing the fact that maternal mortality ratios show "greater disparity among countries than any other public health indicator". The book as a major text on reproductive and sexual health is an exposition on the interrelation between medicine, reproductive health and human rights. The book is very essential to this thesis because the issues maternal health, maternal mortality, safe motherhood and the need to protect and promote maternal health are well situated in reproductive and sexual health rights. Other related areas covered by the book include; health systems, healthcare professionals. However, no matter how succinct or laudable a book may be, it cannot possibly delve into the details or broach every subject or issue. There was no reference in the book to traditional and faith healing maternal practices or their recognition or regulation. This may be understandable as the book portrays

[68]Elujoba, A. A. et al. 2005.Traditional medicine development for medical and dental primary health care delivery system in Africa Ibid.
[69] Cook, R.J et al. 2003. Reproductive health and human rights; integrating medicine, ethics, and law .op cit.

international orthodox medical standards a means of safeguarding and advancing reproductive and sexual health rights. There is no reference to other forms of maternal health care practices.

Kassaye, K. D. et al in their article on traditional medicine practices,[70] reviews the practices and policies on traditional medicine in Ethiopia. The author like other authors such as Bergstrom et al reinstates the important role of traditional medicine in the society with particular reference to the Ethiopian society, tracing the history. The article itemises various categories in the practice of traditional medicine, majoring on the individual aspects of health which includes operative practices, divine healing, and prevention. This confirms that traditional healthcare practitioners do perform some form of surgery or bodily invasion. Furthermore, the article provides an insight into the recognition status and support given by government to traditional medicine in Ethiopia. In conclusion, however, the authors query the commitment of government to sustainable use of traditional medicine and possibility of integrating traditional medicine into modern medical practice.

This article by Kassaye et al, though not specific on maternal mortality or the role of traditional maternal health care practices and their regulation which are the crux of this thesis, the work is relevant as it focuses on Ethiopia, an African country with culture, customs and traditional practices similar to Nigeria. Also relevant is the contribution to knowledge on the different aspects of traditional practice relevant to traditional maternal health care. The conclusion buttresses the current view of writers about the reluctance of governments to integrate traditional medicine with modern medical practice. The article however, did not mention the existence of any formal or legal regulation of traditional medicine in Ethiopia.

Olapade and Lawoyin in their own research article[71] restates that despite recent focus on maternal mortality in Nigeria, maternal mortality rates remain unacceptably high in Nigeria, further establishing the high incidence of maternal mortality in Nigeria. The

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[70]Kassaye, K. D. et al. 2006. A historical overview of traditional medicine practices and policy in Ethiopia. *Ethiopian .Journal of Health Development*. 20.2: 127-137.
[71]Olapade, F. E & Lawoyin T.O. 2008. Maternal mortality in a Nigerian maternity hospital. *African Journal of Biomedical Research* 11.3:267-273

article states that pregnancy and childbirth are a natural process which should bring joy to individuals and their families. In many parts of the world however, pregnancy and childbirth is perceived as risky and possibly fatal for millions of women especially in developing countries. This work by Olapade and Lawoyin emanated from a study carried out in a hospital, to determine the maternal mortality ratio in a secondary health facility, to identify the causes of death and to assess factors associated with the maternal deaths. The authors' work buttresses the reality of maternal deaths and incidence in Nigeria health facilities.

Sandlana N. et al article on African tradition and religious faith practices,[72] a very incisive and pertinent work to this discourse, is one major article of all the works in this literature review that delve into the relationship between health preference, choice and decision. The authors recognize the strong connection which is shared between African traditional and religious faith healing. This is an area that not many of the previous writers have engaged. The article makes reference to related practices among the AmaXhosa tribe of the Eastern Cape, South Africa. They argued that traditional and religious faith based health care ought to be included as a proper aspect under the mainstream forms of therapeutic intervention.[73]

This next article by UNICEF and a non-governmental organization, like the previous one, studies the Apostolic Religion sect, utilization of maternal and child health Services in Zimbabwe.[74] The study seeks to understand beliefs and practices that lead to acceptance or rejection of preventive and promotive health and social practices among apostolic religious groups in Zimbabwe. The study reported that women were refused medical treatment despite having obstetric complications, and some women failing to deliver normally or experience breech were beaten up while in labour and forced to confess their sin or adultery. Sin was viewed as the source of illness or complications, and hence confession of sins must be made for healing and normal delivery to occur. Ironically, some religious fundamentalism which prevents members from turning to orthodox healthcare is rooted in

[72]Sandlana, N. and Mtetwa, D. 2008. African traditional and religious faith healing practices and the provision of psychological wellbeing Among Amaxhosa people. op.cit.

[73] Ibid.

[74]UNICEF and Collaborating Centre for Operational Research and Evaluation. 2011.Apostolic Religion, Health and Utilization of Maternal and Child Health Services in Zimbabwe. UNICEF: Zimbabwe. Retrieved Nov. 25,2015, from www.Zim_resources_apostolicreligion

unwavering religious beliefs and strict adherence to church doctrine that views recourse to orthodox healthcare as a “sign of rebellion and infidelity towards God.” The article advocates the need to collaborate, inform and educate faith based healthcare providers. It calls for a capacity assessment and creating linkages between formal, traditional and religious health systems. It states the need for policy and legislation in this regard. The article like previous and other related articles on the topic, contributes to existing knowledge on link between religion, beliefs and health in Africa. The article exposes the reality of faith based maternal practices in an African society with religious denominations and doctrines similar to those in Nigeria. Faith healing is a religious belief and conviction, which often refuses the need for medical treatment even for life-threatening ailments and obstetric complications. Faith based maternal healthcare is a major thrust in this research without which this work will be regarded as grossly incomplete. The study creates the impetus for a research into the activities of faith based maternal health practices, the practitioners, the legal standards and regulatory framework in Nigeria.

Awodele O et al[75] wrote on the ‘need for integration of traditional health care into the Nigeria national health care’ noting that WHO has proposed the organisation and training of practitioners of traditional medicine for primary health care services to enable the use of traditional systems of medicine with appropriate regulations based on national health systems. The article by Awodele et al states that traditional medicine practitioners are presently employing a series of strategies to ensure integration of their practices into the National Health Care Scheme. While it may be laudable to call for integration, this research opines that integration may not be the first step to improving the services provided. Regulation and recognition by government are necessary preliminary steps to integration which if at all, should entail a gradual process of acceptance by orthodox practitioners who believe that traditional medicine is a trade of illiterates and charlatans and would rather not associate themselves or their profession with.

[75]Awodele, O. et al. 2011.Towards integrating traditional medicine (TM) into National Health Care Scheme (NHCS): Assessment of TM practitioners’ disposition in Lagos, Nigeria. *Journal. of Herbal Medicine*. 1.3-4: 90-94

The article is based on a study carried out in Lagos, Nigeria. The aim is to determine the knowledge of traditional medical practitioners about their practices. The study also assessed the disposition of these practitioners towards ensuring safety measures in their practices towards subsequent integration into national primary health care.

The Awodele study on the Assessment of Traditional Medicine Practitioners' Disposition in Lagos Nigeria confirms that traditional medical practitioners also know that their herbal preparations do have adverse effects. This research observes that the focus of the Awodele study was on traditional medicine. The authors' however limited their study to practices in an area of traditional medicine which is not a reflection of the total and diverse areas and practices of traditional medicine. This is evident from the response of the practitioners interviewed that they were disposed to scientists investigating their herbal preparations.

Awodele et al posits that traditional practitioners are aware of the need to improve their educational status. Also, their study found that the practitioners are ready and do have the intention to collaborate with orthodox medical practitioners if they are given the opportunity. This research is of the view and still reiterates that regulation and standardization rather than integration should be the first step. This will likely encourage young traditional medical practitioners on the need to acquire education which will not only earn them the respect of orthodox medical practitioners but also empower their chances of collaboration. Awodele et al concluded that Government should constitute a body that will facilitate the integration of traditional medicine into national health care system as proposed by the WHO.

Buttressing the position of this research on the right to choose a health care service of one's choice, the Awodele study reiterates that traditional and western medicines are individual valid treatment options, but that yet, each has its limitations and neither of them has all the treatment answers. Finally, the article states that integration may enhance safety use of herbal remedies and appropriate practice. A point on which this research will differ from Awodele et al, maintaining the view that regulation and standardization should be the first step to integration. The call for a body to facilitate integration can only be appropriate if there is first a statutory regulatory body enabled by an Act of the National Assembly. The

Awodele study further affirms the view of this research that the current ills associated with traditional health care practices is a result of the lack of a specific legal framework for the regulation of the various practices under traditional health care, particularly, traditional maternal health care.

Vyagusa et al[76]critically examine the policy implication of involving traditional birth attendants in providing maternal health services in developing countries, using Tanzania as case study. The work opines that access to quality maternal health care is not only about involving TBA's, but depends on other criteria such as policy, regulations, skills, knowledge and perception. Observing the knowledge and practices of TBA's and their involvement in emergency obstetric care in Tanzania maternal health facilities, the authors came to the conclusion that TBA's lack the requisite knowledge required to handle emergency obstetric issues and that government should see to the training and supervision, remuneration and provision of working facilities for TBA's. This article reveals and buttresses one of the positions in this thesis that health care choice is deeply rooted in the cultural beliefs and practices of the people and many people, particularly in rural communities of developing countries still patronize TBA's even where orthodox facilities are available. Concerning health care choices, particularly maternal health care choice and decisions, people in traditional societies have built systems of folk medicine and traditional care to deal with their health problems.[77] The choices and decisions concerning their health are rooted in a common core of beliefs and customs, and included in these are the several kinds of traditional, religious and faith health practitioners.

Owoseni, Sina and two other researchers in the article "Pregnancy Care and Maternal Mortality in Ilesa, Osun State",[78] brings to fore the role of faith based homes and mission houses in maternal healthcare in Nigeria. Their article is based on research which examines maternal health care practices by FBAs and faith based missions and patronage of these places by pregnant women. Owoseni et al article established the fact that many pregnant

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[76]Vyagusa, D. B. et al. 2013.Involving traditional birth attendants in emergency obstetric care in Tanzania: policy implications of a study of their knowledge and practices in Kigoma Rural District. *International Journal For Equity in Health*12:83

[77] Turnbull, L. and Lourdes Verderese, M. 1975. The traditional birth attendant in maternal and child health and family planning: a guide to her training and utilization. Op cit.

[78]Owoseni, J. S. et al. 2014. Pregnancy care and maternal mortality in Ilesa, Osun State Nigeria.op.cit.

women patronize both hospitals and mission houses. It revealed that women combine faith homes with hospitals where they are registered and visit the hospitals for ante-natal care, but when it is time to deliver they prefer to deliver in the mission house. Their article further established that the people's religious belief system has greatly influenced behaviours in seeking maternal health services. Confirming previous literatures on religious belief systems and health care, it is clear from findings that childbearing is believed to be of divine orchestration. Owoseni et al study also reveal that one of the reasons women prefer to deliver in missions and faith maternal homes is that faith maternal homes are more sympathetic and caring.

In the provision of health care, the importance of a health system that cares cannot be overemphasised, more so with regards to maternal health. The reasons for patronizing faith homes as alluded by Owoseni et al has also been identified by Cook et al[79] as short comings in the health care systems of many countries, which includes imbalance in available services, inefficiency and lack of responsiveness to women's expectations and perspectives.[80] The works of Cook et al and Owoseni et al, gives the basis for one of this research's strong arguments for the institutionalization and regulation of traditional and faith based maternal health care in Nigeria. Although traditional and faith based maternal health care practitioners may not perform well in the function of cure as much as the orthodox health care practitioners, despite their clumsy performance, women still prefer to patronize them for the role they play in providing supportive and pastoral function of care.[81] TBAs and FBAs continue to command the respect and prestige of the community they serve.[82]

Owoseni et al study is very pertinent to our research as it reveals the role and activities of faith based maternity missions in maternal deliveries and the fact that women prefer them to orthodox practitioners. It is therefore necessary for there to be an inquiry into the

[79]Cook R.J et al. 2003. Reproductive health and human rights; Integrating medicine, ethics and law, op cit.
[80]Ibid
[81]Owoseni, J. S. et al. 2014. Pregnancy care and maternal mortality in Ilesa, Osun State Nigeria .op.cit.; Cook R.J et al. 2003. Reproductive health and human rights; Integrating medicine, ethics and law, op cit.
[82]Ibid

activities of these faith homes, the standards of practice, whether they are regulated and by which, or under what law.

Okojie E.A. in a very recent article[83] discusses the status of trado-medical practice in Nigeria. The author traced the history and various forms and attempts by government to regulate, standardize and also incorporate trado-medical practice into the National health care delivery, recognizing that many Nigerians do patronize traditional medicine practitioners as first line in seeking health care. The author enumerated a number of regulatory provisions, bills,[84] agency[85] starting with provisions of the Nigerian Constitution.[86]Okojie in his article traced the history of attempts at standardization and regulation by government. By chronicling the history and attempts at standardization and regulation, the article exposes the origin of the current confusion about scope and meaning of traditional, alternative and complementary medicine in Nigeria. Presently in Nigeria, there exist different associations claiming to be practitioners of alternative/ complementary medicine, and those practicing traditional medicine. Each of these associations are recognised and registered as trade unions under the CAMA[87], claiming different scope, practices and mode of operation. This confusion which is yet to be resolved due to lack of a decisive regulatory body and framework is an existing gap. This is an area which the research will merely gloss over since it is not the actual focus of the research. Okojie opines that there is a regulatory mechanism for trado-medical practice in Nigeria, of which this research disagrees and will contend in the subsequent chapters of this thesis.[88] Okojie's article is relevant in its attempt to convince that there exists a decisive regulatory mechanism or body for trado-medical practice in Nigeria. The article however, neither

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[83]Okojie, E. A.2015.Impact of regulatory mechanisms on trado-medical Practice in Nigeria. *Journal of Law, Policy and Globalization*38 ISSN 2224-3240(Paper)ISSN 2224-3259(online). Retrieved Aug. 18,2016, from www.iiste.org

[84]Complementary and Alternative Medical Council of Nigeria Bill, it is noted that the author did not mention the proposed 2004 bill, Traditional Medicine Council of Nigeria (Establishment, ETC.) Bill,2010

[85]National Agency for Food and Drugs Administration Commission (NAFDAC)

[86]1999 Constitution of the Federal Republic of Nigeria. LFN 2004

[87]Companies and Allied Matters Act. C20, Laws of the Federation of Nigeria 2004.

[88]Anon.2015.Who regulates traditional medicine? *The Nation.* Aug 6. Retrieved Aug. 16, 2016 from thenationonlineng.net. There is a lot of controversy over who regulates and what is regulated in traditional, alternative and complementary medicine in Nigeria. (Comment of Prof Katchy,President, National Complementary and Alternative Medical Association.)
In recent years, several bills have been proposed, and all are currently before the National Assembly, waiting to be passed into law.

discusses nor envisages faith based health practice nor the impact of trado-medical or other alternative health practices on maternal health or mortality.

Balogun M, Odeyemi K.[89] was of the view that Traditional Birth Attendants (TBAs) and Faith Birth Attendants (FBAs) in Nigeria have the potential to contribute significantly to maternal health outcomes because of their high utilization within the country. TBAs do not receive formal medical training when compared to other health professionals such as obstetricians and gynecologists. However, TBA's are much more affordable and accessible than the orthodox medical health institution in most parts of the country. Most TBAs are middle-aged or older women and are highly respected in their roles as midwives to rural communities.

Olasanya, Alakija, and Inem[90]stated that growing evidence suggest; despite the socio economic status of many women in urban areas where physical access and financial barriers to facility-based obstetric services are minimal, resort is still made to TBAs in their residential homes as well as mission houses (FBAs). Apart from the increase in the attention of skilled attendants there is a need for some form of regulation to ensure that certain minimum standard should be observed.

Ofili and Okojie[91] revealed that traditional Birth Attendants undergo training and in places like Lagos State, they require a license to function and practice. In spite of the high patronage of traditional birth attendants, many of their practices during childbirth have been found to adversely affect the health of mothers

According to Chibuike Alagboso[92] Since the adoption of the Primary Health Care (PHC) approach in Nigeria in 1979, government has recognized the need for integrating

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[89] Balogun M, Odeyemi K. 2010. Knowledge and practice of prevention of mother-to-child transmission of HIV among traditional birth attendants in Lagos State, *Nigeria. Pan African Medical Journal.;5(7)*:1–12

[90] Olasanya, Alakija, and Inem, 2010, traditional birth attendants and maternal care delivery service *Pan African Medical Journal.;5(6):3*

[91] Ofili and Okojie, Assessment of the traditional birth attendants in maternal health care in Oredo Local Government Area, Edo State, Research Gate. https://www.researchgate.net/publication/277765319_Assessment_of_the_role_of_traditional_birth_attendants_in_maternal_health_care_in_Oredo_Local_Government_Area_Edo_State_Nigeria#downloadCitation

[92] Chibuike Alagboso, Traditional Birth Attendants; Friend or Foe, Nigeria Healthwatch, Health Torchlight series, July 16, 2018. Accessed from Http://Nigeria Healthwatch.com/traditional-birth-attendants-friend-or-foe/ Xxi8-M0o80M

traditional birth attendants (TBAs) into the PHC system and had consequently initiated TBAs training programmes. Many of these programmes are also run by both local and foreign NGO fuled with the passion of reducing the risk and complication in maternity birth by Traditional and Faith Based maternity. Although most cases Faith based Birth Attendants are more informed than Traditional Attendants about certain medical risk and complication that result from child birth because they are usually Nurses, Medical specialist such as paediatricians and gynaecologist who may be in private practice.

The Lagos State Government through the Lagos State Traditional Medicine Board (LSTMB), established under the Lagos Ministry of Health to oversee the activities of the TBAs, is also making efforts to improve the capacities of the TBAs in the areas of hygiene and standard practice. The Board has three separate courses designed to orientate and expose TBAs to a code of ethics and help familiarize them with harmful practices that could be dangerous to pregnant women and their new born. Two of the courses are mandatory courses created to teach TBAs basic human anatomy and physiology, health statistics, primary health care, traditional medicine and food nutrition for nutritional medicine, and each course runs for six weeks. Where there's a breach of the code of conduct; the Lagos State Health Sector Reforms Law 2006 ensures that offenders are fined. The LSTMB has a monitoring task force which goes round birthing homes in search of unregistered/untrained attendants. The code of ethics also bars TBAs from attending to any pregnant woman who has had a miscarriage or undergone a caesarean section before or if they see danger signs like oedema (swelling of the hands and feet), high blood pressure, and bleeding. The code of ethics authorizes them in these cases to refer these women to the nearest general hospital for proper care. The TBAs are also mandated to alert the nearest General Hospital in case of any emergencies while conducting deliveries, and an ambulance will be dispatched from the hospital to their birthing homes.

At this juncture it is important to note that there are no specific federal laws or regulations that regulates the affairs of TBAs and FBAs, however some states have set up agencies and parastatals to coordinate their activities and setting up certain minimum standard of operation. Lagos State is taking the leading role in this wise. More states in the country could use Lagos State's approach of training and regulating Traditional Birth Attendants to

improve their work and contribute their quota towards the global goal of reducing maternal mortality. Although, various workshops, sensitization and training programmes are ongoing within the country chaired by NGO and Governmental Organizations. For example a one-day training workshop for TBAs took place at Aliero in Aliero Local Government[93] Area of Kebbi State, Nigeria in 2006.[94]

Global One 2015, an International NGO in one of its recent publication[95] discusses the prevalence of maternal mortality in Nigeria as well its shortage in health care facilities and access, as responsible for the country's high incidence of maternal morbidity and mortality. Their article reveals costs as the major factor responsible for discouraging families and patients from the notion of looking to professional care in both private and government health facilities. Their article concludes that inability to afford these costs which often leads to seeking alternative treatment from unskilled professionals explains the higher rates of maternal mortality and morbidity. Global One's article establishes the works of other researchers on cost and accessibility as one of the major hindrances to seeking maternal health care in orthodox health care facilities, hence the resort to alternative maternal care provided by TBA's and FBA's where the cost is minimal or sometimes gratis.[96]

In conclusion, with the copious number of extant literature on the pertinent areas, issues and focus of this thesis, many of which have dealt extensively on traditional and faith birth attendants, maternal mortality and regulation, it is the observation of this research that alternative/ traditional health care practices and issues pertaining or arising from traditional health care systems affords researchers the opportunity to carry out future research. While many of the literature have touched on various issues and aspects relating to this research topic, they are by no means exhaustive, thus there is still need for more research on the regulatory framework for traditional and other maternal health practices in Nigeria. Many

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[93] Their sensitization efforts targeted pregnant women in Bwari area council, about 20km off the Abuja – Kaduna expressway, focusing on educating them about the dangers of home deliveries

[94] 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*.

[95] Maternal health in Nigeria: a statistical overview, June 2012. Global One 2015.op.cit.

[96] Maternal health in Nigeria: a statistical overview, June 2012. Global One 2015.Ibid

of the literature have also confused on faith based maternal practices with those of traditional maternal care. There are therefore existing gaps in this area of knowledge, which this research will attempt to bridge by contributing to discourse on the need for a specific legal framework for traditional and faith based maternal healthcare practices towards reducing maternal mortality in Nigeria.

2.3. THEORETICAL FRAMEWORK

In this discourse, it is necessary that the logic of explanations and theorizing of the topic and issues related to this research be founded upon some jurisprudential theories of law for a better understanding of the topic. In our analysis, we therefore adopt two major schools of jurisprudence, namely; Historical School and Sociological School of law. These various schools with their own notion of what is the nature, origin and purpose of laws, exposes the evolution, history, role and importance of Traditional health (Maternal health) care to indigenous cultures. These schools of jurisprudence help to locate the appropriate place, form and nature of law in these societies. The focus is on Nigeria and the three major ethnic groups.

There are three major ethnic groups in Nigeria. They are the Igbos, Yoruba and Hausa/Fulani tribes. The Igbos are found in Nigeria's south-eastern states of Abia, Anambra, Ebonyi, Imo, Enugu and parts of Delta and Rivers States. According to Ifemesia[97], the Igbo country covers an area of over 15,800 miles. Nwala[98] puts this area to be roughly circumscribed between 60 and 8½0 East longitudes and 4½0 and 7½0 North latitude[99]

The Yoruba people dominate the South-western part of Nigeria. The population was approximately 30 million, about 21% of the entire Nigerian population[100].According to Abimbola[101] some Yoruba's are also located in the Republics of Togo and Benin in West Africa and also in Cuba and many Caribbean countries. Some of the major Yoruba

[97]Ifemesia, C. 1979. Traditional humane living among the Igbos. Enugu: fourth Dimension pub. Ltd.
[98]Nwala, T. 1985. Igbo philosophy. Lagos: Lantern Books.
[99]Nwankwo, I. 2014. Resilience of folk medicine among the Igbos of Southeast Nigeria. *European Scientific Journal* Dec.10.6 ISSN: 1857 – 7881 (Print) e - ISSN 1857- 7431.
[100]Ogundele S. 2007. Aspects of indigenous medicine in South Western Nigeria. *Ethno-Med*; 1.2:127-133
[101]Abimbola K. 2006.Yoruba Culture: a philosophical account. Birmingham: IAP.

settlements in Yoruba land are Ibadan, Lagos, Abeokuta, Ijebu-Ode, Ilesha, Ado-Ekiti, Osogbo, Ogbomoso, Ilorin and Ile-Ife, popularly accepted religious-cultural center for all the Yoruba people. The Yoruba nation has several sub-groups like the Ekiti, Ijesa, Oyo, Egba, Ijebu, Yewa and Igbomina[102] in addition to Ondo, Akoko and even the Edos. Yoruba land is characterized by forest vegetation as well as patches of derived savannah types arising basically from human activities like bush burning for agricultural and hunting purposes[103]

2.3.1. Historical Law School

'Before they addressed themselves to the impractical task of changing men by changing laws, the justices might have pondered the words of Savigny, who wrote, 'Law is no more made by lawyers than language by grammarians. Law is the natural moral product of a people……the persistent customs of a nation, springing organically from its past and present. Even statute law lives in the general consensus of the people.'[104]

The historical school of jurists was founded by Friedrich Karl von Savigny (1779–1861). Its central idea was that a nation's customary law is its truly living law and that the task of jurisprudence is to uncover this law and describe in historical studies its social provenience. To followers of Savigny, the identification of law with custom and tradition and the Volksgeist, or genius peculiar to a nation or folk, generally meant a rejection of rationalism and natural law; a rejection of the notion of law as the command of the state or sovereign, and therefore a disparagement of legislation and codification; and a denial of the possibility of universally valid rights and duties and of the individual's possession of non-derivable and inalienable rights.

In positive terms, historical jurisprudence identified law with the consciousness, or spirit, of a specific people. Law is "found" by the jurist and not "made" by the state or its organs. Law is a national or folk and not a political phenomenon; it is a social and not an

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[102]Olagunju O. 2012. The traditional healing systems among the Yoruba. *Arch Scientific Journal* 1.2:6-14.
[103]Borokini, T. I. and Lawal I. O. 2014. Traditional medicine practices among the Yoruba People of Nigeria: a historical perspective. *Journal of Medicinal Plants Studies* 2.6: 20-33
[104]Robertson, W. 1981. The dispossessed majority. Racewas: Oxford University Press. Rpt. Howard Allen Publishers, Cape Canavarel 1972.

individual production; like language, it cannot be abstracted from a particular people and its genius; it is a historical necessity and not an expression of will or reason, and therefore it cannot be transplanted

The concept of the Volksgeist, or "the spirit of the Volk," was developed by German philosopher Johann Gottfried von Herder (1744–1803). Herder's Volksgeist is a manifestation of the people; it animates the nation. Every Volk is, as an empirical matter, different from every other Volk, each nationality characterized by its own unique spirit. Every people possesses its own cultural traits shaped by ancestral history and the experience of a specific physical environment, and mentally constructs its social life through language, law, literature, religion, the arts, customs, and folklore inherited from earlier generations. The Volk, in other words, is the family writ large.

The application of Herder's theory to law was made by German jurist and legal historian Friedrich Karl von Savigny (1779–1861). The basic tenet of the school is that law in its essence is not something imposed on a community. It is a product of the times, the essence and spirit of the people. Law grows with the growth and strengthens with the strength of the people, and finally dies away as the nation loses its nationality. Von Savigny, in the foundation document of the school, puts the matter this way:

> *In the earliest times to which authentic history extends, the law will be found to have already attained a fixed character, peculiar to the people, like their language, manners, and constitution. Nay, these phenomena have no separate existence, they are but the particular faculties and tendencies of an individual people, inseparably united in nature, and only wearing the semblance of distinct attributes to our view. That which binds them into one whole is the common conviction of*

the people, the kindred consciousness of an inward necessity, excluding all notion of an accidental and arbitrary origin.[105]

According to the historical law school, the nature of any particular system of law was a reflection of the spirit of the people who evolved it.[106]Laws must be adapted to the spirit of each nation, for rules applied to one nation are not valid for another. The only legitimate governments are those that develop naturally among particular nations and reflect, in their differences from other polities, the cultures of the people they govern.[107]

According to this school of law, custom is the main source of law and it precedes legislation. It is a truism that Africa has mainly and largely existed and relied on her traditions, customs and culture and as such has relied heavily on an existing set of unwritten rules or laws in which custody of such is placed in one man or group of people in which these people more often than not, hold such titles as *Priests* or *Chiefs.* They are the custodians of the culture and traditions of the people. These ones are the custodians of the law and they are the ones who hold the spirit of the people. They are the ones who interpret the laws and also make laws for the people through divine guidance.

'*This volksgeist was a unique, ultimate and often mystical reality'*[108]

Yoruba legends hold it that Orunmila was the first man to practice herbal medicine. He was reported to have been endowed with this knowledge by God. Orunmila was reported to have had a younger brother, Osanyin who had gained the knowledge of medicinal herbs through assisting his brother in making the herbal formulations. It was therefore concluded that Orunmila is the divinity for spiritual healing, while the gift of herbalism is traced to Osanyin[109].

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[105]Savigny, F. C. V. 1831. Of the Vocation of our Age for Legislation and Jurisprudence, tr. Abraham Hayward. London, Littlewood. Rpt. Birminghom, Legal Classics Library, 986. 24. The translation is from the 1828 German edition. The first edition appeared in 1814.

[106]Mahajan. V. D. 1987. Jurisprudence and legal theory. Lucknow: Eastern Book Company. 5th ed. Rpt 2014. 486.

[107] Hamilton A. 2011.Savigny: the Volksgeist & law. San Francisco: Counter-Currents Publishing. May 27. Retrieved Aug. 29, 2016, from http://www.counter-currents.com/2011/05/savigny-the-volksgeist-and-law/.

[108]Mahajan V. D. 1987. Jurisprudence and legal theory, op cit. 487.

[109]Sofowora A. 2008. Medicinal Plants and Traditional Medicine in Africa,3rd ed. Ibadan: Spectrum Books Ltd.

Traditional healers as traditional medical practitioners (TMPs) are the live wire of folk medicine in Yoruba, Igbo and Hausa and other ethnic communities[110]. They are the persons recognized by the community in which they live as competent to provide health care using vegetable, animal and mineral substances[111]. Their methods are based on the social, cultural and religious backgrounds as well as knowledge, attitude and beliefs that are prevalent in the community regarding physical, mental and social wellbeing and the causation of disease and disability[112].

In traditional societies, TMPs are persons who by learning, observations, divine or spiritual revelation or encounter have carved for themselves an important role, having solution to the health problems of the people. For example, in Yoruba land, several local names have been used to describe TMPs, and these include; *Olosanyin*, *Elegbogi* or *Oniseegun*[113] as well as *Babalawo*. Although *Oniseegun* and *Oloogun* are used as synonyms, they are distinct from Elegbogi in the sense that the Oloogun use charms, amulets and incantations in their magical practices. Different areas of specialization include general medicine practitioners (*gbogbonise or Adahunse*)[114] stroke and hypertension healers, bone settings (*teguntegun*), traditional paediatrician (*eleweomo*) and local traditional pharmacist (*lekuleja*), in addition to the charmers, diviners, necromancers and stargazers (*ateyanrin*).[115] According to the account of Rev. Johnson,

> *There are certain persons, doctors by profession (general practitioners) to whom people resort to in an emergency. They are called Adahunse. There are no institutions like hospitals, but some of these doctors do keep on their premises a number of invalids.*

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[110]Nwankwo, I. 2014. Resilience of folk medicine among the Igbos of Southeast Nigeria. op. cit.
[111]Ibid
[112]World Health Organization 1978.The Promotion of Development of Traditional Medicine. Geneva: WHO. *Technical Report Series*. No. 622.
[113] Jacob, A. 1977. A Textbook of African Traditional Religions. Ibadan: Aromolaran Publishing Company.
[114] Johnson, S. 1921. The history of the Yorubas; from the earliest to the beginning of the British Protectorate(Reprint 2009). Lagos: CSS Bookshops. 144-145
[115]Olagunju. S. 2012. The traditional healing systems among the Yoruba .op.cit.

The traditional birth attendants (*Agbebi, Iya Abiye, Iya Osun*) are the local midwives, and this is not any different from the Igbos or Hausa/Fulani cultures.

Among the Igbos, native or traditional healers are further distinguished in accordance with their areas of specialization. They have '*DibiaAfa*' (diviner) and '*Dibia – Ogwu*' (medicine man). The former is a diagnostician while the latter is the physician. They also have '*Dibiamgborogwuna-nkpaakwukwo*' (herbalist); '*Dibia-Okpukpu*' (bone setter); '*Dibia-Ogbanje'* (Paediatrician), traditional surgeons, traditional birth attendants, etc.

Traditional healers are responsible for carrying out healing ceremonies, religious rituals and other rites intended to ensure the safety and health of the communities. Erinosho[116] categorized traditional healers in Nigeria into native healers and faith healers. According to him, the former have been a part of the Nigerian society from time immemorial while the latter only began to play a vital role in the healing art only about the middle of the 19th century. In whatever form traditional medicine knowledge is acquired, it is transmitted from generation to generation; father to son, mother to daughter so as to sustain the knowledge and practices of traditional medicine. Early childhood education in indigenous medicine is done mainly in the rural people. Every opportunity is turned into a teaching affair by the parent of the child to the child or apprentice. For example, on the way to the farm, the parent stops to obtain some plants and explains their medical values to his child. On the farm, he does the same thing and gradually such a child becomes knowledgeable about some local plants and the environment in general[117]. Such knowledge and skills were closely guarded secrets because each practitioner had his or her own formula that made them unique and were either a product of research on their part or passed down from generations and also because the practitioners made their living and sustained their dependents with income from the successful provision of health care.

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[116]Erinosho, O. A.1998. Health Sociology. Bulwark Consult: Nigeria: Ogun, Ijebu-ode.
[117]Borokini, T. and Lawal I. 2014. Traditional medicine practices among the Yoruba People of Nigeria: a historical perspective .op.cit.

Quoting Rev Johnson;

> *The art of medicine is kept a profound secret by those who profess it; an increased knowledge can only be gained by an interchange of thoughts between brother professionals, many die without imparting their secrets to others and thus much valuable knowledge is entirely lost. But some do impart their secret to those of their children male or female who show special aptitude for such knowledge or whom they particularly love.*[118]

In addition, traditional medicine practice was also learned through apprenticeship.

From the above provided premise, we can therefore infer that traditional medicine is something that has existed through the ages as Erinosho puts it "from time immemorial" and is tightly and jointly connected with the history of the people. In a way, it can be referred to as having connection with the *Volksgeist* of the people and is so intertwined with the people that it has become a force of nature in itself. If this is true, then it is only reasonable according to the Historical School of Law and Jurisprudence that it informs the law by virtue of its existence. In Nigeria, we can see the influence of the *Volksgeist* in Customary Law which is a valid law of the land that guides indigenous marriages in terms of Family Law and Land Law, having its own say in Legitimacy, Validity of marriages, Succession and Inheritance, Property Ownership and transfer. If Customary Law is given such a free hand in such matters, it is safe to then say that the people who put themselves under the scope of this law would also want to be guided by all things indigenous, which would also include traditional and faith healing practices. If the rules of customary law reflect the spirit of the population according to this school, then, a legal framework for traditional medical practice which includes maternal health practice is highly needed as it represents a very important aspect of the lives of the people.

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[118] Johnson, S. 1921. The history of the Yorubas; from the earliest to the beginning of the British Protectorate. op cit.

2.3.2 Sociological School of Law

Jurists belonging to the sociological school of thought are concerned more with the working of law rather than its abstract content. Their principal premise is that the law must be studied in action and not in textbooks. They are concerned with the study of law in relation to society. They concentrate on actual social circumstances which give rise to legal institutions. They insist that the legal order is a phase of social control and that it cannot be understood unless taken in its whole setting among social phenomena.

The relations between the individual, society and the State have been changing and various theories have been propounded from time to time[119]. However the sociological law school is concerned with the following, as the main characteristics of this school:

Sociological jurists are concerned more with the working of the law, of the legal order and legal precepts rather than its nature.

According to Analytical jurists, law is made consciously. To Historical jurists, it is something found; but the Sociological jurists regard law as social institution. Sociological jurists lay stress upon the social purposes and securing social interests rather than on sanction. Sociological jurists look on legal institutions, legal doctrines and legal precepts functionally. These jurists only consider law from the functional view.

The objective of sociological source of jurisprudence is to resolve immediate problems of society with legal or extra-legal tools and techniques which promote harmony and balance of interest of society. According to the sociological jurists, Law is a social function, an expression of human society concerning the external relations of its individual members.[120] Every society has certain basic assumptions upon which its ordering rests. These assumptions are the Jural Postulates of the legal system as embodying the fundamental purpose. In a civilized society, men must be able to assume that others will commit no intentional aggressions upon them. In a civilized society, men must be able to assume that they may control for beneficial purposes what they have discovered and appropriated to

[119]Mahajan V. D. 1987. Jurisprudence and legal theory, op cit.523
[120]Mahajan V. D. 1987. Jurisprudence and legal theory, op cit.523

their own use, what they have created by their own labour or what they have acquired under the existing social and economic order.

In a civilized society, men must be able to assume that those with whom they deal in general intercourse of society (others) will act in good faith. In a civilized society, men must be able to assume that those who engage in some course of conduct will act with due care not to cast an unreasonable risk of injury upon others. In a civilized society, men must be able to assume that others, who maintain things or employ agencies, harmless in the sphere of their use but harmful (things) in their normal action elsewhere, will restrain them or keep them within their proper bounds.

The above itemized was postulated by Roscoe Pound. He is perhaps the most respected and relied upon as far as the sociological law school is concerned. In his theory of social engineering, he propounded that the task of a lawyer is like engineering. The aim of such social engineering is to build a very efficient structure of society as it is possible which includes maximum satisfaction of wants while having the minimum amount of friction and waste. He stated that there were three major interests to be protected by the law and that they were: Private interests, public interests and social interests.

Explaining private interests Roscoe Pounds states that private interests were the individual's interest of personality which include but not limited to his physical integrity, freedom of volition, freedom of conscience, reputation and so on. These in turn are safeguarded by Criminal Law, Law of Torts, Law of Contract and the limitation of the interference of government in matters of personal opinion and belief. Also, individual interests including marriage, inheritance, property rights and proprietary rights, testamentary rights and so on.

Public Interests are claims or demands or desires asserted by individuals involved in and looked at from the standpoint of political life such as (i) Interests of the State as a juristic person e.g. (a) integrity, freedom of action and honour of the State personality; and (b) claims of the politically organized society as a corporation to property acquired and held for corporate purposes; (ii) Interests of the State as guardian of social interests, and this seems to overlap with the next category of interests i.e., Social Interests.

Social Interests, Roscoe Pound explains, are claims or demands or desires thought of in terms of social life and generalized as claims of the social group. They concern:

a) Interest in the preservation of peace, public health and order and maintaining general security;

b) Interest in preserving social institutions like marriage, domestic and religious institutions;

c) Interest in preserving general morals by counteracting corruption, drunkenness, prostitution, gambling, etc.;

d) Interest in conserving social resources;

e) Interest in general progress (economic, political and cultural) which is to be achieved by freedoms of education, speech, trade, property, etc.;

f) Social interest in individual life like promotion of human personality, self-assertion, etc. – each individual to be able to live a human life according to the standards of the society.

After establishing the above premise, it has been observed that in recent times, more and more Nigerians and the Yoruba's in particular, are consulting traditional medical practitioners. Exorbitant medical bills of charges, in the face of chronic material poverty, of a wide range of people are a major factor bringing about this behavioural change. Consequently, traditional health care practice that was once on the threshold of extinction, following its clash with some Western values, has started to regain its lost popularity as a significant component of our cultural heritage.[121] According to Lucas and Hendrickse,

[121]Ogundele S. S. 2007. Aspects of indigenous medicine in South Western Nigeria. op.cit.

Although many of the traditional religious practices have been displaced by Islam and by Christianity, many traditional beliefs are still widely held and they become most prominent in moments of stress.[122]

There are numerous advertisements of herbal products on the newspapers, the media and other forms of information dissemination. The yearly herbal medicine trade fair in Nigeria and increasing publicity and patronage this attracts, irrespective of the social, educative or religious background of the people, are indicative of acceptance of traditional medical practice.[123] Similarly, there is currently hardly any newspaper in Nigeria that does not have a column on herbal remedies at least once in a week[124]. The National Demographic and Health Survey report[125] indicate that only 32.6% of births take place in health facility. This means that the remaining 63% of births were handled by traditional birth attendants or proliferating church-established maternity centres. According to Schiller and Levin,[126] there is some level of religious factor in health care utilisation. Other studies have consistently maintained that religion is associated with health care utilisation and improved health outcomes.[127]. Religion is thus one of the outstanding social institutions that shape

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[122] Lucas A. and Hendrickse Yoruba ideas of disease revealed by hospital patients in Robert G. Armstrong, ed. The traditional background to medical practice in Nigeria. University of Ibadan Institute of African Studies, Occasional Publication No.25

[123] Ukwuomah, B. and Da Costa, K. 1997.Government may soon formulate crude drugs herbal policy. *The Guardian* Newspaper Nigeria.Oct.3.4.

[124] Ogbulie, J..et al. 2007. Antibacterial properties of Uvariachamae, Congronemalatifolium, Garcinia kola, Vernonia and Aframomummelegueta. *African Journal of Biotechonolgy*6.13:1549-1533.

[125] National Population Commission Nigeria, ORC Macro. April. 2004. *Nigeria Demographic and Health Survey 2003*, Calverton, Maryland: National Population Commission and ORC Marco.

[126] Solanke, B. et al. 2015. Religion as a social determinant of maternal health care service utilisation in Nigeria. *African Population Studies* Vol. 29, No. 2, p. 1868 http://aps.journals.ac.za Retrieved 17th May 2018; Schiller and Levin 1982. Is there a Religious Factor in Health Care Utilization?: A Review. *Social science & medicine.* 27.(12) 1369-79.

[127] Gyimah et al. 2006 Challenges to the reproductive health needs of African women: on religion and maternal health utilization in Ghana. *Social science & medicine* 62: 2930- 2944; Hebert et al. 2007 Religious beliefs and practices are associated with better mental health in family caregivers of patient with dementia: Findings from the REACH study. *American Journal of Geriatric Psychiatry* 15 (4): 292 -300 ; Chiswick & Mirtcheva, 2010 Religion and child health. Discussion paper No, 5215 Retrieved May 15, 2018 from ftp.iza.org/dp5215

individual and community health behaviour.[128] All these indicate that people hold a strong belief in their cultural and spiritual heritage.[129]

Every society makes provisions for health care delivery systems for its members. This is with a view to providing medical and related services for the maintenance of good health, particularly through the prevention and treatment of diseases.[130] This is in recognition of the pervasive importance of good health upon which life is contingent. These societies thus developed indigenous medical systems through interactions with their environment wherein the health needs of the people were met. The aftermath of Christianity and colonization in Nigeria has however brought about the two health care systems; traditional and orthodox of which one is entirely different from the other. While orthodox practice enjoys official recognition, traditional practice is derided by the authorities.[131] Yet a significant proportion of the population (about 75 per cent) still patronize the traditional health practitioner. It is obvious that the two forms of medical practice have come to stay and it is logical therefore to explore the possibility of both being available to the people for improved health care delivery system for the people. The relationship between people, religion and health is aptly captured in the words of Robert Mitchell, discussing the rise of independent African churches and new religious movements of the 19th century as a result of missionary imperialism and dissatisfaction with how the task of relating Christianity to African life was ignored by the early missions. In his narration he stated,

> *It is of interest to note that some of the African church leaders were concerned deeply about the lack of medical facilities available to their members and experimented with "Christian native medicine" as a possible alternative to the use of "juju" by their members… Superintendents in the early decades of*

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[128]Benjamins, M. et al, 2000. Religious attendance, health maintenance beliefs, and mammography utilization: findings from a nationwide survey of Presbyterian women *Journal for the Scientific Study of Religion* 45(4):597–607

[129]Borokini, T. and Lawal I. 2014. Traditional medicine practices among the Yoruba people of Nigeria: a historical perspective. op.cit.

[130]Adefolaju T. 2014. Traditional and orthodox medical systems in Nigeria: The imperative of a synthesis. *American Journal of Health Research*. 2.4, 2014:118-124.

[131]Ibid

> *this century were practicing native herbalists who separated what they considered to be curative aspects of traditional herbs from associated herbs, rituals and sacrifices.*[132]

Various countries have enunciated health care policies geared towards the maintenance and improvement of the health status of their populations. This is borne out of the realization that good health care is paramount for the well-being of the citizens and subsequently the socio-economic development of their various societies. [133] According to Nigeria's Federal Ministry of Health, the national health policy is 'based on the philosophy of social justice and equity'. This policy is aimed at preventing, treating and managing illnesses as well as preserving mental and physical well-being of the people through the services of health personnel. The policy is in tandem with the traditional healing system in Nigeria. Prior to the introduction of orthodox medical practice, health care delivery was the sole responsibility of traditional healers whose medical knowledge and the understanding of their environment made the people to patronize them for their medical needs.

Part of individual interests is marriage and in marriage, especially in Africa, the basic aim of marriage is to procreate. As said earlier, only 32.6% of the births take place in health care facilities. As such, since the sociological school is of the opinion that the society informs the law and that the majority of the society dictate the law, then there should be laws that are guiding or that seek to guide TMPs in such a way that the obligation of the "duty of care" of a reasonable man can be inferred and where there is negligence or a lack of due care then the proper justice be given.

In *Justice According to Law,* Pound said;

> *We come to an idea of a maximum satisfaction of human wants or expectations. What we have to do in social control and so in law, is to reconcile and adjust these desires-wants or*

[132] Robert, M. 1971, WitchCraft, sin, divine power and healing: the Aladura churches and the attainment of life's destiny among the Yoruba, in Robert G. Armstrong, ed. The traditional background to medical practice in Nigeria op cit. 61-62
[133] Ibid

> *expectations, so far as we can, so as to secure as much of the totality of them as we can.*[134]

Meeting the majority of society's wants and expectations with as little fuss as possible is the main reason according to the sociological school for the existence of the law. Therefore protecting the interests of society by regulating the health care system which they prefer to orthodox medicine is necessary, and its importance cannot be over emphasized for the smooth running of society and also as a machine to bring about social control.

Here, traditional and faith-based health care practitioners fall in the line of social customs. There is therefore a departure from what is just or wise but emphasis is now placed on the law stemming from the social customs. Following the preceding trend of argument, it then seems only reasonable that a legal framework be set for an enterprise that has been able to wield such a tremendous sway over society in order to make for better accountability and growth in the society.

[134] Pound, R. 1959. Jurisprudence. St. Paul, Minn.: West publishing Co.

2.4 CONCEPTUAL CLARIFICATION

2.4.1 The Concepts of Reproductive Health and Reproductive Right

Reproductive health as a concept is of recent emergence. The concept emerged in response to the need for a comprehensive and integrated approach to the health needs and services related to reproduction. Reproductive health encompasses and envisions both women and men as agents in the human reproductive process, however, reproductive health as a concept puts women at the centre of the reproductive process, recognizes, respects and responds to the needs of women as right bearers and not only as mothers.[135] The concept of reproductive health was first recognized at the 1994 United Nations International conference on Population and Development (ICPD). Prior to the ICPD 1994, the need to control population had narrowly focused on family planning. Reproductive health is defined in the context of WHO positive definition of health. According to Mahmoud F. Fathalla, the definition of reproductive health is encapsulated in a number of basic elements:

- That people have the ability to reproduce
- To regulate their own fertility
- That women are able to go through pregnancy and childbirth safely
- That reproduction is carried to the a successful outcome through infant and child survival and wellbeing, and
- That people are able to enjoy and are safe in having sex.

This research engages a general discussion of reproductive health; however the focus is on the aspect of women being able to go through pregnancy and child birth safely, regardless of the type of maternal health care service preferred or chosen in the process of carrying

[135] Cook R.J et al. 2003. Reproductive health and human rights; Integrating medicine, ethics and law, op cit. 11

out their reproductive function. The process of reproduction must end in a successful maternal health outcome.

2.4.2 The Concept of Maternal Health

Maternal health as a concept traditionally refers to the needs of women as mothers, hence the term or concept maternal and child health (MCH). Maternal and child health have as its focus the birth of a healthy infant as the desired outcome of every reproductive process. This focus has negatively impacted the health of women because less emphasis is placed on the health risks associated with pregnancy and delivery particularly where there is no access to quality maternal health care services. The tragedy of maternal mortality clearly shows the neglect of women's maternal health. Women are regarded as a 'means to an end' in the reproductive process and not as end in themselves.[136] The concept of maternal health in this research is explained and understood as women's health as the successful outcome and priority of every reproductive process. The concept of maternal health will mean that women are able to go through pregnancy and access delivery services without the tragedy of maternal death or complications of maternal ill health or morbidity even after the reproductive process.

2.4.3 The Concept of Safe Motherhood

Safe motherhood as concept in this research focuses on the obligation of government and other role actors in the process reproduction to assured that women receive high quality care and achieve the optimum level of maternal health. Safe motherhood in this context means that pregnant women are ensured of high-quality care during and after their delivery. Safe motherhood in the context of this research will require that government takes all appropriate and positive measures to identify and acknowledge that TBAs and FBAs are a part and parcel of the healthcare system providing maternal health care to women during the reproductive process. Safe motherhood will require that government takes appropriate measures including legislation to protect women who patronize TBAs and FBAs from quacks and prevent further maternal deaths. According to the Cairo Programme of

[136] Cook R, et al. 2003. Reproductive health and human rights; Integrating medicine, ethics and law, op cit.

Action,[137] safe motherhood requires access to appropriate healthcare services that will enable women to go safely through pregnancy and child birth.

Safe motherhood is understood in this research as closely linked to the concept of reproductive rights which includes the right to life and other related rights such as the right to health, right to choice of maternity, right to maternity protection, right to found a family and other related rights. Safe motherhood is understood in the context of interrelation, interdependence and indivisible nature of human rights as reproductive health rights of women. Linking safe motherhood and the right to health will include such interrelated features as the accessibility, availability, and acceptability of the practice of safe motherhood in accordance with health rights. Women tend to feel safer when healthcare is culturally appropriate and reject alien healthcare. These interrelated features of the right to health were developed by the General Comment (CESCR) on Health as content on the right to health.

Safe motherhood will also include duty to implement and take positive action against third party violators and private persons such as erring healthcare providers. Cook et al in their book[138] aligning with the thought of this research on safe motherhood opined that where government and other relevant delegated authorities like the legislature fail to take appropriate measures necessary to protect reproductive and sexual health, they might also be held accountable for violating the rights to life, liberty and security of the person[139]; in the context of this research, of women.

[137] Cairo Programme of Action
[138] Op. cit. 162
[139] Ibid

2.5 SUMMARY AND CONCLUSION

A review existing of literatures shows that many researches have been carried out on the maternal mortality, the role of TBAs and FBAs and regulation. However, the review shows that there are existing gaps in these researches, particularly on the regulation of traditional maternal healthcare in Nigeria.

Conceptual clarification of reproductive health and rights, maternal health and safe motherhood properly situates the research as a reproductive health and rights discourse delimiting the scope.

The two major schools of jurisprudence, that is, the historical and sociological law schools exposes the evolution, history, role and importance of traditional and faith based health (Maternal health) care to indigenous communities and cultures. Having established the role and importance of traditional health care through the various literature, conceptual analysis and theorizing, the next chapter examines the different types of maternal health care practices, namely; orthodox, traditional and faith based maternal health care. It exposes the historical evolution of these maternal health practices and their regulation.

CHAPTER THREE

MATERNAL HEALTHCARE PRACTICES, LAWS AND REGULATION

3.0. INTRODUCTION

Healthcare practice is as old as man himself. Healing was integrated with the tribe's general cultural belief system, religion, and view of nature than they are in recent centuries.[140] Anthropologists discovered that primitive people had their own ways of treating illness and attending to reproduction. Thus maternal healthcare practices are *sui generis*.

> *The first evidence of surgery is skulls from the Stone Age. Some adults had holes cut in their skulls. At least sometimes people survived the 'operation' because the bone grew back. We do not know the purpose of the 'operation'. Perhaps it was performed on people with head injuries to release pressure on the brain. In the 19th and early 20th centuries anthropologists studied primitive societies…Primitive people had simple treatments for these things e.g. Australian Aborigines covered broken arms in clay, which hardened in the hot sun. Cuts were covered with fat or clay and bound up with animal skins or bark. However primitive people had no idea what caused illness. They assumed it was caused by evil spirits or magic performed by an enemy. The 'cure' was magic to drive out the evil spirit or break the enemies spell.*[141]

Maternity and the reproduction of our species is the special contribution that women make to society.[142] Reproduction is the means by which each society perpetuates itself and its

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[140] Blatner A, A very brief overview of the history of medicine(1: Prehistory to renaissance) Retrieved June 3, 2018 http://www.blatner.com/adam/consctransf/historyofmedicine/1-overview/brief.html

[141] Lambert T, A Brief history of medicine, retrieved June 3, 2018 http://www.localhistories.org/medicine.html

[142] Cook R, et al. 2003. Reproductive health and human rights; Integrating medicine, ethics and law, op cit.185

traditions.[143] Without reproduction, any society or its specie be it human, animal or any organism will surely go into extinction. The function of reproduction, though not limited to women as men also play a significant role in the reproductive process by providing the spermatozoa; women however carry the greater burden of the reproductive process.[144] There is no society, religion, culture, and system of law that has disregarded the issue of reproduction.[145] From the earliest of times, man's continual existence has been hinged on reproduction of his species.[146] Maternity can be a thing of joy[147] where the reproductive process ends in the birth of a healthy child by and with a healthy mother, and it can also be a harrowing or tragic experience where the process terminates abruptly or ends without the expected outcome.

Through the ages, societies have sort to protect the sanctity and also ensure the safety of the reproductive process. Some societies, particularly traditional African societies hold the reproductive process as sacred, a mystery, the link between the dead and the living, passage of life, and a dangerous process requiring utmost care and divine intervention.[148] Among many traditional societies in Africa, health and religion are tightly inter-related.[149] There is a mind-set belief that healing is affected and effected by a supreme being (God) and that there is a spiritual or mystical angle to every life issue even health.

In many societies, the reproductive or birth process is the exclusive function of the respected and experienced, men and women who have overtime carved a niche for themselves in the art of the birth process. As earlier stated in the previous chapters, these men and women are referred to by different names and accolades in their different communities

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[143] Ibid.
[144] Cook, R.J et al. 2003. Reproductive health and human rights; integrating medicine, ethics, and law .Op cit. 58.
[145] Ibid .3
[146] Ibid .32
[147] Ibid .15
[148] Callister, L.C AND Khalaf I. 2010. Spirituality in Childbearing Women. *The Journal of Perinatal Education* 19.2:16-24 Retrieved. Oct 9, 2016, fromhttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC2866430/
[149] Awojoodu, O. and Baran, D. 2009. Traditional Yoruba medicine in Nigeria: a comparative approach. *Bulletin of the Transilvania University of Brasov*. 6.51:129-136.Supplement – *Proceeding of the 11th Balkan Congress of History of Medicine*

In these societies, maternal health care practices are subject to rules, norms, customs, practices and other guidelines that must be observed by both the care giver and care seeker for a safe and smooth transition of the reproductive process. Several traditional beliefs and practices are associated with pregnancy, labour and the post-partum period.[150]

This chapter discusses maternal health care practices, the multiple sources of maternal health care practices and the historical evolution from the early societies to modern day maternal health care practices. It exposes the laws and regulations relating to maternal health care practices in varied societies. It seeks to investigate what maternal healthcare practices are in the early societies, what laws, rules or customs validate maternal health care practices, and how these practices have evolved overtime, including ways in which they have been affected or influenced by modern and orthodox maternal health care practice. This chapter discusses extensively the role and practice of traditional birth attendants and faith based birth attendants within maternal health care systems.

3.1. MATERNAL HEALTHCARE PRACTICES

3.1.1. Orthodox Maternal Healthcare

For many decades, notwithstanding that many primitive societies knew and practiced the art of healing and health care in traditional or religious ways, orthodox or modern (allopathic) medicine on emergence took preference relegating traditional and faith health care to the background.[151]Attention was shifted and pre-eminence placed instead on the newly introduced western form of medicine. There was stigmatization of the traditional and faith health care.

The history of medicine can be traced from the primitive times. According to history, the roots of modern medicine are in ancient Greece. Medical schools were formed in Greece

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[150]Aziato, L. et al. 2016. Religious beliefs and practices in pregnancy and labour: an inductive qualitative study among post-partum women in Ghana. *BMC Pregnancy and Childbirth* 16:138Retrieved Oct.9, 2016 from
https://bmcpregnancychildbirth.biomedcentral.com/articles/

[151] Adefolaju T. Traditional and orthodox medical systems in Nigeria: the imperative of a synthesis. *American Journal of Health Research.* op cit.

and in Greek colonies around the Mediterranean. As early as 500 BC a man named Alcmaeon from Croton in Italy said that a body was healthy if it had the right balance of hot and cold, wet and dry. He theorized that if the balance was upset the body grew ill. Aristotle (384-322 BC) was one of the earliest doctors; however the most famous Greek doctor is Hippocrates (C.460-377 BC). In 332 BC, after Alexander the Great conquered Egypt, he founded the city of Alexandria and the first medical school was established.

The Romans later conquered Greece with Greek doctors practicing in Rome. The Romans had hospitals called Valetudinaria where wounded soldiers were treated. After the fall of Rome in the 5th century, the Byzantine Empire arose and later Muslims took their knowledge of medicine from there.

In the middle Ages due to increase in literacy level learning in Europe, Greek and Roman books which had been translated into Arabic were now translated into Latin. In the late 11th century a school of medicine was founded in Salerno in Italy. In the 12th century another was founded at Montpellier, and by the 13th century more medical schools were founded at Bologna, Padua and Paris. Many students studied medicine in European universities and medicine became a profession.

In the middle Ages the church operated hospitals. In 542 AD a hospital called the Hotel-Dieu was founded in Lyon, France. Another hospital called the Hotel-Dieu was founded in Paris in 1660. The number of hospitals where monks and nuns cared for the sick in Western Europe greatly increased from the 12th century. Meanwhile, during the middle Ages many hospitals were also founded in the Byzantine Empire and the Islamic world. From the 16th to the 18th Century, there were some improvements in medicine but the aetiology and causes of disease was still attributed to astrology, superstitious beliefs and magic. It was not until the end of the 18th Century that superstition began to decline, giving way to the emergence of science and scientific explanation of diseases.

During the 19th century medicine made rapid progress with the emergence of scientists like Louis Pasteur, Joseph Lister, John snow, Edwin Clebs and a host of others. The 19th Century also saw the emergence and contribution of two nurses, Florence Nightingale and Mary Seacole to the advancement of the nursing profession. In the 19th Century several

hospitals and many more were established in London. Since the 19th Century to our 21st Century, medicine has continued to take giant strides in many of its specialized areas particularly obstetrics and gynaecology for example; the first womb transplant was carried out in 2012.

Orthodox maternal health care of females and the female reproductive system is a major area of specialization in medicine known as obstetrics and gynaecology. The care of women during pregnancy, child birth and postpartum is obstetrics and the treatment of female reproductive diseases is referred to as gynaecology. These two developed along different historical paths, but are now combined in practice.

> *Obstetrics had for a long time been the province of female midwives, but in the 17th century, European physicians began to attend on normal deliveries of royal and aristocratic families; from that beginning, the practice grew and spread to the middle classes. The invention of the forceps used in delivery, the introduction of anesthesia, and Ignaz Semmelweis's discovery of the cause of puerperal ("childbed") fever and his introduction of antiseptic methods in the delivery room were all major advances in obstetrical practice. Asepsis in turn made cesarean section, in which the infant is delivered through an incision in the mother's uterus and abdominal wall, a feasible surgical alternative to natural childbirth. By the early 19th century, obstetrics had become established as a recognized medical discipline in Europe and the United States.*[152]

[152]Obstetrics and Gynecology Medicine, Retrieved June 2,2018 from https://www.britannica.com/science/obstetrics

In the 18th and 19th centuries midwifery care became established as part of the health care system in Europe and most midwives were trained as both nurses and midwives.[153]

3.1.2. Traditional Maternal Healthcare

Long before the emergence of modern orthodox medicine, people of most nations and of various cultures always relied on various forms of what has come to be called traditional medicine, a term extending from applications of herbal medicine to faith-healing and other practices based on the supernatural.[154] Traditional medicine has been described to be a cultural gem of various communities around the world. Traditional medicine has been referred to as folk medicine, unconventional or unorthodox medicine.[155] Traditional medicine are the healthcare delivery methods and practice that are directly traceable or related to culture and ancestral heritage of the people.[156]

The World Health Organisation (WHO) defined traditional medicine as the total combination of knowledge and practices whether applicable or not used in diagnosing, preventing or dominating a physical or mental or social disease and which may rely exclusively on past experience and observation handed down from generation to generation verbally or in writing.[157]

The traditional medical practitioner also referred to as traditional healer is defined as:

> *someone who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious backgrounds as well as the*

[153] Association for Wholistic Maternal and Newborn Health, A brief history of midwifery in America, Retrieved June 3, 2018 http://wholisticmaternalnewbornhealth.org/professional-education/history-of-midwifery/
[154]Stepan, J. 1985.Traditional and alternative systems of medicine: a comparative review of legislation. *International digest of health legislation.* op.cit. 284
[155]Ibid
[156]Anon. 2015. Who regulates traditional medicine? *The Nation.* Aug 6. Retrieved Sept.15, 2016 from thenationonlineng.net
[157]WHO. 2000. General guidelines for methodologies on research and evaluation of traditional medicine. Geneva: WHO. WHO/EDM/TRM/2000.1 Definition of traditional medicine Retrieved Dec. 18, 2015, fromhttp://www.who.int/medicines/areas/traditional/en/

prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causation of disease and disability in the community.[158]

Traditional medical practitioners do not all perform the same function, nor do they fall into the same category.[159] According to Prestorius, each area of traditional health care is a specialized area, and each of them has their own field of expertise. Even the techniques employed differ considerably. They have their own methods of diagnosis and their own, particular medicine.[160]

In Africa, before the advent of missionaries and other foreign incursions, traditional health care practice was the indigenous folk medicine. There are many categories of traditional health care practices dealing with different aspects of health; these include spiritual healing, prevention, as well as curative and surgical practices. There are however two main categories of indigenous health care practitioners, these are; diviners and herbalists. Diviners are the most important intermediaries between humans and the supernatural. Unlike herbalists, no one can choose to become a diviner. Only a person "called" by the ancestors can become one.[161] They are called by the ancestors and regard themselves as servants of the ancestors. Diviners specialize in diagnosing the unexplainable. They analyse the causes of specific events and interpret the messages of the ancestors. They use divination objects and they explain the unknown by means of their particular mediumistic powers. Their vocation is mainly that of divination, but they often also provide the medication for the specific case they have diagnosed.[162]

Herbalists are ordinary people who do not, typically, possess occult powers but have acquired extensive knowledge about curative herbs and medicines, and are well versed in

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[158] W.H.O. 2001. Legal status of Traditional Medicine and Complementary/Alternative Medicine: A World Wide review. Geneva: WHO.
[159] Prestorius, E.1999. Traditional Healers. *South African Health Review*. N. Crisp and A. Nutuli Eds. Durban: Health Systems Trust.2000. 250
[160] Prestorius, E.1999. Traditional Healers. *South African Health Review*. Ibid.
[161] Kale, R. 1995. Traditional healers in South Africa: a parallel health care system.*BMJ*.May.6.310:1182-1185.
[162] Prestorius, E.1999. Traditional Healers. *South African Health Review*. op.cit.

its usage.[163] They diagnose and prescribe medicines for everyday ailments and illnesses, to prevent and to alleviate misfortune or evil, to provide protection against witchcraft and misfortune, and to bring prosperity and happiness. In the healing practices of herbalists, empirical knowledge plays an important role, as they are able to diagnose certain illnesses with certainty and to prescribe healing herbs for those illnesses. In general, herbalists use magical techniques and magical powers.[164] Similar to what obtains in orthodox medicine, traditional medicine can be classified into three categories; namely: herbalism, spiritualism and occultism, traditional orthopaedics and surgeries.[165] In the past, traditional medical practitioners have little or no education, knowledge and practices are based only on experience handed down mainly orally from generation to generation and occasionally in writing.[166]Today, however, due to modernization, the situation is changing and the distinction between the two types of healers (herbalists and diviners) is no longer clear, mostly as a result of the overlapping of roles.[167] For example in Nigeria, the Yoruba's refer to them as "Babalawo": the Hausa's call them "Boka", while the Igbo's refer to them as "Dibia".[168]

Other categories of expertise of traditional medicine include traditional surgeons, psychiatrists, bone setters,[169] birth attendants or traditional midwives, and more recently, prophets and faith healers. [170] Historically, women's main human resource for childbirth has been traditional birth attendants (TBAs). They are constant in various cultures, and play varying roles according to said cultures and times.[171] Traditional birth attendants are usually elderly women and sometimes men. They are known members of their community; they serve as an avenue of social support for women during childbirth. TBAs are respected

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[163]Kale, R. 1995. Traditional healers in South Africa: a parallel health care system. op.cit.
[164]Prestorius, E.1999. Traditional Healers. *South African Health Review*. op.cit.
[165]Anon. 2015. Who regulates traditional medicine? *The Nation.* op.cit.
[166]Ihekwoaba, E.2014. Strategies for enhancing information access to traditional medical practitioners to aid health care delivery in Nigeria. *Library Philosophy and Practice (e-journal).Paper* 1179:6Retrieved Sept.10,2016, from http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=3062&context=libphilprac
[167] Ibid
[168]Owumi, B. and Taiwo, P. 2012.Traditional healing practices and health reforms in Nigeria in Peoples and Cultures of Nigeria., A.Jegede, O. Olutayo, and B. Owumi. Department of Sociology, University of Ibadan, Ibadan.: Samlad Press. 241
[169] Ibid
[170]Prestorius, E.1999. Traditional healers. *South African Health Review*. op cit.
[171]Bergstrom, S.,Goodburn, E. 2001. The role of traditional birth attendants in the reduction of maternal mortality op.cit.

in society for their skills; however, in such cultural settings as the Indian sub-continent, TBAs are considered low caste and have no reputable influence.[172]

The conditions for becoming a TBA includes having gone through the birth process by personal experience, this denotes that the women must have also given birth to their own children, and must have been under apprenticeship lasting some years.[173] TBAs do not charge for their services but may accept gifts. Where complication occurs, the traditional birth attendant usually seeks the advice of the diviner or herbalist.[174] Some times by reason of time and experience, a traditional birth attendant may also practice the use of herbs in his or her practice.[175]

> *Apprenticeship was the traditional route of entry into the profession, and still is in many parts of the world. WHO calls informally educated women who attend births Traditional Birth Attendants (TBAs) or Indigenous Midwives. A few fitting this description still practice today in America. Called "Partera" in the South western United States, they attend Latino women. There are also Native American midwives who attend members of their own tribe. These Indigenous Community Midwives are the keepers of knowledge and art of childbirth and pass their wisdom down to younger generations of aspiring midwives, yet they do not have formalized training, licensure or certification.*[176]

Traditional birth attendants also referred to as traditional 'midwives' enjoy the universal respect in their communities and the constant demand for their services make these practitioners an important factor in the health care system. TBA's are well known in Africa,

[172] Ibid.5
[173] Stepan, J. 1985.Traditional and alternative systems of medicine: a comparative review of legislation. op.cit.315
[174] Kale, R. 1995.Traditional healers in South Africa: a parallel health care system. op.cit.
[175] Inyang, M. P. and Anucha, O. U. 2015. Traditional birth attendants and maternal mortality, *IOSR Journal of Dental and Medical Sciences* (IOSR-JDMS). Feb.14. 2 Ver. II I: 21-26 Retrieved Oct.10,2016, from www.iosrjournals.org
[176] Association for Wholistic Maternal and Newborn Health, A brief history of midwifery in America, op. cit

Asia, and Latin America. They are reputed to deliver a very large proportion of babies, about two-thirds of the neonates in the world.[177]

After the introduction of Christianity, Islam and colonization, indigenous folk medicine also known as traditional medicine became less popular. Recently however, with the recognition of traditional medicine by WHO, traditional medicine is reclaiming its 'lost glory'. Quoting Yakubu A.,

> *With the advent of orthodox medical practice, natural healing device or alternative medical practice was relegated to the background. Notwithstanding lack of initial recognition by government over the years, their popularity among rural dwellers cannot be denied… with the success they have been able to achieve with respect to baby delivery… this recognition has become a necessity.*[178]

3.1.3. Faith Based Maternal Healthcare

Recognizing the problem of maternal mortality and inequities in maternal health between developed and developing countries, and within countries, some factors have been recognized as the social determinants of health. According to WHO, list of the social determinants of health include the social gradient; stress; early life development; social exclusion; work; unemployment; social support; addiction; food; and transport.[179]However, the WHO list of social determinants of health may not be exhaustive without religion, as this is contrary to several research findings that religion is a significant correlate of health care utilization.[180] Several researches have demonstrated that religion has profound effect on the health care beliefs and health care seeking behaviours of people.[181]

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[177]Stepan, J. 1985.Traditional and alternative systems of medicine: a comparative review of legislation. op.cit.314

[178]Yakubu, A. 2002. Medical Law in Nigeria. op.cit

[179] WHO, 2013

[180] Solanke, B. et al. 2015. Religion as a Social Determinant of Maternal Health Care Service Utilisation in Nigeria. *African Population Studies Vol. 29, No. 2*, p. 1868 http://aps.journals.ac.za 5/17/18 ; Mekonnen & Mekonnen, 2002; Benjamins .M et al 2005, op cit ;Gyimah, et al, op cit 2006; Benjamins, et al, op cit 2007)

[181] Ibid

Religion and health are therefore inter-related especially within the African context where illnesses have for many years been linked to spiritual effects[182] Witchcraft is associated with illness within the African context including issues of childbirth[183] Also, pregnancy and childbirth are associated with religious and traditional beliefs and practices in many countries.[184] For example, among the Yoruba's in Nigeria, as in many African cultures, health and religion are tightly interrelated. The set belief is that there is a spiritual angle linking a Supreme deity with health. The reproductive process of pregnancy and child delivery is believed to be spiritually and physically linked. This belief is not only in traditional health care but also includes orthodox western healthcare[185].

Faith based maternal health care practices is common practice in many African societies, and faith-based organizations (FBOs) have historically played an important role in providing maternal/new born health services in African countries.[186] According to W.H.O estimates, 30 to70% of the sprawling healthcare infrastructure across the African continent is owned or run by FBOs, with percentages varying within this range in different countries.[187] According to Baiyeri[188] faith based organizations refer to religious and or religious-based groups connected with a stable faith community and concerned with human development or societal development.[189] Faith based organizations have also been defined as "religious and religious-based organizations, places of religious worship or congregations, specialized religious institutions and registered or unregistered non-profit

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[182]Aziato, L. et al. 2016. Religious beliefs and practices in pregnancy and labour: an inductive qualitative study among post-partum women in Ghana. op.cit

[183]Ibid

[184]Ibid33.

[185]Awojoodu, O. and Baran, D. 2009. Traditional Yoruba medicine in Nigeria: a comparative approach. op.cit.

[186]Widmer, M. et al. 2011. The role of faith-based organizations in maternal and newborn health care in Africa.
International Journal of Gynecology and Obstetrics.114: 218-222

[187]WHO. 2009. Faith-based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa Countries. Retrieved, Oct 9,2016 from www.who.int.http://www.who.int/mediacentre/news/notes/2007/np05/en/index.html

[188]Baiyeri, H. . 2013. The role of faith-based Organizations (FBOs) in human development: a study Of Kogi State. MA.Project. Dept. of Religion and Cultural Studies. Facutly of The Social Sciences, University of Nigeria. +76pp. Retrieved Oct,9,2016, from http://www.unn.edu.ng/publications/files/BAIYERI,%20H.%20B.pdf

[189]Ibid. 8

institutions that have religious character or missions."[190] As is the case with traditional medical practitioners, faith-based organizations are trusted entities within many communities.[191] Pentecostal/Charismatic faith based missions or organisations are fast growing churches in Nigeria, Ghana and many other traditional African societies.[192] Within the Christian and Islamic religion are leaders who contribute to the spirituality of women during pregnancy and labour. A growing phenomenon in both Ghana and Nigeria is religious prayers and delivery assistance for pregnant women before and during labour.

Healthcare delivery particularly provision of maternal healthcare remains one of the major activities of FBOs in Nigeria. For instance, the Christian Health Association of Nigeria (CHAN) provides forty percent (40%) of healthcare services in rural areas of Nigeria, according to World Health Organization.[193] Apart from providing healthcare services, FBOs in Nigeria also engage in income generation programmes, agriculture and food programmes, pastoral counselling and psycho-social support services, civic education and human rights programmes.[194]

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[190]Woldehanna, et al (2005)

[191]National Center for Cultural Competence Georgetown University Child Development Center and Faith Partnership Initiative Office of Minority and WINTER 2001. Sharing a Legacy of Caring Partnerships between Health Care and Faith-Based Organizations. National Center for Cultural Competence Georgetown University Child Development Center, Department of Paediatrics, Georgetown University Medical Center, IN COLLABORATION WITH: Women's Health Center for Communities in Action Bureau of Primary Health Care, Health Resources and Services Administration U.S. Department of Health and Human Services. Retrieved Oct.10,2016, fromwww.http://nccc.georgetown.edu/documents/faith.pdf

[192]Asamoah-Gyadu, K. 2006.African Pentecostal/Charismatic Christianity: An Overview. Retrieved Oct.10,2016, from http://www.lausanneworldpulse.com/themedarticles-php

[193]Odumosu, O. et al 2009. Mapping the activities of faith-based organizations in development in Nigeria. Religions and Development Research Programme. *Religions and Development Working Paper 38*.Nigerian Institute of Social and Economic Research, Ibadan. Retrieved Oct.9, 2016, from http://www.rad.bham.ac.uk ; see also Baiyeri, H. B. 2013. The role of faith-based Organizations (FBOs) in human development: a study Of Kogi State. op.cit.

[194]Baiyeri, H. B. 2013. The role of faith-based organizations (FBOs) in human development: a study Of Kogi State.op.cit.20

3.2. HISTORY AND EVOLUTION OF REGULATION OF HEALTH CARE PRACTICES.

3.2.1. Imperative for Regulation and Forms of Regulation

A regulation is a legal provision that creates or limits a duty or allocates a responsibility. It has to do with control of activities or processes especially by rules that guide a particular human endeavour, trade, practice or profession.[195] Professional regulation can be defined as a process of laying down regulations, ethics, rules, guidelines and standards that control the activities of a given profession.[196]

In orthodox health care practice, a health care professional is a qualified person who delivers proper health care in a systematic way professionally to an individual in need. Health care professionals are highly skilled workers, in professions that usually require extensive knowledge including university-level study leading to the award of a first degree or higher qualification. This category includes physicians, dentists, nurses, midwives, pharmacists, physiotherapist, optometrist and other emerging professionals.

The practice of healthcare professionals and operation of health care institutions is typically regulated by national or state authorities through appropriate regulatory bodies for purposes of quality assurance. The rationale underlying regulatory laws and bodies was partly concern for the health of the population, perceived as requiring protection against quacks, unqualified healers, and charlatans, and partly a genuine belief of the medical profession that every attempt at healing outside the framework of recognized medicine was harmful, or at best, ineffectual.[197]

In addition, the need to regulate health care practice is informed by the notion that health care at all levels is dominated by the presence of uncertainty.[198] The future health status of

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[195] WHO. 2002. Nursing and midwifery A guide to professional regulation, EMRO Technical Publication series 27.Cairo: Regional Office for Eastern Mediterranean. Retrieved Oct.12, 2016, from http://applications.emro.who.int/dsaf/dsa189.pdf
[196] Ibid
[197]Stepan, J. 1985.Traditional and alternative systems of medicine: a comparative review of legislation. *International digest of health legislation.*op.cit.284
[198] CRNBC. 2012. Underlying Philosophies and Trends Affecting Professional Regulation.7. Retrieved Oct.16,2016, from https://www.crnbc.ca/crnbc/Documents/783_framework.pdf

anybody is uncertain because activities that lead to ill health usually begin with seemingly random events. Therefore, the consumption for health cannot really be planned for. Health care as a commodity is very important as it has to do with life and as a right need to be protected.[199] These peculiarities of health explain the reason why the health sector is the most intervened sector by government and hence the need for the regulation of health care practice, its practitioners and professionals.

Current regulatory policy concerning health care practice and health care professionals is based on the assumption that the market for health care services fails because consumers do not have full information about the quality of services provided. As a result, a health care practitioner or professional may exploit consumers by providing lower-quality services.

Economic theory suggests that where there is no regulation, health care professionals may provide services that are of low quality at a higher cost to uninformed consumers.[200] Human beings generally have the tendency of wanting to be free to do what is convenient. A typical individual wants what will cause minimal discomfort for him at every point in time. Health care providers and professionals, being human beings if left unregulated could carry out their activities without due regard for quality and standards of technical competence which could result in serious bodily injury, catastrophic destruction or deprivation of legal rights.[201] On this basis, it is difficult to dispute the necessity and the value of some form of regulatory intervention in the health care service market.

3.2.2 The reasons for regulation of health care practice and its providers are enumerated below;

1) Protection of life: Health care professionals deal with the lives of human beings, Life is very precious and there are no spare parts for life, hence any incompetence could lead to serious injury or even death.

[199]Ibid

[200] Wilson, D 1992. The regulation of health care professionals other than physicians. 15 *Regulation* 40 Retrieved Oct. 9 2018 https://heinonline.org/HOL/LandingPage?handle=hein.journals/

[201]Lieberman, J. 1970.Tyranny of the Experts: How Professionals and Specialists Are Closing the Open Society. Op cit.

2) Protection of the interests of the public: The primary reason for government involvement in what would otherwise be an unregulated market is the need for the protection of the public. Health is a right and needs to be protected. Another concern that drives the need for regulation is that the performance of health care providers and professionals without regard for professional standards of technical competence could result in morbidity or mortality.

3) Asymmetric distribution of information about health care between providers and consumers (also called "information failure"): Government intervention in the regulation of health care practice and profession is generally justified in economic terms by the argument that health care is an area in which market forces perform poorly. In the language of economists, this means that the health market is not a perfect market. It does not meet any of the conditions of a perfect market leading to complete market failure. This failure, it is argued occurs as a result of the health care markets distinctive features which include:

-Risk and uncertainties associated with contracting illness (because generally it is not possible to plan one's consumption of health care services);

-Externalities; and

-Asymmetric distribution of information about health care between providers and (also called information failure).

Of these factors, information failure is the type of market failure that justifies regulation of health care providers and professionals. This failure occurs in a market where the producers/sellers of a product or a service are significantly better informed than buyers about the product or service, characteristics and their value to buyers. This asymmetric knowledge exists between health care providers and patients as the knowledge difference is massive. There is the tendency for healthcare providers and professionals not to reveal adequate information and hence exploit patients or health care users.

4) Relevance of profession: Another argument for regulation of health care providers and professionals is in order to ensure professional relevance. For instance in Nigeria, in the medical profession, strict requirement is put in place to prevent mass entry into the

profession so as to increase the value for the profession. This can be seen in the extremely high scores required to get into the undergraduate programme and even after getting in, the academic requirements to stay is another serious issue. This is done so that bargaining power for professionals remains high amongst other reasons. Similarly, some of these strict measures are put in nursing and other health professions.

5) To increase the quality of health care services: The outcome of service rendered by the professional needs to be influenced by the regulatory body in order to ensure quality, by setting standards and ensuring enforcement, thereby, compelling the health care provider to give the best to consumers who entrust their health and indeed their lives to these professionals.

3.3. FORMS OF REGULATION

In the regulation of health care providers or professionals, there are two forms of regulation; namely; Input Regulation and Output Regulation

Input Regulation

Input regulation seeks to regulate or control quality by controlling the provider of health care service. It seeks to ensure high quality of professional services by placing restrictions on who can provide as well as how the services can be provided. In input regulation, various methods and techniques are adopted to elevate the level of competence and ethical practice of a profession by imposing entry and practice standards such as mandatory education and training periods and codes of conduct. Input regulation is proactive in nature. It seeks to protect the public from incompetent service by providing a 'quality signal'. It does not wait for malpractice leading to injury to occur, but will rather ensure that only those capable of providing particular type of service are paraded to the public either by title or other means, of being capable of carrying out such duties.

Some instances of input regulation include:

- Admission into Training Programme: Input regulation is involved in the admission of the aspiring professionals even before training commences. For example, the cut off marks for

courses such as Medicine and Dentistry into Universities is higher than those for other courses. This serves to sieve out those who will be able to cope from those who will not, on the assumption that the candidate who meets the admission cut off marks will be able to better withstand the academic rigors involved in the training of doctors and dentists. In the nursing profession, each school of nursing is allowed to admit only 50 candidates who score the highest in entrance examination.

Training of the Professional: Regulatory bodies set standards of training via curriculum and expect a certain degree of pass all through the training with "check points" in form of examinations to further 'drop' those considered unfit. Example of this in the Medical training of doctors is Second MB[202] examination. The pass mark is 50 and candidate must pass all the subjects. Some drop out at this stage. Those who continue still have to face other examinations at different levels and pass before they can be certified fit to treat people. Also at the various schools of nursing, the total numbers of entrants do not graduate after the 3years training. As a matter of fact, an examination takes place after 6months of enrolment in the school after which those who fail are sent out of the school.
Postgraduate Training: Another regulatory phase comes to the fore when the professional seeks to leave the stage of general practice and wants to specialize. There are various areas of specialization in medical practice today. Entry into these postgraduate trainings called Residency training also involves setting of high standards by the regulatory bodies. Examinations are written, cut off marks are set such that the higher the pass rates the higher the pass mark. Up to 200 candidates may sit for examination and only 10 are able to scale the hurdle (that is according to the standard set). These measures are to ensure that only the best are allowed to train to become specialists.

- Continuing Medical Education (CME): Some professional bodies, for example Nigerian Medical Association (NMA), organise training programmes to keep members abreast of new innovations in the practice. Proof of attendance at these training has become a prerequisite for renewal of license to practice. There are 2 main types of input regulation, namely: certification and licensure.

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[202] Bachelor of Medicine.

Certification

Certification is the process of guaranteeing formally that certain requirements based on expert knowledge of significance, pertinent facts have been met by an individual seeking entrant into a profession. It is the process of empowering an authority or an agency to certify professional individuals to the public as having satisfied particular training requirements which are adjudged to be relevant indices of competence in the subsequent performance of a particular range of professional services. For example in Nigeria

- Medical and Dental Council of Nigeria (MDCN) is the regulating body for doctors.
- Nursing and Midwifery Council of Nigeria NMCN) is the regulatory body for nurses
- Pharmacist Council of Nigeria (PCN) is the regulatory body for pharmacists.
- Medical Laboratory Science Council of Nigeria is the regulatory body for medical laboratory scientists.

It is these certification bodies that give the bearer professionals the right to bear designated professional titles of MBBS[203], RN[204], RM[205] as applicable to each professional.

Licensure

Licensure is the granting of a permit which, without it, would be illegal to practice as a professional in a particular field, art or trade. Licensing entails an exclusive scope of practice e.g. the exclusive right to perform a set of activities of a given profession. For instance, obstetricians and gynaecologists attending to pregnant women instead of general practitioners, the professional becomes a specialist in that field and a higher degree of competence is expected of him.

There are two types of licensure namely:

[203] Bachelor of Medicine and Surgery.
[204] Registered Nurse.
[205] Registered Midwives.

- Individual licensure: This is the granting of a legal permit that is personal and cannot be transferred to another. The individual seeking the licensure must meet standards as established by the regulatory body. In most instances, the initial license is granted upon successful completion of an examination administered by the regulatory body of the specific vocation, and annual re-registration is required to maintain the license.

- Institutional licensure: This is licensure of an institution providing a particular service to the public. For instance, for a university to run a medical programme, some specific relevant requirements must be met.

Output Regulation

This form of regulation regulates or controls the practice of a profession by monitoring services provided to detect faults and shortcomings in order to take punitive actions against erring professionals and offenders. The outcome of service rendered by the professional is influenced, to ensure quality, by setting standards and ensuring enforcement, thereby, compelling the health care provider to give the best to consumers who entrust their health and indeed their lives to these professionals. It is to examine and also monitor the effect of services on the individuals, impose penalties that both compensate the victims of incompetent services and prevent incompetent and unethical practice by placing a constraint on professional behaviour.

There are three forms of output regulation namely; civil liability, criminal liability and professional discipline/ monitoring.

Civil Liability

Civil liability, in the form of the tort of negligence, imposes on a professional, a duty of care and a standard, which gives rise to liability upon a breach and awards compensation to the victim.

The benefits of civil liability as a mechanism to ensure quality of services are as follows:

- It focuses directly on actual outcomes, i.e., the effect of the service on the individual client.

It is a constraint on professional behaviour that is imposed upon the profession by external forces; as a result it is perceived to be more objective than a system based on enforcement by the profession itself. It imposes penalties that both compensate the victims of incompetent service and deter incompetent practice.

Civil liability as a form of regulation is dynamic, in that the standard of quality required can change over time to reflect changing norms. Although the benefits of civil liability as a method of quality control are substantial, they are balanced by some significant disadvantages such as:

- The system is victim initiated and therefore depends upon the victim's ability to discover that the service provider has failed to act in accordance with established professional standards. Moreover, victims may have difficulty obtaining assistance in establishing that the service rendered is substandard. For example in cases of medical negligence, it is often difficult for a victim to obtain the assistance of an expert witness in proving and establishing negligence against a fellow professional.
- The system is based on factual determination which must be made on a "case-by-case" basis and it can be very costly to administer.
- The system is reactive in nature i.e. it is only capable of responding to problems but does not really prevent such problems from arising.
- It is not possible to compensate the victims fully.

Discipline/Professional Monitoring:

The disciplinary process is administered by the professional's peers. The credibility of the process is lent to it by professional colleagues. It is costly and prevents innovation because of its rigidity.

Attributes of Output Regulation

- It is reactive.
- It responds and reacts to what has occurred.

- It focuses directly on actual outcomes i.e. the effect of service on individual client.
- It is dynamic in nature in that standard of qualities required can change over time to reflect changing norms.
- It is a constraint on professional behaviour in that; it is imposed upon the profession by external forces
- It is objective since enforcement is not by the profession.
- It imposes penalties that both compensate victims of incompetent service and deter incompetent and unethical practice.
- The system is victim initiated and therefore depends upon the victim's ability to discover that the service provider has failed to act as expected.

The malpractice or injury has to be detected and proven for measures to be taken. That means a professional that is able to hide his act of negligence or malpractice might inflict injury on several people without being caught.

Disadvantages of Output Regulation

- It waits until the injury has been inflicted before acting.
- It is not preventive
- It is victim initiated: The victim who knows next to nothing about how the event occurred has to be the one to initiate the process.
- Victims may have problem obtaining assistance from a professional as to whether he/she is mismanaged or not.
- It is very expensive: It involves court cases and costs of litigation, prosecution and compensation.

- It may not be possible to compensate the victim fully: A patient who has lost a limb due to another's act of negligence or malpractice cannot have the limb back no matter the amount paid as compensation.

3.3.1 History of Healthcare Regulation

Going by the history and evolution of many professions that are beneficial to society, many started as an art or trade and later metamorphose into a profession. The regulation of any profession begins the moment that art or trade attains the status of a profession. The validation of an art or trade and its elevation to the status of a profession is by the society when that art or trade is seen to be beneficial to the society. The entrance of members, acquisition of training, recognition of the body of persons or group practicing the art or trade are some of the features that determines whether an art or trade have attained the status of a profession. Every profession has its benefits and attendant risk and therefore should be subject to a system of regulation that is proportionate to the risks and benefits entailed. Health care is an endeavour that has attained the status of a profession. As much as there are health care practices that are regulated, there are emerging and existing unregulated health care practices.

The history and evolution of regulation of health care practice is highly fragmented and varies from one society to another, and one country to country. Within a country's health care system, various regulatory bodies are established to protect members of the public from risks associated with health care practice and health care providers. Regulations and standards are needed to ensure compliance and to provide safe and quality health care to everyone who accesses the healthcare system. According to Patricia Hewitt, the following key principles should be the bedrock of any statutory professional regulation: safety and quality of the care provided by the healthcare professionals, the public and the profession must have confidence in the professional regulation through demonstrable impartiality and independence, the regulation should be professional regulation that is self- sustaining, improving and assuring the professional standards by identifying and addressing poor practice or bad behaviour. Other principles that have been identified with professional

regulation are: flexibility, effectiveness and ability to adapt to change.[206] The regulation of healthcare is complex, diverse and wide ranging, affecting health care consumers, health professionals, the general public and other stake holders.

History and evolution of regulation of healthcare differs from one country to the other. Regulation of health care in England dates back to over 150 years.[207] Health care professionals in England are governed by regulatory councils that guide and oversee the administration of policies and procedures. Members also sit on panels that decide on a professional's fitness to practise and registration of member professionals. These established regulatory bodies operate within a wide variety of legal frameworks enacted by Parliament.

In the United States regulations for healthcare have been in existence for over 150 years. Regulations are developed and enforced by federal, state, and local governments and also by a large array of private regulatory bodies. The 20th century witnessed the entry of private regulatory bodies into the regulatory scene.[208] Private regulatory bodies such as the American Medical Association (AMA) are also involved in the regulation of health care.

According to historical accounts Western Medicine was first introduced into Nigeria by Portuguese traders and explorers to cater for their own health. After the explorers and traders, came, the missionaries later extended healthcare to the indigenes.[209] Origin and development of the Nigeria medical service spanned the years 1861 and 1960.[210] The beginnings of organized orthodox medical service in modern Nigeria may be traced to the administrative arrangements made in 1862 by Mr Henry Stanhope Freeman who was then Governor and Commander in Chief of the settlement of Lagos. Dr Hughes was appointed as the Colonial surgeon in 1863. The Nigerian medical service for three decades after that

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[206] London Stationery Office Trust .(2007), Assurance and Safety, the Regulation of Health Professionals in the 21st Century, White Paper Presented to Parliament by the Secretary of State for Health by Command of Her Majesty. Retrieved May.9, 2018. fromhttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC2730786

[207] Ibid, p 23

[208] Field, R (2008) "Why is health care regulation so complex?" *P T*, vol. 33(10): 607-608. Retrieved May 9,2018 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2730786

[209] Scott-Emuakpor A. 2010 The evolution of health care systems in Nigeria: Which way forward in the twenty-first century. *Niger Med J* ; 51:53-65

[210] Akinfenwa A (1964) A special list of records on origins and development of the Nigerian medical and sanitary services 1861-1960. National Archives Headquarters, Ibadan.

existed as a minor organization catering only for the health of a small band of government officials and European commercial agents.

The growing importance of Lagos as a commercial emporium in the 1880's led to the enactment of the first ordinance: The Lagos Hospital Ordinance 1881 for expansion and regularisation of the administration of the 'Colonial Hospital'. As the need arose to extend medical care to the natives, a more comprehensive legislation The Hospitals and Dispensaries Ordinance No.3 was passed in 1889 when Lagos was separated from the Gold Coast and constituted as a separate colony. The primary object of the hospital according to the ordinance "…was to provide medical and surgical aid to such persons belonging to the poorer classes as shall be unable for want of means to procure themselves proper professional assistance at their homes." The ordinance empowered the Governor to make rules for the "further and better carrying into effect the purposes of the ordinance. Hospitals were established in Asaba and Calabar.

Prior to 1887, Lagos medical service was manned solely by expatriate surgeons despite the fact that there were natives who had undergone medical training and qualified for appointment as medical officer. In 1884, the application of Dr C Jenkins Lumpkin, M.D a native medical officer was turned down for reasons of racial prejudice. Dr Obadiah Johnson was the first African Assistant Colonial Surgeon at Lagos to be appointed in 1889; he however resigned his appointment in 1897 for racial reasons.

After the merging of the Northern and Southern Protectorates with Lagos, in 1906 the administration of hospitals were placed under a single head. In 1951, for the first time in the history of medical service in Nigeria, a Nigerian, Dr (later Sir) S.L.A Manuwa was appointed to head the medical establishment of the country. Between 1953 and 1954, following an agreement reached at the Nigerian Constitutional Conference, public health and medical matters became the exclusive jurisdiction of the States and Federal Government; a reflection of what obtains today between the states and the federal government as provided by the 1999 Constitution under the concurrent legislative list.

3.4 LAWS AND REGULATION OF MATERNAL HEALTHCARE IN NIGERIA

Every country, no matter the stage of its social and economic development, has a concern in meeting the health needs of its entire people. This is particularly true in developing countries, where many obstacles of every kind face the government in the provision of the basic health services, particularly maternal health care.[211] Globally, the existence of multiple sources of health care has never been in dispute.[212] There are essentially two systems of maternity care, namely; the centrally organized system of maternity care and the locally organized system. The centrally organized system of maternity care is the one planned and operated within the context of the general health services, which includes public, generally government-sponsored sector at peripheral, intermediate and central levels, and the non-public or private sector, supported by special groups.[213] Under the locally organized system, maternity care is operated by private individuals or organisations.

In Nigeria, government hospitals and maternity centres providing orthodox maternal healthcare services are located both in the urban and rural areas under the centrally organized system of maternity care; while the locally organized system includes, traditional birth attendants (TBA's), local midwives and faith birth attendants (FBAs) operating in communities and under Faith based organizations (FBOs) religious settings such as church missions and mosques.[214] Faith based organizations (FBOs) unlike traditional birth attendants (TBAs) are more recent following the introduction of Christianity and Islam.[215] In Nigeria, FBAs like TBA's often serve the communities located in isolated and remote areas where they are consulted as a matter of necessity due to the unavailability of orthodox maternal health care services. However, they also render their

[211]Turnbull, L. and Lourdes Verderese, M. 1975. The traditional birth attendant in maternal and child health and family planning: a guide to her training and utilization. op.cit.
[212]Owumi, B. and Taiwo, P. 2012. Traditional healing practices and health reforms in Nigeria in Peoples and Cultures of Nigeria.op.cit.
[213]Turnbull, L. and Lourdes Verderese, M. 1975. The traditional birth attendant in maternal and child health and family planning: a guide to her training and utilization. op.cit
[214]Adefolaju. T. Traditional and Orthodox Medical Systems in Nigeria: The Imperative of a Synthesis op cit.
[215]Ibid.

services in urban/semi-urban communities,[216] which despite exposure to orthodox health care services may still prefer TBAs and FBAs.[217] Many pregnant women even in urban and semi-urban settings visit ante-natal clinics but when it is time to give birth; they prefer to give birth at home, seek the assistance of local midwives in faith/ healing homes or unskilled traditional birth attendants.[218] This wide acceptance and patronage of TBAs and FBAs, therefore calls for an examination of the regulatory frameworks, standardization, assurance of safety and quality of services rendered to the populace.

3.4.1. Historical Regulation of Traditional Maternal Healthcare

Every society strives to achieve an ideal state of good health for their members as 'only the healthy can fulfil their various obligations to the society …'[219] Every society no matter how primitive or the level of development evolves a system of healthcare best suited for its own people and environment. Traditional healthcare institutions stem from traditional societies. In traditional societies, traditional authority remains a relevant vital social control platform.[220] While there may not be written accounts of regulation of traditional health care institutions in early traditional societies, it would be presumptuous to assume that there was no form or system of regulation. In these societies, maternal health care practices are subject to rules, norms, customs, practices and other guidelines that must be observed by both the care giver and care seeker for a safe and smooth transition of the reproductive process.

3.4.2. Laws Regulating Traditional Maternal Healthcare in Nigeria

In Nigeria, apart from orthodox health care and traditional health care (including faith based health care), there exists other categories of health care providers and health care practice referred to as alternative and or complementary medicine. Before any discussion on regulation of traditional maternal health care under traditional medicine in Nigeria, it

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[216]Sogunro, G. O. 1987. Traditional Obstetrics: a Nigerian experience of a traditional birth attendant training program. *International Journal of Gynaecology and Obstetrics* October. 25.5: 375-379. A survey was conducted on 150 traditional birth attendants living in the peri-urban slum area of Ibadan, Oyo State. Nigeria
[217]Ibid.351
[218]Maternal health in Nigeria: a statistical overview, June 2012. Global One 2015.op.cit.
[219] Ibid.
[220] Ibid.

would seem necessary to make reference to the clarification that this research made earlier in chapter Two on the confusion over the use of the term or nomenclature ‘alternative medicine’ and ‘complimentary medicine’ as there seem to be some disagreement among the various health care practitioners over the alternate use and reference to traditional medicine as alternative medicine and vice versa. While many see traditional medicine as alternative medicine, practitioners and providers of alternative/ complementary medicine have sought to distinguish traditional medicine from their own practice. Strive and confusion created by the situation has no doubt impacted the regulation of traditional medicine in Nigeria.

Though informal interaction between the Government and traditional medicine practitioners can be traced back to the 19th century, formal legislation promoting traditional medicine dates to 1966 when the Ministry of Health authorized the University of Ibadan to conduct research into the medicinal properties of local herbs. Efforts to promote traditional medicine continued throughout the 1970s in the form of conferences and training programmes.

In 1973, Lagos Ministry of Health, in conjunction with the Department of Chemistry, University of Lagos, Nigeria sponsored an International Scientific conference in traditional medicine and medical therapy. In 1979, the Federal Ministry of Health organized the very first nationwide seminar on Traditional Medicine, an intensive training exercise, where both orthodox and traditional medical practitioners participated actively. In the 1980s, policies were established to accredit and register traditional medicine practitioners and regulate the practice of traditional medicine.

Later in 1984, the Federal Ministry of Health set up the National Investigation Committee on Traditional and Alternative Medicine (NICTAM). A National Committee on the training of Traditional Birth Attendants was also inaugurated in 1987. In 1988, the Federal Ministry of Science and Technology inaugurated a committee mandated to undertake research and development on alternative medicine.[221]

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[221]Borokini, T. and Lawal I. 2014. Traditional medicine practices among the Yoruba People of Nigeria: a historical perspective .op.cit.

The Nigerian Medical and Dental Practitioners Act of 1988[222] forbids the practice of medicine or dentistry by unregistered practitioners, specifically the issuance of death certificates, performance of post-mortems, or certification of leprosy or mental disability. However, traditional medical activities are protected by a provision in Section 17.6 which reads as follows:

> *Where any person is acknowledged by the members generally of the community to which he belongs as having been trained in a system of therapeutics traditionally in use in that community, nothing in [the provisions of the Act dealing with offences] shall be construed as making it an offence for that person to practice or hold himself out to practice that system; but the exemption conferred by this subsection shall not extend to any activity (other than circumcision) involving an incision in human tissue or to administering, supplying, or recommending the use of any dangerous drug within the meaning of Part V of the Dangerous Drugs Act.*[223]

A 1992 decree[224] created the National Primary Health Care Development Agency with a broad mandate concerning health matters, including the endorsement of traditional birth attendants. Among other things, the Agency is responsible for supporting village health care systems by:

- paying special attention to and providing maximum support for the training, development, logistic support, and supervision of village health workers and traditional birth assistants, along with the relationship between those workers and their communities and the mechanisms that link those workers to other levels of the health system;

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[222]Cap M8 LFN, 2004
[223] Cap D1 LFN, 2004.
[224]National Primary Health Care Development Agency Decree.

- Paying special attention to the involvement of women and grassroots organization of women in the village health system.

In 1994, all state health ministries were mandated to set up boards of traditional medicine in order to enhance the contribution of traditional medicine to the nation's official health care delivery system. The National Traditional Medicine Development Programme was established in 1997. Since then, the Federal Ministry of Health has been instituting measures to formally recognize and enhance the practice of traditional medicine. These measures include the constitution and inauguration of the National Technical Working Group on Traditional Medicine; development of policy documents on traditional medicine, including the National Policy on Traditional Medicine, National Code of Ethics for the Practice of Traditional Medicine, the Federal Traditional Medicine Board Decree, and Minimum Standards for Traditional Medicine Practice in Nigeria; and advocacy for traditional medicine at all levels and in relevant forums, such as the National Council on Health (since 1997), Consultative Meetings of the Honourable Minister of Health with State Commissioners for Health and Local Government Chairmen (in 1999), and the Presidential Think Tank Forum (in 1999).

In 2010, a national law for the regulation of traditional medicine was proposed with the introduction of a bill to the National Assembly for the establishment of a Traditional Medicine Council of Nigeria.[225] The functions as stated in the bill are as follows:

a) Facilitate, coordinate and harness all efforts aimed at the development of traditional medicine in Nigeria;

b) establish institutional framework and propose policies for the practice of traditional medicine in Nigeria;

c) liaise with the relevant regulatory authorities on traditional medicine at the State and Local Governments with respect to implementation of the national policies and guidelines on traditional medicine;

[225]Traditional Medicine Council of Nigeria (Establishment, ETC.) Bill,2010.

d) encourage and promote the establishment of model services and institutions on traditional medicine such as clinics, schools, botanical gardens, herbaria, drug manufacturing units, etc. In the six geopolitical zones in Nigeria;[226]

One major function of the Council is facilitating the practice and development of traditional medicine; establishing guidelines for the regulation of traditional medical practice to protect the population from quackery, fraud, and incompetence; liaising with state boards of traditional medicine to ensure adherence to the policies and guidelines and collaborating with organizations with similar objectives within and outside Nigeria.

The provisions of the bill also provide for:

e) The establishment and maintenance of a register of persons entitled to practice traditional medicine in Nigeria and publish annually, a list of persons so registered;[227]

f) Prepare and review, from time to time, code of practice for practitioners of traditional medicine in Nigeria; [228]

g) in col1aboration with the relevant agencies or bodies, develop curricula of studies, and determine the standards of knowledge and skills for training in traditional medicine in Nigeria.[229]

Furthermore, the bill states that;[230]

the Council shall have power to;-

a) Set standards for certifying persons seeking registration with the Council as traditional medicine practitioners;
b) make regulations for the discipline of erring traditional medicine practitioners;
c) set national guidelines for the establishment of Boards and Committees for the regulation and practice of traditional medicine in the State and Local Government;

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[226] See S.5 (a) – (d) Traditional Medicine Council of Nigeria (Establishment, ETC.) Bill,2010
[227]See S.5 (f) Traditional Medicine Council of Nigeria (Establishment, ETC.) Bill,2010
[228]See S.5 (g) Traditional Medicine Council of Nigeria (Establishment, ETC.) Bill,2010
[229]See S.5 (h) Traditional Medicine Council of Nigeria (Establishment, ETC.) Bill,2010
[230]See S.6 (a) – (e) Traditional Medicine Council of Nigeria (Establishment, ETC.) Bill,2010

d) establish and periodically review and update the guidelines for the regulation of traditional medicine practice in Nigeria with a view to protecting the population from quackery, fraud and incompetence;

e) have right of access to all records of any institution or bodies to which this Act applies.

However, this regulatory instrument is still a bill and does not have the force of law to regulate traditional healthcare and the practitioners in Nigeria.

The Nigeria Medical Council which is the body regulating orthodox medical practice in Nigeria is presently contemplating integrating homeopathy into the country's health care delivery system. This has however not been concretized. Other laws regulating albeit from a distance, traditional medical practice in Nigeria are:

The 1999 Constitution of the Federal Republic of Nigeria (as amended)

The 1999 Constitution in chapter 4, section 33(1) protects the right to life and the sanctity of life. This can be interpreted as imposing a duty of care on the traditional medical practitioner as to the fact that the life he or she is dealing with is sacred, and as such, utmost care must be taken to ensure that there is no harm to life or death.

National Health Act 2014

S. 1 (1) (a) – (e) provides inter alia that

> *there shall be established for the Federation the National Health System which provide a framework for standards and regulations of health service which shall encompass public and private providers of health services, promote a spirit of cooperation and shared responsibility among all providers of health services in the Federation and any part thereof, provide for persons living in Nigeria the best possible health services within the limits of available resources, set out the rights and duties of health care providers, health care workers, health*

> *management and users and protect, promote and fulfil the rights of the Nigerian people to have access to health care services*

S. 1(2) (a) – (h) further provides that the National Health System shall comprise of the following; the Federal Ministry of Health, State Ministries of Health and the Federal Capital Territory, parastatals under the Federal and State Ministries of Health, Local Government Health Authorities, Ward Health Committees, Village Health Committees, private health care providers and traditional and alternative health care providers.

S. 2 (1) (a) – (m) of the Act provides that the Federal Ministry of Health shall ensure the development of a National health policy and issue guidelines for its implementation, ensure the implementation of the National health policy, collaborate with National health departments in other countries and international agencies, promote adherence to norms and standards for the training of human resources for health, ensure the continuous monitoring, evaluation and analysis of health status and performance of the functions of all aspects of the National Health System, co-ordinate health and medical services delivery during national disasters, participate in inter-sectorial and inter-ministerial collaboration, conduct and facilitate health systems research in the planning, evaluation and management of health services, ensure and promote the provision of quarantine and port health services, determine the minimum requirement to monitor the status and use of the resources, promote the availability of good quality, safe and affordable essential drugs, medical commodities, hygienic food and water and issue guidelines and ensure the continuous monitoring, analysis and good use of drugs and poisons including medicines and medical devices.

Apart from the Constitution and national legislation like the National Health Act, there are various policies on reproductive and sexual health that also form part of the framework for the regulation of reproductive and maternal health. The National Reproductive Health Policy and Strategy of 2001, the National Policy on HIV/AIDS, 2003, the National Health

Policy and Strategy, 1998 and 2004, National Policy on Women, 2000 and 2004, National Policy on the Elimination of Female Genital Mutilation, 1998 and 2002 amongst others[231]

Other Regulatory Bodies

Other bodies and governmental agencies play a significant role in the regulation of traditional and faith health practices.

Federal Ministry of Health and State Ministries of Health

In Nigeria, the various states Ministries of Health enact laws for the regulation of Trado-medical practice. For example, the government of Oyo State enacted a Law establishing the Oyo State Advisory Board on Traditional Medicine.[232] This law provides under S.3 (2) (a) that the Board on Traditional Medicine shall "be an extra-ministerial department of the Ministry of Health"

S.4 (1) provides for the composition of the Board as follows;

> (a) a chairman who shall be a renowned Traditional Medicine practitioner with a minimum educational qualification of Secondary School certificate;
>
> (b) the Secretary who shall be the Director of the Secondary Health care in the Ministry of Health and Social Welfare;
>
> (c) four other renowned Traditional Medicine Practitioners from each of the four health zones of the State
>
> (d) One representative each from the Ministry of Health and the Hospitals Management Board;
>
> (e) One representative from the Alternative Health Group of the University of Ibadan Institute of African Studies…

S.10 (1) provides for the duties of the Board as follows:

> The duties of the Board shall be;

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[231] Review of existing reproductive health policies and legislation in Nigeria…www.gamji.com/article5000/NEWS5997.htm

[232] Oyo State Advisory Board on Traditional Medicine Edict, 1996,(now law) an edict to provide for the establishment of the Oyo State Advisory Board on Traditional Medicine and other Matters Connected Therewith in Supplements to the Oyo State of Nigeria Extra-Ordinary Gazette No.2 Vol.22 of 9th January 1997

a) to carry out the directives of the State Government on traditional medicine;
b) the preparation of the criteria for registration and maintenance of the register of all practitioners of traditional medicine such as herbalists, traditional birth attendants, or other practitioners in the traditional medicine in the state;
c) to formulate plans for the development of traditional clinics, health centres and traditional hospitals;
d) to submit request for funds to the Commissioner in accordance with soundly- based plans;
e) to compile and maintain a register of all practitioners of traditional medicine;
f) to consider all other matters relating to traditional medicine as the Commissioner may specifically refer to the Board from time to time;
g) to supervise the activities of all practitioners of traditional medicine in the state

The powers of the Board as provided under S.11 are;

a) to standardise training in traditional medicine and the type of medical service to be rendered;
b) to establish within the State registration of offices for the purposes of registering traditional herbalists, birth attendants, and other practitioners in traditional medicine in clinics and hospitals within the State;
c) to lay down conditions to be followed by traditional herbalists, traditional birth attendants and other practitioners in traditional medicine in clinics and hospitals within the State;
d) to regulate the code of conduct and practice of traditional herbalists or healers, birth attendants or other practitioners in traditional medicine in the State;
e) to charge and collect fees for registration as traditional medicine practitioner and to review such fees;

f) to do anything generally which, in its opinion, shall ensure the achievement of the purposes of this Edict.

S.16 also provides for further regulations by the Commissioner "as may be deemed necessary or expedient".

Recently also , the Oyo State legislature (House of Assembly) considering the high incidence of maternal mortality in the state, proposed a bill titled the Oyo State Family Planning, Reproductive Health and Maternity Services Bill, 2017, which is to be passed into law. All relevant stakeholders were invited to a public hearing on the bill. Many stakeholders such as health care practitioners(orthodox and traditional), religious leaders, advocacy groups, reproductive health experts and academics, lawyers, pharmacist including students of the Faculty of Law, University of Ibadan to mention a few and members of the public were present to debate and make submissions on the bill. The bill is a 12 paged document containing 17 sections with sub-paragraphs and a schedule providing for the regulation of reproductive health and safe maternity services in Oyo State.

Particular sections of the bill that are relevant to the current discuss are sections 8, 9 and 10.

S.8 states as follows;

> (6) (i) No person not being a qualified Health Care Provider with the requisite qualification and cognate experience in maternity services shall engage in such services.
>
> S. 9 provides that,
>
> (1) Nothing in this bill shall prevent a trained, certified and registered Traditional Birth Attendant from providing safe maternity services provided such Attendant shall refer complicated pregnancies promptly to any appropriate registered Health Care Provider offering maternity services
>
> (2) Every Traditional Birth Centre shall be registered by the appropriate authority.
>
> (4) Every Traditional Birth Centre shall have personnel that are qualified and trained in maternity services.

Analysing the provisions of S.8 (6) and S.9, there seems to be a contradiction. Although going by S.9 (1) traditional birth attendants are not prevented from providing safe maternity services, the provision of S.8 (6) (i) states clearly that it is only a qualified health

care provider with requisite qualification and cognate experience that can render maternity services.

Going further, sub-section (ii) of S.8 (6) states that 'any person who contravenes the provision of S.8 (6) is guilty of an offence and liable on conviction to a fine of N500, 000 or to imprisonment for a term of one (1) year'. In a similar manner, S.10 criminalizes home delivery by stating that any woman who contravenes section 9(1) or 'husband of an expectant mother who prevents, hinders or denies an expectant mother from delivering in a registered health care provider or Traditional birth centre offering maternity services is guilty of an offence and liable to a fine of N50, 000 or imprisonment for a term of six (6) months'

The foregoing provisions no doubt represent criminalisation of the reproductive process, violates the right to the choice of maternal health care and or services. The pertinent questions to ask therefore are:

a) Is there a right to choice of healthcare including maternal healthcare that is ethically and culturally appropriate?
b) Can criminalization be an effective solution to the problem of high incidence of maternal mortality in Nigeria?
c) Will criminalization of TBA and FBA maternal services dissuade patronage by pregnant women?
d) Is there a better alternative to criminalization?

The CESCR General Comment on health provides guidance on what should be the content of the right to health. The General Comment highlights availability, accessibility and acceptability as essentials in the protection and promotion of right to health,[233] and that includes women's reproductive health.

Traditional healthcare particularly maternal health care and anything relating to maternity is *sui generis* to culture and community. Before the advent of orthodox maternity services, various cultures and communities have their own ways of addressing issues of reproduction. Many of these practices are rooted in culture and religion. TBAs and FBAs are respected members of the communities in which they practice; they assist women in the

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[233]Cook, R. J.et al 2003. Reproductive health and human rights: Integrating medicine, ethics, and law. New York: Clarendon Press. 189

process of pregnancy and giving birth. Many of these older women and men either learnt the art through apprenticeship or inherited the art from their parents. TBAs and FBAs are cheaper to patronize as they do not charge exorbitant fees unlike the orthodox where an uneventful delivery can attract as much as 25,000 Naira. In a doctoral research carried out by the writer, many of the women and couples in the focus group discussions state that the major reasons for patronizing TBAs and FBAs is that the services are more or less free and that TBAs and FBAs show more empathy than orthodox health care personnel.

According to Cook R.J et al, 'the control of human reproduction and sexuality by penalties of criminal law was supported by traditional political and religious institutions as a defence of marriage, the family, and moral values'.[234] This statement was drawn from the Authors exposition on the transition and evolution of reproductive health law from the era of morality to democracy; to crime and punishment; to health and welfare and now, to the era of human rights.[235] Although there still exists areas of reproduction that are still controlled by criminal sanctions and penalties, for example the varied restrictive abortion laws still existing in many countries, human rights principles such as respect for privacy, choice and self-determination, have afforded individuals protection against legislative and other criminal sanctions by states. The case of *R v Mogentaler*[236] where the Supreme Court of Canada held that the restrictive Criminal code provision is unconstitutional and inoperative 'forcing a woman by threat of criminal sanction to… meet criteria unrelated to her priorities and aspirations, is a profound interference … and a violation of the security of a person',[237] is very instructive as a landmark decision against the use of criminal and other punitive measures in reproductive health.

Notwithstanding the good intention of government to protect women against harm and quackery in the hands of TBAs and FBAs, the principles of human rights relating to women and couples reproductive choices must be respected and recognized. The Nigerian legal system like many others must move beyond criminal prohibitions and sanctions in matters relating to reproduction and reproductive choices such as choice of maternal

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[234] Cook, R. J.et al 2003, op cit.
[235] Ibid.
[236] *R v. Morgentaler* (1988), 44 Dominion Law Reports(4th) 385 (Supreme Court of Canada)
[237] Ibid.

healthcare service. Where a woman or couple decide to have a home delivery through a local midwife, TBA or FBA, the choice must be respected and safe delivery ensured.

Government responsibility to give effect to concepts of health, safe motherhood, welfare and respect for choice, privacy and the right to self-determination cannot be more apt in this era of democracy and human rights. Federal and State governments in Nigeria should see to and ensure that the existing policies on health contain provisions regulating TBAs and FBAs for safety and quality rather than criminalization of TBA and FBA maternal healthcare practices. Any proposed national or state bill must consider first the right to health from the point of acceptability, accessibility and availability. In rural areas where health care providers are not available traditional or faith based maternal healthcare practitioners should be allowed to operate without fear of prosecution. Guidelines for the practice of TBAs and FBAs should be provided with provisions stipulating standards, duty of care, training, professionalism, duty to refer and other practice guidelines as obtained in other jurisdictions such as Malaysia, Tanzania and South Africa that have lower incidence of maternal mortality.

Complementary and Alternative Medical Council of Nigeria

Recognizing that traditional medicine has for many centuries been part of the health culture of the people and the need to incorporate traditional health care practice into the existing health care system caused the government to fund experts to travel to India to study Alternative Medical Practice. The Federal Ministry of Health has established a college for the same reason and purpose. This is the Federal College of Complementary and Alternative Medicine with its headquarters in Abuja. The programme includes Certificate or Diploma in Alternative Medicine, Bachelor of Science in Alternative Medicine and a Master of Science in Alternative Medicine in the area of Acupuncture, Naturopathy and Homeopathy.

Complementary and Alternative Medical Council of Nigeria is another major regulatory body whose purpose is to promote the growth and regulate the practice of alternative medicine,[238] conduct assessment examinations in the relevant disciplines, register and /or

[238]Complementary and Alternative Medical Council of Nigeria Bill.

issue practicing license to qualified candidates as appropriate, and for such purpose as the council shall prescribe fees in respect thereof;[239] create and regularly upgrade minimum standard required for the establishment of clinics, hospitals of complementary and alternative medicine;[240] register, de-register, expel, suspend, seal and apply any form of disciplinary measure that is deemed fit by the council for any erring practitioner, clinic, hospital, or private medical institution of complementary and alternative medicine;[241] validate through scientific research the various claims on complementary an alternative medicine products by the manufacturers and practitioners;[242] promotion of scientific research and clinical trials in complementary and alternative medicine;[243] collate, publish, disseminate and exchange information on complementary and alternative medicine research;[244] establish a data base management system/library on all form of alternative complimentary medicine resources;[245] determine the standards required for academic and non-academic staff, offices, classrooms, structures, equipment and learning environment in respect of institution(s) established in Nigeria for the purpose of awarding certificates or diplomas and degrees in any discipline(s) of complementary and alternatives medicine;[246] evaluate foreign diplomas and degrees in any discipline(s) of complementary and alternatives medicine for purposes of registering the practitioner in Nigeria;[247] ensure the full integration of complementary and alternative medicine in the national healthcare delivery system;[248] promote integration between practitioner's of complementary and alternative and other health related workers;[249] and to carry out any other activity that would assist in achieving the objectives of the council.[250]

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[239] See S. 4 (1) (d) Complementary and Alternative Medical Council of Nigeria Bill.
[240] See S. 4 (1) (e) Complementary and Alternative Medical Council of Nigeria Bill.
[241] See S. 4 (1) (f) Complementary and Alternative Medical Council of Nigeria Bill.
[242] See S. 4 (1) (g) Complementary and Alternative Medical Council of Nigeria Bill.
[243] See S. 4 (1) (h) Complementary and Alternative Medical Council of Nigeria Bill
[244] See S. 4 (1) (i) Complementary and Alternative Medical Council of Nigeria Bill
[245] See S. 4 (1) (j) Complementary and Alternative Medical Council of Nigeria Bill
[246] See S. 4 (1) (k) Complementary and Alternative Medical Council of Nigeria Bill
[247] See S. 4 (1) (l) Complementary and Alternative Medical Council of Nigeria Bill
[248] See S. 4 (1) (m)Complementary and Alternative Medical Council of Nigeria Bill
[249] See S. 4 (1) (n) Complementary and Alternative Medical Council of Nigeria Bill
[250] See S. 4 (1) (o) Complementary and Alternative Medical Council of Nigeria Bill

Associated Bodies and Trade Unions

It is reported that since the 19th century, associations of herbalists or traditional healers have existed among the Yorubas. With the passage of time, a few of these associations "were registered along the lines laid down by the government for trade unions ... these associations were charged with the responsibility of drawing up guidelines and codes of conduct to discipline erring members ... also to assess the quality of the knowledge of herbalists ... certificates of proficiency were issued by some associations ... ".[251] Association of different specialities under traditional medicine exists in many communities in Nigeria. In the course of this research much information was gleaned from members and heads of associations of different specialties of traditional healthcare practice.[252]

3.4.3. Laws Regulating Faith Based Maternal Healthcare

Faith-based maternal health care and FBAs in Nigeria stem from faith-based organizations (FBOs). This refers to religious and or religious-based groups connected with a stable faith community,[253] for example, the Roman Catholic extended healthcare to natives in the East, the Sudan United Mission concentrated on middle belt, and the Sudan Interior Mission worked in the Islamic north. Christ Apostolic, Cherubim and Seraphim (Aladura), The Apostolic and other Christian denominations are latter day missions that have also played a significant role in the provision of healthcare in Nigeria. FBOs have historically played an important role in providing maternal healthcare services in Nigeria.

Records reveal that Christian faith based medical missions rendering maternal and infant welfare services have been in Nigeria before colonial administration.[254] Some of the notable medical missions include: Christian Missionary Society, Wesleyan Methodist Missionary, American Baptist Missionary Society, United Free Church Missionary Society,

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[251].Stepan, J. 1985.Traditional and alternative systems of medicine: a comparative review of legislation. *International digest of health legislation*.op.cit.303

[252] See report on summary of findings in chapter six of Thesis

[253]Baiyeri, H. 2013. The role of faith-based organizations (FBOS) in human development: a study of Kogi State A Master's Thesis, Department of Religion and Cultural Studies, Faculty of the Social Sciences, University of Nigeria,
Nsukka. 8

[254] Schmid B et al 2008. The contribution of faith based organisations and networks to health in sub-Saharan Africa

Qua Ibo Mission, Primitive Methodist Missionary Society, Seventh Day Adventist Mission and the Roman Catholic Missions just to mention a few. Little is known about the contribution of Islamic faith organisations to the provision of healthcare during the colonial era. However, historical records from the National Archives reveals that Christian missions such as Sudan Interior Missions worked in the Islamic north, providing healthcare to the natives.

According to Woldehanna et al faith-based organizations are "religious and religious-based organizations, places of religious worship or congregations, specialized religious institutions and registered or unregistered non-profit institutions that have religious character"[255].

According to the World, Health Organization, FBOs own up to 70 percent of the health infrastructure in sub-Saharan African countries and often work in remote States where government and NGO services are limited. FBO's are critical to improving maternal health as they fill gaps in the health system – particularly in low-resource settings – and approaching culturally sensitive barriers that often prevent mothers from seeking health care. The level of trust communities place on their religious leaders explains one of the main reasons why FBOs are attaining success. A study conducted by Pew Charitable Trust found that a vast majority of people in sub-Saharan Africa identify themselves as adherents of Christianity or Islam, and approximately 75 percent trust their religious leaders.[256]

In a particular research,[257] it has been argued that the role and contribution of FBOs in maternal service delivery is insufficiently recognized and less well understood.[258] The researchers found that maternal health services provided by FBOs were similar to those offered by governments, but the quality of care received and the satisfaction is better and therefore recommend the establishment of a stronger partnerships with FBOs in Africa as

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[255]Woldehanna, et al.2005. Preliminary report at a Glance: Faith in action: Examining the role of faith-based organizations in addressing HIV/AIDS. Washington D.C: Global Health Council.
[256] Essaw, R. 2011. The role of faith-based organizations in maternal and newborn health care
[257] Widmer, M. *et al*. 2011.The role of faith-based organizations in maternal and newborn health care in Africa
Int J Gynaecol Obstet 114:218-22
[258] Essaw, R. 2011. The role of faith-based organizations in maternal and newborn health care
op cit.

an untapped route to achieving Sustainable Development Goals on maternal health and safe motherhood. However, with the current estimates of high incidence of maternal mortality in Nigeria and the proliferation of different religious denominations, there is a need to enquire into the evolution and history of laws regulating faith-based maternal services in Nigeria.

Sometimes, it is a bit difficult to delineate faith based maternal healthcare from orthodox maternal healthcare but an enquiry into the history and evolution of faith based maternal health care in Nigeria has established the connectivity between faith based maternal healthcare practice and orthodox maternal healthcare practice. Faith Based Organizations also known as missions during the colonial administration provided orthodox maternal health care services to natives long before the colonial period. The decision of the colonial administration to extend healthcare to the natives brought about the need to regulate mission hospitals in 1928. In a letter written on the 11th of October 1927 by the Director of Medical and Sanitary Services Lagos to the Chief Secretary to the Government titled "Extension of Medical Aid to Nigeria By Direction, Control and Subsidy of Medical Mission", the director informed the chief secretary on the need to expand on the medical aid provided to the people. Recognizing the limitation of government with regards to medical personnel, he made a suggestion of collaboration or partnership with the medical missions by granting financial aid to the medical missions and 'the possibility of utilizing them for greater benefit of the people'. He however expressed his fears on the effectiveness of such collaboration without government exercising control over the medical missions. He therefore suggested to the Chief Secretary on the need to bring all medical work of missions under the direction and control of government and for a reorganisation with a view to increasing efficiency.

In the letter, it was further stated that government had in the past given assistance to some missions such as Father Coquard's hospital at Abeokuta but that this needs to be regularised and supervised by government. In the letter, Maternity and child welfare centres were among the areas listed as requiring extension of medical services by missions. In response to the proposal on collaboration, the Government vide another letter approved a tour of inspection of the medical missions to determine the need and financial implication

for government. Following the tour of inspection, it was noted that in all the medical missions, service is hampered and restricted by “want of suitable buildings, lack of equipment and insufficient supplies especially the expensive drugs”. The collaboration and rendering of financial aid subsequently led to the control of missions’ educational activities including the training and recruitment of health care staff.

The earliest indigenous medical practitioners were trained in Britain. Subsequently, several other indigenous people travelled outside of Nigeria to train as healthcare professionals in various fields of medical practice. Later, some hospitals were established. With the establishment of Universities in Nigeria came the opportunity to include the study of medicine as one of the courses. In 1948, the University College was established at Ibadan and the University College Hospital was established in 1952 as a teaching hospital for the training of doctors.[259] Since this period, spanning 1861 to 1960 till date, faith based medical missions have developed, and are regulated along same lines with orthodox or western medicine which has become the officially recognized healthcare system.

[259] Yakubu, A. 2002. Medical law in Nigeria. op. cit

3.5 SUMMARY AND CONCLUSION

For many decades, notwithstanding that traditional medical practice held sway in Nigeria as the indigenous health care system, however, following colonization came the introduction of orthodox or modern (allopathic) into Nigeria and the emergence of orthodox medical practitioners in Nigeria. Traditional medical practice plays appreciable role in health care delivery in the country. Despite the rapid expansion of conventional medicine in the last three decades and the rapid increase in its human resources, a majority of Nigerians still utilize Traditional Medicine. The theory of the use of traditional healthcare and medicine with WHO probably dates back to 1977 when the World Health Assembly (WHA) drew attention to the potential of traditional medicine, especially its human power reserve in National health care systems, urging member countries to encourage traditional healthcare practices. For many decades, traditional birth attendants have been providing maternal health care and delivery services in both rural and urban Nigeria.[260] However, following the introduction of Christianity, Islam and colonisation, there was stigmatization and relegation of the traditional health care system. The dawn of Nigeria's independence in the 60's however saw the bold and open re-emergence of traditional medicine, traditional health and faith healing practitioners.[261]

In the traditional rural communities and even urban areas the woman is assisted by a trusted companion, usually the mother-in-law, a locally accepted or recognized midwife who may also be a member of a religious sect, faith mission and healing home. Traditional values and religious practices in Nigeria have created health-care choices,[262] particularly maternal health care.

The statement and writings of various writers over many years of academic discourse have grounded the existence of laws and rules as instruments of social control. There is no society however primitive that has not sort in one way or the other to put in place

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[260]Salako, A. A. 2002. The traditional birth attendant and the high Nigeria's maternal mortality. *Nigerian Journal of Clinical Practice.* June.5.1:69-70.
[261] Gamaniel, S. 2003 Evaluation of Traditional Medicine for the management of Sickle Cell Anaemia in Nigeria: Country Report *African Health Monitor* Vol. 4, No. 1. 27
[262]Owumi, B. and P. A. Taiwo, 2012. Traditional healing practices and health reforms in Nigeria, in Jegede A et al Eds. Peoples and Cultures of Nigeria, op.cit.

structures or measures to regulate conduct or behaviour with a set of values and acceptable behaviour. Social control therefore, is the mechanism put in place by societal structures to regulate behaviour within a given social space with a view to moderating infractions from the laid down rules.[263] Regulation of conduct through law involves two forms; namely, formal social control and informal social control.

Traditional and faith health care, being a child of necessity in the face of man's innovative and adaptive potentials unlike orthodox health care does not necessarily bother itself with explanations or scientific rationalizations but rather draws its strength of acceptance from among other things, cultural roots, religious faith and its results. However, there have been a lot of criticisms against these forms of health care and claims by the practitioners. This does not by any means however serve to undermine the practice but rather state that for its maximum utilization; it would require some form of regulation and standardization to meet up with the contemporary medical demands of a developing society. Traditional maternal health care providers need to be backed up legally for effective monitoring, assessment and evaluation of their activities.[264]

[263]Aderinto, A. and Tade, O. 2012. Culture, deviance and social control in Jegede A et al Eds. Peoples and Cultures of Nigeria, op cit.

[264] Owunmi B , Taiwo P. 2012 Traditional healing practices and health reforms in Nigeria in eds; Jegede A et al Peoples and Cultures of Nigeria op cit. 241

CHAPTER FOUR

LIMITATIONS AND INADEQUACIES IN REGULATION OF TRADITIONAL AND FAITH BASED MATERNAL HEALTH CARE PRACTICES IN NIGERIA

4.0. INTRODUCTION

The traditional birth attendant (TBA) is an institution as old as the birthing process in the human species. Through the ages, traditional birth attendants and local midwives have been the main human resource for women, providing maternal healthcare and delivery services during child birth in traditional communities.[265] In recent times however, following the introduction of Christianity and Islam, another variant of local midwives and birth attendants providing maternal health care are the FBAs. In Nigeria, the roles of traditional birth attendants and faith birth attendants have increased over the years, contributing to the health system and giving support to providers of orthodox maternal health care and services.[266] Traditional birth attendants and local midwives of mosques, church missions and other faith healing centres provide maternal healthcare services to both rural and urban women.[267]

Many women living in low-resource and rural settings and even urban areas continue to seek the care of a TBAs and FBAs, despite the knowledge that a health facility delivery is often safer.[268] As earlier stated, poverty is seen as the major contributing factor to why these women cannot seek out adequate medical services.[269]

Traditional and faith maternal practices are part of the socio-cultural and religious fabric of various communities in Nigeria[270] and have consequently come to the fore once again as a

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[265]Bergstrom, S. and Goodburn, E. 2001.The role of traditional birth attendants in the reduction of maternal mortality.op.cit.
[266]Ebuehi, O. M. and Akintujoye, I.A. 2012. Perception and utilization of traditional birth attendants by pregnant women attending primary health care clinics in a rural Local Government Area in Ogun State, Nigeria.*International Journal Womens Health*.4: 25–34 Retrieved Oct.20, 2016, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3282603/
[267]Ibid.
[268]Pyone, T. et al 2014. Changing the role of traditional birth attendants in Somaliland.op.cit.
[269]Owoseni, J. S. et al. 2014. Pregnancy care and maternal mortality in Ilesa, Osun State Nigeria.op cit.
[270] Oshonwoh, F. et al Traditional birth attendants and women's health practices: A case study of Patani in Southern Nigeria. *Jour of Public Health and Epidemiology*. 2014; 6(8): 252-261

major alternative to orthodox maternal healthcare in Africa and Nigeria in particular. This conceptualizes clearly the present state of shifting paradigms within the health sector both at the National level and on the International scene, calling for state recognition and regulation of these forms of maternal health care practices, towards reducing preventable causes of maternal mortality and the high rate of morbidity among women in Nigeria.

This chapter, referencing the previous chapter on regulation exposes the defects in mechanisms for regulating traditional and faith based maternal health practices in Nigeria. Along these lines, the chapter discusses the rights to choice of maternity, safe motherhood and maternal health within the confines of reproductive health. This chapter also reassesses government obligation to protect, respect and fulfil women's rights and choices in reproductive health. Furthermore, this chapter enquires into the extent of Nigeria's compliance with international obligations under international human rights agreements relating to maternal health and rights.

This chapter posits that ensuring governmental compliance with human rights obligations would include taking all measures, for example; adequate and effective legal framework, to foster and ensure protection for women seeking traditional and faith based maternal healthcare services.

4.1. REPRODUCTIVE HEALTHCARE PRINCIPLES AND OBLIGATION OF GOVERNMENT IN MATERNAL HEALTH

Reproductive healthcare is driven by certain legal principles that are core to maximizing protection and promotion of reproductive health. It is the obligation of government in each legal system to uphold these core principles through legislation or by judicial interpretation of an enacted law.[271] The key legal principles in the provision of reproductive health care services are: informed decision making, free decision making, privacy, confidentiality, competent delivery of services and safety and efficacy of products.

[271] Cook R.J et al. 2003. Reproductive health and human rights; Integrating medicine, ethics and law, op cit.p. 103

Free decision making with respect to the right to choice of maternity and competent delivery of safe services is at the core of government social duty to respect, protect, and fulfil the rights of women in maternal healthcare. Going by these legal principles, governments are obligated to respect women's right to pursue their own health goals and must protect women against public or private health care providers and ensure that they respect women's right while accessing healthcare. Government, in cases of violation, is expected to take action by imposing sanction for harm done to women by private healthcare providers or organizations, for example, incompetent TBAs, FBAs or FBOs.

Part of these obligation on the part of government include "taking appropriate legislative, judicial, administrative and budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health"[272] According to the General Recommendation by CEDAW, maternal mortality and morbidity are clear indicators of governments possible neglect in their obligations towards ensuring women get access to quality maternal health services.[273] Governments are therefore expected to provide reports that show the measures that government have taken to ensure women appropriate maternal services, ante-natal and post-natal services. Emphasis is therefore placed on governmental duty towards facilitating women's right to safe motherhood and emergency obstetrics care.[274]

4.1.1. Reproductive Health and the Right to Safe Motherhood

Maternity is a social function of women that is undertaken by women, and in the words of Fathalla Mahmoud,

> *'it is the means by which the human species is propagated. Pregnancy and childbirth are a privileged function of women, essential for the survival of our species…These women are risking death to give life. Women have a right, a basic human*

[272] CEDAW General Recommendation 19, UN GAOR 1992, UN Doc. A/47/38.
[273] CEDAW General Recommendation 19, UN GAOR 1992, UN Doc op cit.
[274] Art. 12(1) CEDAW, General Recommendation 24, UN GAOR 1999, UN Doc. A/54/38/Rev.1

right, to be protected when they undertake the risky business of pregnancy and childbirth.'[275]

The concept of reproductive health recently emerged but reproductive rights are not a new set of rights. It is the application of existing human rights to the process of reproduction.[276] Reproductive health offers a comprehensive and integrated approach to health needs related to reproduction.[277] While reproductive health is considered to be an important component of health for both women and men, the issues are more critical for women than men, because the unfair burden for reproductive health lies more heavily on women due to women's reproductive function of child bearing. Women therefore assume a disproportionate responsibility as far as the reproductive process is concerned[278] The right to safe motherhood is very crucial to women's maternal health, bearing in mind that pregnancy and child bearing is indeed a risky enterprise where women lack access to government assured quality maternal healthcare services.

Maternal mortality is a major cause of death and disability among women of reproductive age. 500,000 women die every year from complications related to childbearing. Maternal mortality and morbidity adversely affect the health and welfare of children, families, and communities.[279] Maternal mortality is the leading cause of death for women of reproductive age in Asia and Latin America[280]. In Africa, it is recorded as the second major cause of mortality for women, indicating that child bearing in the continent is still dangerous, and many do not return. The global concern over the high incidence of maternal

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[275] Fathalla, M. 2006. Human rights aspect of safe motherhood. *Best Practice & Research Clinical Obstetrics and Gynaecology* Vol. 20, No.3, pp. 409-419, doi: I0.10 I6/j.bpobgyn.2005. I 1.004 Retrieved May 5, 2018 from http://www.sciencedirect.com

[276] Fathalla M 2001. Reproductive rights and reproductive wrongs. Women's *Health Rep* 200 I; I: 169-170.

[277] Ibid. p. 20

[278] Ibid, p.16

[279] The National Academies of Sciences Engineering and Medicine, 2000. Consequences of maternal morbidity and mortality: Report of a workshop. National Academies Press Retrieved October 18,2018 https://www.nap.edu/read/9800/chapter/2

[280] Cook R, et al. 2003. Reproductive health and human rights; Integrating medicine, ethics and law .op.cit. 33

mortality brought about the Safe Motherhood initiative. The right to safe motherhood is basically a woman's right to life.[281]

The Safe Motherhood Initiative 'is a worldwide effort that aims to reduce the number of deaths and illnesses associated with pregnancy and childbirth. Ways to achieve safe motherhood include: government ensuring skilled attendance at all births, access to quality emergency obstetrical care, access to quality reproductive health care, including family planning and safe post-abortion care'.[282] Safe motherhood is a human rights issue because it is concerning the lives of women. Although human rights treaties and conventions do not have an explicit right to safe motherhood, because this is about women's right to life and health, human rights committees have now included a gender perspective in the interpretation of human rights. Therefore, any commission or omission on the part of government to address the preventable causes of maternal death is a violation of women's human rights, for which states can be held accountable.[283] Where government fail to appropriately regulate or standardize the practice of local providers of maternal healthcare leading to preventable loss of women's live during pregnancy and childbearing are violations of the right to health, right to life and right to safe motherhood.

4.2. LIMITATIONS AND INADEQUACIES IN REGULATION OF TRADITIONAL AND FAITH BASED MATERNAL HEALTH CARE PRACTICE IN NIGERIA.

Traditional medicine is a bona fide medical system. All people of the world are known to have their indigenous ways of treating illnesses. Nigeria as a country has the largest population in Africa and holds the key to Africa's growth and development[284]. Sustainable Development Goals 3 deal particularly with maternal health and new born health and

[281]Ibid

[282]The UCSF Bixby Center for Global Reproductive Health. 2016. Pregnancy and childbirth. The Regents of the University of California. Retrieved Oct. 20,2016, from https://bixbycenter.ucsf.edu/research/safe_motherhood.html

[283] SDG 3 calls for a global drastic reduction in maternal mortality, neonatal and child mortality by the year 2030

[284]Federal Ministry of Health. 2011. Saving newborn lives in Nigeria: new born health in the context of the integrated maternal, new born and child health strategy. 2nd ed. Abuja: Federal Ministry of Health, Save the Children, Jhpiego.

safety,[285] as a result there is a need to strive towards the achieving of certain goals that ensure the safety and well-being of its citizens so as to promote a stable environment that supports growth and development for the general good of the continent.

According to the World Health Organization, traditional medicine is the total combination of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental or social diseases and which may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing.[286] As has been established earlier, traditional medicine has been an integral part of the Nigerian Health system and as such, an importance in society that cannot be overemphasized. Nigeria is a signatory to the Convention of the United Nations (UN) and as such agreed to the domestication protocol that traditional medicine should be developed further to support orthodox medicine. It is clear that traditional medicine continues to hold sway over the Nigerian Population. Unlike popular belief, the people at the grass-root level outnumber the elites in Nigeria. Even said, elites have begun to rely heavily on traditional and faith based homes rather than orthodox hospitals. A WHO survey reported that more than 75% of Nigerians still depend on medicinal plants for primary health care[287]. However, despite the apparent reception and growth that has taken place or that seemed to take place, it is very important to know that traditional medicine has been challenged especially by orthodox practitioners on the basis or grounds of its authenticity. The argument being that where there is accurate measurement on drugs and usage, contraindications and side effects, the organic and chemical compounds of each individual drug known and gauged, the reverse seems to be the case for traditional medicine. Also, that its popularity is based on the anecdotal experiences of patients.[288] It was noted that the practitioners inflate the claims attached to advertisement and its products as well as not

[285]Ibid.
[286]WHO. 2008. Traditional Medicine Fact Sheet 134.
[287]Borokini, T. I. and Lawal I. O. 2014. Traditional medicine practices among the Yoruba People of Nigeria: a historical perspective. op.cit.
[288]Ibid

having scientific explanation or data about its effectiveness and methods, thus making it difficult to ascertain legitimate and effective therapy and its therapist.[289]

Traditional medical practitioners however claim to know what they use in terms of the practice, procedure, methods, drugs and its exact percentage and usage. They also claim that their results are effective and are not over exaggerated unlike the claims made against their practice. Due to issues like this, despite its popularity, traditional medicine seems to be the last resort for the elitist after trying the orthodox system, also it is viewed generally as dangerous and fraudulent without having much of a say in "real medical practice". Modern-day technology, innovations and education have, however, made a lot of impact on the traditional medical practitioner and on the practice of traditional medicine in Nigeria. The general populace now wants to compare the traditional medical practitioner with the orthodox medicine general practitioner.

Good health represents an ideal state towards which all human societies strive to achieve for all their members[290]. It is due to this that the National Health Policy seeks to stir up a desire in both the government and its people to provide a comprehensive and well balanced health care system for the people of Nigeria.

According to Nigeria's Federal Ministry of Health, the National Health Policy is 'based on the philosophy of social justice and equity'[291]. This policy is aimed at preventing, treating and managing illnesses as well as preserving mental and physical well-being of the people through the services of health personnel. The policy is in tandem with the traditional healing system in Nigeria prior to the introduction of orthodox medical practice. Health care delivery before orthodox medicine in Africa was the sole responsibility of traditional healers and traditional medical practitioners whose medical knowledge and the

[289]Osborne, O. 2007. Healthcare system in Post-colonial Africa. Microsoft Student 2007 DVD.
[290]Owumi, B. and Taiwo, P. 2012. Traditional healing practices and health reforms in Nigeria in Peoples and Cultures of Nigeria.op.cit.241
[291]FMOH. 1988. The National health policy and strategy to achieve health for all Nigerians. Lagos: Federal Ministry of Health.

understanding of their environment made the people to patronize them for their medical needs[292].

Nigeria is the only country in Africa where there is no specific law to regulate traditional medical practice. Many have entered into the trade, without oversight or any form of control calling themselves traditional medicine practitioners without being queried.[293]Dr Azugbo, President-General of Traditional Medicines Practitioners' Association of Nigeria, opines that 'in the ancient days, our forefathers did not take modern medicines. They used to take herbs and leaves and that is why they lived longer and stronger[294]. Africa's disease burden is growing rapidly. He further states that to ignore the potential of traditional health care is to omit a part of the solution. Indigenous African healthcare has the potential to bring affordable remedies within reach of millions who are unable to access orthodox care due to cost, geographical inaccessibility and non-availability.[295] He furthermore said that:

> *Nigeria could have a thriving, home grown traditional pharmaceutical industry in the near future. The missing ingredient is the active support of the federal government, which sets policy, and Nigeria's 36 states, which are responsible for regulation and technical backing for primary health care services. The issue is less about funding than about political will and providing creative leadership to make room for traditional care; and about changing perceptions in a sometimes resistant mainstream health system.*

Tracing the history of regulation of traditional medicine in Nigeria with all the steps and attempts made at regulation, one will agree that it has only been more of talk and no real

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[292]Adefolaju T. 2014. Traditional and Orthodox medical systems in Nigeria: The imperative of a synthesis. op.cit.

[293]Oyeyemi, G. and Adepoju, W. 2015. Wanted: Law in traditional medicine practice. *The Nation*..April.23 Document 10, October 2016. Retrieved Oct.19, 2016, from http://thenationonlineng.net/wanted-law-in-traditional-medicine-practice/

[294] Anon. 2012. *Vanguard*, May.2 .17.

[295]Anon. 2012. *Vanguard*. op.cit. Statement by the Director of Pax Herbal Clinic and Research Laboratories, Ewu, Edo State, Fr. Anselm Adodo.

action. According to The Nation online news, quoting The Chief Executive Officer (CEO), Health Forever Limited, Otunba Olajuwon Okubena,

> *At present, traditional medicine is being suppressed. The fractious regulations and institution, and the lack of support from the Federal Government have further negated its integration into the health care system. It is, therefore, not sufficient to recognize traditional medicine, but self-sustaining and empowered structures and a system must be provided for its effective institutionalization.*[296]

He furthermore said that the intention must be allowed for the proper development and enrichment of traditional medicine and practice as a system in the sector, equal in status to allopathic/orthodox medicine as it is in China and India, and more recently, South Africa.

The method of administering health care and the preparation of traditional medicine has been subjected to adverse comments and criticism especially by pro-western medicine and such includes the lack of standardization and safety which makes it technically difficult to identify with precision the hundreds of chemical constituents of the plants, roots, herbs and other ingredients used and their dosage.[297] Lack of scientific diagnosis is also a factor, methods of treatment which cannot be verified by scientific means, lack of scientific proof of its efficiency, quackery and unhygienic conditions under which traditional medicine is prepared and preserved.[298] As of 2007 one of the targets for 2015 was to reduce by three quarters, between 1990 and 2015, the maternal mortality rate[299].

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[296]Oyeyemi, G. and Adepoju, W. 2015. Wanted: Law in traditional medicine practice. *The Nation*..op.cit.
[297]Okojie, E. .2015.Impact of regulatory mechanisms on trado-medical Practice in Nigeria.op.cit.
[298]Ibid. Also, in a prospective study carried out in Nigeria and India, 25 percent of childhood blindness was attributed to traditional eye medicines. See further Harris, A. and Cullinan, T. 1994. Herbiset Orbis: the dangers of traditional eye medicines. Lancet.344 :1588
[299]Federal Ministry of Health. Department of Health Planning and Research, National Health Management Information System (NHMIS) Unit. Revised Policy-Program and Strategic Plan of Action. NHMIS Policy Document. P.3. in its declaration, items two and three state inter alia that;
ii. All Governments of the Federation are convinced that the health of the people not only contributes to better a quality of lives but is also essential for the sustained economic and social development of the country as a whole.
iii. The people of this nation have the right to participate individually and collectively in the planning and

With reference to the above, one can then safely infer that the key to reduced mortality especially maternal mortality and also the promotion of good health standards in Nigeria lie within the ability to embrace every aspect of medicine and medical practice in Nigeria which would then include traditional medicine and consequently, traditional maternal health practice.

Noting that traditional medicine is widely used, that there is no uniform system of traditional medicine in the country but that there are wide variations with each variant being strongly bound to the local culture and beliefs, the local health authorities shall, where applicable, seek the collaboration of the traditional practitioners in promoting their health programmes such as nutrition, environmental sanitation, personal hygiene, family planning and immunizations. Traditional health practitioners shall be trained to improve their skills and to ensure their cooperation in making use of the referral system in dealing with high risk patients. Governments of the Federation shall seek to gain a better understanding of traditional health practices, and support research activities to evaluate them. Practices and technologies of proven value shall be adapted into the health care system and those that are harmful shall be discouraged.[300]

The above is an excerpt from the NHMIS policy document of 2007 found at section 2.6. It is interesting to note that while the fact that traditional health practices exist, they are still treated and referred to as subordinates of the allopathic system. This in itself gives reason for the stagnation of growth in homeopathic or traditional medical practice. To view the percentages, according to the Federal ministry of health:

1. Almost 40% of women in Nigeria give birth with just a relative or no attendant present at all. 39% of deliveries are with a skilled birth attendant – doctors, nurse/ midwives or auxiliary midwives. Traditional birth attendants assist 22% of births.

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implementation of their health care. However, this is not only their right, but also their solemn duty.

[300]Federal Ministry of Health. Department of Health Planning and Research, National Health Management Information System (NHMIS) Unit. Revised Policy-Program and Strategic Plan of Action. NHMIS Policy Document. Ibid.

The proportion of home births is 90% in the North West and 87% in the North East zones of the country.[301]

2. The level of assistance that a woman receives during childbirth is a strong determinant of the overall outcome for her and her newborn. The presence of a skilled attendant during birth is therefore imperative. The term 'skilled attendant' refers to caregivers with midwifery skills, including doctors, nurses and midwives (this definition excludes traditional birth attendants – TBAs)[302].

3. There is a lack of national data on the number of missionary and faith-based organizations, for-profit private health facilities, not for- profit private facilities and NGOs involved in health service delivery. There are also numerous unknown and unsupervised traditional maternity homes.[303]

4. Nigeria Demographic and Health Survey (NDHS) 2003, MICS 2007 and NDHS 2008 did not specify which deliveries occur in faith-based maternity homes/churches. Deliveries at churches and other faith-based establishments (clearly distinguished from mission hospitals or clinics) that are not registered for medical purposes may not be able to provide skilled attendance for births, or be subject to regulation and standards of services. The FMOH Safe Motherhood Survey states that up to 9% of mothers from Akwa-Ibom State and 7% from Ebonyi State deliver in faith-based maternity homes.

5. Furthermore according to 2003 Nigeria's National Demographic and Health Survey (NDHS) only 36% of deliveries took place with a skilled attendant – doctor, nurse/midwife or auxiliary midwife; and the 2007 Multiple Indicator Cluster Survey (MICS) showed a promising increase to 44%.[304]. NDHS 2008 reported that 39% of births were assisted by a skilled health worker; 9% by a doctor; 25% by a

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[301]Federal Ministry of Health, 2011. Saving newborn lives in Nigeria: Newborn health in the context of the integrated maternal, newborn and child health strategy. op.cit.

[302] Ibid. See further Thomson A. 20005. The joint WHO/ICM/FIGO statement on skilled attendants at birth. *Midwifery Journal* March.21.1:1

[303] Ibid .57

[304]Federal Ministry of Health. 2011. Saving newborn lives in Nigeria: Newborn health in the context of the integrated maternal, newborn and child health strategy. op.cit. See further National Population Commission, ORC Marco. Nigeria Demographic and Health Survey 2003.

nurse or midwife; and 5% by auxiliary nurse/midwife TBAs dealt with 22% of deliveries and relatives attended to 19% of all births.[305] In 2013 however, NDHS recorded that only 36% of deliveries were attended by skilled birth attendants with overall deliveries of 38% in health facilities.

6. There is an on-going debate including a concept note for discussion by the Federal Ministry of Health (FMOH) on exploring the possibility of including traditional birth attendants (TBA) within the care system. If this were the scenario when the 2008 NDHS took place 60 percent of deliveries would have been considered assisted. The concept of integration of TBAs into the care system presents an interesting opportunity to scale up access to antenatal and delivery care.[306]

All these statistics show a need for the integration of traditional medical practice into a proper health care system that is up to date and well regulated. The reason for this is that the percentages given for the use is still very high and only less than 3% from that of the skilled nurses and midwives.

Also when defining skilled birth attendants, traditional birth attendants seem to be left out when they should be included. Inclusion will not only legitimize but also puts a duty of care upon TBAs which goes a long way into making sure that utmost care is taken and given while attending to their patients.

The limits of the traditional medical practice in Nigeria is unfortunately very tight, it seems that homeopathic medicine is given as little a room as possible to grow and then cast in the light of quackery and illegitimacy. Regulatory agencies have also noted their frustration in regulating traditional medicine due to 'lack of documentation, inadequate coordination of the practitioners' activities, poor communication between the practitioners and their patients, secrecy of methods and procedures, actual contents and/or difficulty in determining actual ingredients.[307]

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[305]Ibid

[306]UNICEF Nigeria. 2012. Situation analysis of children and women in Nigeria: 2011 update. Nigeria: UNICEF.

[307] Anon. 2012. *The Nation*. Aug.7.28

The greatest challenge facing traditional medical practice in Nigeria is perhaps the government's attitude towards it which is with disdain and disrespect. This is not surprising as it is definitely a carry-over from the colonialists who due to the integration system they used needed to uproot this traditional practice for their own health system to thrive and therefore portrayed indigenous healthcare practice as nothing but 'witchcraft' and 'fetish'[308]. The successor native government have not proved better; but rather they have continued the same western propaganda to smear the historical and indigenous health care system. (And as was mentioned earlier to wipe out our traditional health care system would be to wipe a huge chunk of our culture into extinction.) This is even made evident in the fact that Nigeria has not accorded traditional medicine its primate position in its health care delivery system.

The National Demographic and Health Survey report[309] indicate that only 32.6% of births take place in health facility. This means that the remaining 68.4% of births were handled by traditional birth attendants or proliferating church-established maternity centres. All these indicate that the people especially at the grass root level still hold a strong belief in their cultural system and spiritual heritage[310]. In spite of the sophistication of orthodox medicine, traditional medicine still has its potential significance and advantages, which cannot be over-ruled.

Erinosho[311] noted that some of the other arguments that act as limitations against traditional medical practice include:

1. That traditional medical practitioners lack the skills required for correct diagnosis of serious disorders;

2. That they are always unwilling to accept the limitations of their knowledge, skills and medicines particularly in complicated organ disorders;

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[308]Adefolaju T. 2014. Traditional and Orthodox medical systems in Nigeria: The imperative of a synthesis. op.cit.
[309]National Population Commission, ORC Marco. Nigeria Demographic and Health Survey 2003.op.cit.
[310]Borokini, T. and Lawal I. 2014. Traditional medicine practices among the Yoruba People of Nigeria: a historical perspective. op.cit.
[311]Erinosho, O. 1998. Health Sociology. Ibadan: Sam Bookman Educational Communication.

3. That traditional medicine lacks standard dosage and have not been subjected to scientific verifications;

4. That even though the educated are convinced that the healers have supernatural knowledge and that this knowledge is medically useful, they have found them to be unscrupulous and dubious;

5. That the healers lack the equipment required to conduct physical examinations.

Today, traditional medicine in Nigeria is practiced without an enabling legislation, as the National Assembly is yet to pass the Traditional Medicine Council Bill (TMCB) presented to it since 2007. The bill is expected to ensure the integration of traditional medicine into the mainstream health care delivery by setting up a council parallel to the Medical and Dental Council of Nigeria (MDCN) and the Pharmacy Council of Nigeria (PCN)

The Nigerian government has however come up with a document tagged "Traditional Medicine Policy for Nigeria"[312]. The main objectives of the policy paper are:

1. To develop and facilitate the use of traditional medicine in Nigeria in the official health care system;

2. To harness the potential and economic benefits of traditional medicine practice to accomplish the provisions of the National Economic Empowerment and Development Strategy (NEEDS); and

3. To establish a country-specific institutional medicine.

This policy declaration by the Nigerian government is a follow-up to the launch of the 2000-2010 Decade for African Traditional Medicine (ATM) by the Summit of the African Union (AU), in July, 2000, in Lusaka, Zambia. This is in the realization of the fact that in some communities, traditional medicine is all the health care services available, affordable and accessible to majority of the people on the African continent to whom traditional medicine is certainly, not an alternative. The main objective of the Plan of Action of ATM

[312]FGN/WHO. 2007.Traditional Medicine Policy for Nigeria 2007. Abuja: Federal Ministry of Health.

is the recognition, acceptance, development and integration of Traditional Medicine by all Member States into the public care system on the continent by 2010. Unfortunately, Nigeria seems to be the only country that has not passed a bill to that effect out of all of the countries that signed to the effect in 2000.

The safeguard guaranteed by the 1999 Constitution is not enough. There should be justiciable laws, rules and regulations specifically applicable to traditional medical practitioners and their practice. Traditional medical practice is a parallel but different modus of general Medicare; and as such should accordingly have rules and regulations different from those applicable to the orthodox Medical and Dental Association or Council.

As regarding the National Health Act 2014, although the Act recognizes the traditional health care providers and alternative health care providers as part of the National Health System,[313] the mere fact that traditional medical practitioners and alternative health care providers are recognized is however not enough to regulate their practice because there is presently no recognized statutory body to regulate and monitor the activities of traditional and alternative health care practitioners.[314]

Secondly, from the provisions of the Act, Government seems to have deliberately relegated the relevance of traditional medicine and alternative health care. For instance, there is lack of representation of traditional and alternative health care practitioners in the National Health Ethics Committee which is responsible amongst other functions for adjudicating complaints about the functioning of health research ethic committees and hear any complaint by a researcher who believes that he has been discriminated against by any of the health research ethics committees, recommend to the appropriate regulatory body such disciplinary action as may be prescribed or permissible by law against any person found to be in violation of any norms and standards, or guidelines set for the conduct of research under the Act.[315] The only provision where reference is made to traditional medicine practitioners and alternative health care providers is in the Technical Committee as established under S.6 of the Act, wherein it is stated that the Committee members shall

[313] S. 1(1) (h) and (i) National Health Act 2014

See also Okojie, E .2015.Impact of regulatory mechanisms on trado- medical Practice in Nigeria. Op.cit

[315] See generally S. 33(1) – (7) for functions of the Committee, National Health Act 2014.

consist of "one representative each of the registered health professional associations including traditional medicine practitioners and alternative health care providers" [316]

This just goes further to prove what was said earlier about the fact that though there is posturing to the acceptance of traditional medical practice, there is no real integration of it within the national health legislation unlike what obtains in other places for example Malaysia. Traditional medicine and the provision of traditional maternal health care has, for many centuries, been part of Nigeria's health culture and if the desirable aspects of the culture are incorporated into the existing health care system, all stakeholders stand to benefit. Mere recognition of an integral part Nigeria's health culture will not suffice in the protection of the right to life of women and the right to safe motherhood.

Apart from laws there is the role that the Federal Ministry of Health plays in the regulation of Traditional medical practice. Traditional medical practice plays appreciable role in health care delivery in the country. Despite the rapid expansion of conventional medicine in the last three decades and the rapid increase in its human resources, a majority of Nigerians still utilize Traditional Medicine. The realization of this has caused the government to fund experts to travel to India to study Alternative Medical Practice.

The Federal Ministry of Health has established a college for the same reason and purpose called the Federal College of Complementary and Alternative Medicine with its headquarters in F.C.T. Abuja. The curriculum includes Certificate or Diploma in Alternative Medicine, Bachelor of Science in Alternative Medicine and a Master of Science in Alternative Medicine in the area of Acupuncture, Naturopathy and Homeopathy.

Complementary and Alternative Medical Council of Nigeria

Despite the elaborate functions and scope of this council, there is no enabling law except its bill, therefore rendering the proposed regulation of alternative medicine impossible. This however is the same old story, since it has not been passed into law yet, it lacks enforceability and cannot be used to enforce the law and regulate traditional health

[316] S. 6 (2) (j) National Health act 2014, See also Okojie, E. A.2015.Impact of regulatory mechanisms on trado-medical Practice in Nigeria. Op.cit

practice. Another major limitation to the regulation of traditional or homeopathic medical practice in Nigeria is the disagreement between practitioners of alternative medical practice and traditional medical practitioners. The two practitioners, particularly practitioners of alternative medicine seem to distinguish themselves from traditional medical practitioners who they see as illiterates, charlatans, quacks and fetish.[317] There has been a continual denial of traditional medical practitioners by alternative medicine.

Finally, there is also the discrimination against traditional medical practitioners by orthodox medical practitioners. The unwillingness of orthodox medical practitioners to accommodate alternative or traditional medical practitioners is not only obvious in practice but also in the comments[318] of some orthodox health care practitioners.

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[317]Ehinmore, O. and Ogunode, S. 2013. Fish in indigenous healing practices among the Ilaje of coastal Yoruba land of Nigeria: a historical perspective. *European Scientific Journal* May 9.14 ISSN: 1857 –7881 (Print) e –
ISSN1857-7431 Retrieved Oct. 14, 2016, from http://eujournal.org/index.php/esj/article/viewFile/

[318]Owumi, B. and Taiwo, P. 2012. Traditional healing practices and health reforms in Nigeria in Peoples and Cultures of Nigeria.op.cit.

4.3. SUMMARY AND CONCLUSION

In Nigeria, traditional health care practices including faith health care are well established and popular and highly patronized despite the obvious risks to life.[319] Even though not entirely sincere some government policies on traditional health care exist but these are not comprehensive enough to give traditional health care providers and other alternative health care providers the important place. In spite of government affirmation of the importance and role of traditional health care, little has been done in recent decades to enhance and develop the beneficial aspects of traditional health care.

There are many gaps between the policies and actual practices. There are clearly deficits in the organized approach towards ensuring an optimal contribution of traditional health care to the national health system. For example, there is currently no regulation as to safety and efficacy, licensing, as well as registration and guidelines for practitioners. Moreover, there is no training institute on traditional health care.

The Nigerian government seemingly acknowledges the importance of traditional health care and other alternative forms of health care as part of the health care system, but there is need to show this support more assuredly by putting in place decisive regulatory frameworks for regulation. For example, signing the current proposed bill into law will be a giant stride in the right direction, more so, has the World Health Organization has strongly encouraged the formulation of regulatory structures, policies and legislation to standardize traditional healthcare practice within member states.[320] Admittedly, recognition of traditional healthcare is long overdue. But, when it does come, it must be institutionalized and standardized. There must be regulatory and other legal mechanisms to oust quacks and charlatans from this kind of health care. With the lack of sincere commitment, Government risk ignoring the important cultural and social roles TBAs and FBAs fulfil in their local communities and the nation's maternal health care. Giving the

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[319] Ibid.

[320] In May 1977 the World Health Assembly urged "interested governments to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations as suited to their national health systems". WHO Meeting on the Promotion and Development of Traditional Medicine, held in Geneva in 1977, proposed a policy of integration of traditional medicine into primary health care. See also Stepan, J. 1985.Traditional and alternative systems of medicine: a comparative review of legislation. *International Digest of Health Legislation.* op.cit.285

present state of development and economy, the provision of skilled attendants for all birthing may not be feasible and thus safe maternal health care cannot occur in isolation from standardized and well regulated TBAs and FBAs.

Following the Safe motherhood Conference held in 1987, Nairobi, Kenya, many initiatives have been undertaken both internationally and by national governments to stem the scourge of maternal deaths. Along these lines, nothing the importance of Traditional Birth Attendants and other local unskilled midwives, the World Health Organization has strongly encouraged the formulation of regulatory structures, policies and legislation to standardize traditional medical practice as an alternative healthcare choice within member states.[321]

There is therefore a need for a legislative re-orientation towards acceptability, availability and standardization other than criminalization. Acceptability requires that maternity services are ethically and culturally appropriate, respecting the culture of individuals.[322] The current use of criminal law against patronage of TBAs and FBAs will not deter expectant women from seeking maternity services from these care providers but will likely lead to clandestine provision of unsafe maternity services by quacks which will further embroil the already high incidence of maternal mortality in Nigeria.

The fact is whether government like it or not, rural women who make up more than 50% of the female population would continually seek the services of these women. Moreover, it is posited that regulation with regards to quality, standardization coupled with educational programmes for TBAs and better integration into the health care system are essential for lowering maternal mortality and morbidity rates in areas where most mothers are not open to nor have access to professional care in childbirth.[323]

TBAs are the custodians of socio-cultural practices some of which might be harmful.[324] The power of training TBAs on changing harmful cultural practices are underscored by

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[321] WHO,2005, National policy on traditional medicine and regulation of herbal medicines: Report of a WHO global survey Retrieved Jan 10 2016 from http://apps.who.int/medicinedocs/pdf/s7916e/s7916e.pdf

[322] Cook, R. J.et al op cit.189

[323] Itina, S.M. (1997) Characteristics of traditional birth attendants and their beliefs and practices in the Offot Clan, Nigeria. Bulletin of the World Health Organization 75, 563–567.

[324] Kayombo, E.J. (1992) Distribution of TBAs and Herbalists in Dodoma and Singida. A Consultant Report Submitted to the National Family Planning of Ministry of Health and African Medical Research Foundation.

another study done in Nigeria[325], where a TBA who was involved in carrying out traditional female genital mutilations was turned into an advocate for eradication of the practice. The argument presented above on the impact of training TBAs on reducing maternal and newborn mortality from literature review suggests improvement on training TBAs in order to bring meaningful impact. The studies that showed negative impact on training TBAs on reducing maternal and new-born mortality can be explained partly by poor approach on training and unwillingness of health workers to train TBAs.[326]

[325] This Day Nigeria (2007) TBAs Advocate Ending Harmful Practices, All Africa Com: http://allafrica.com/stories/200710240460.html

[326] Grieco, M. & Turner, J. (2005) Maternal Mortality: Africa's Burden; Tool kit on gender, Transport and maternal mortality. www.worldbank.org/afr/ssatp/Resources/HTML/Gender.

CHAPTER FIVE

COMPARATIVE STUDY OF MODELS OF REGULATION OF TRADITIONAL AND FAITH BASED MATERNAL HEALTHCARE IN SELECTED JURISDICTIONS

5.0. INTRODUCTION

Following the global recognition of traditional and alternative forms of health care, the W.H.O. has enjoined all governments to 'take all measures including legislation' to ensure the standardization of traditional and alternative health care practice. Many countries of the African and Asian region have validated and ensured quality and standardization in the practice of traditional healthcare in their jurisdiction through legislation and other policy formulations. Asian countries like India and China have been at the forefront of elevating traditional health care practice. Within the African region, countries such as Tanzania, South Africa, Kenya, and Ghana, have developed their health systems to include traditional health care.

The formulation of policies, laws and any form of regulation for traditional health care practice in Nigeria will require a study of models from other jurisdictions particularly from common law or nearly common law jurisdictions.

5.1. REGULATION OF TRADITIONAL MATERNAL HEALTH CARE IN TANZANIA

Tanzania has made impressive progress in the reduction of child mortality; however, maternal mortality changed insufficiently between 2000 and 2010. The most recent estimate (2017) of Tanzania's maternal mortality ratio is 57 per 100,000 live births[327]. In 2010,[328] it was estimated that 43% of all women made four or more antenatal care ANC visits. There seems to be a severe decline compared to 2005, when 62% of all women did

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[327]USAID from American People.(2017), Maternal and Child Health Tanzania retrieved ;21 August 22, 2019from
https:www.usaid.gov/Maternal_and_child_Health_Fact_Sheet.
[328] National Bureau of Statistics (NBS) and ICF Macro: Tanzania Demographic and Health Survey 2010. 2011, Dar es Salaam: Calverton, Maryland: ICF Macro

so. The health facility delivery rates are still rather low in Tanzania. In 2010, 48% of all pregnant women gave birth at home, and 50% delivered in a health facility

Traditional birth attendants (TBAs) attend to more than 60% of the births in Tanzania[329]. TBAs have remained a life-line for especially many rural women in maternal health care provision. Moreover, TBAs have also gradually found their way into the urban areas. The shift in international policy and health funding toward skilled birth attendants (i.e., an accredited health professional) has materialized into impressive policy making in the light of a concerted effort by government to increase numbers of both midwifery training institutions and midwives themselves.[330] Although there are many assumptions about the TBAs' work, there has been little formal investigation into the practice itself.

In Tanzania, the term TBA *stricto sensu* only refers to traditional, independent (of the health system), informally trained and community-based providers of care during pregnancy, childbirth and the postnatal period[331] For many women living in the global south, antenatal care and institutional deliveries attended by skilled health workers remain a distant reality. Therein women's "choices" and or "preference" for home births are heavily influenced by both micro- and macro factors including cultural norms, religious beliefs, cost, and accessibility of the services[332].

Naume noted that TBAs speak the local language, have the trust of community members, and can provide psychosocial support at birth; thus, they are an integral part of birth related services[333]. Many countries often have a shortage of trained medical professionals and maternal health care is consequently provided by TBAs. According to the name, TBAs have traditionally been assisting women during childbirth, providing local women with

[329] Sparks BT. *A descriptive study of the changing roles and practices of traditional birth attendants in Zimbabwe.* https://www.ncbi.nlm.nih.gov/pubmed/2366097 retrieved on 22/June 2018

[330] Naume Z.C, 2015 "Traditional and Skilled Birth Attendants in Zimbabwe: A Situational Analysis and Some Policy Considerations," *Journal of Anthropology, vol. 2015, Article ID 21590,* https://doi.org/10.1155/2015/215909.

[331] World Health Organization: Making pregnancy safer: The critical role of the skilled attendant. 2004, Geneva: World Health Organization.

[332] Ibid.

[333] Also see B. T. Sparks, "A descriptive study of the changing roles and practices of traditional birth attendants in Zimbabwe," *Journal of Nurse-Midwifery*, vol. 35, no. 3, pp. 150–161, 1990. See further Bij de Vaate A. et al, "Knowledge, attitudes and practices of trained traditional birth attendants in the Gambia in the prevention, recognition and management of postpartum haemorrhage,", vol. 18, no. 1, pp. 3–11, 2002.

delivery and pregnancy monitoring services, and giving them and their babies care after childbirth. The official government position and policy regarding TBAs in the country have been wavering in the past decade.[334]

A recent study conducted however showed that two-thirds of women who gave birth in a health facility reported being very satisfied with the experience, compared with 21.2% of women who delivered at home with TBAs. A sizeable proportion of women felt that TBAs had poor medical skills (23.1%), while only 0.3% of women felt the same about doctors' and nurses' skills. Of women who delivered with a TBA, 16.0% reported that TBAs had poor medical skills whereas 0.5% stated the same for doctors and nurses.[335]

Langwick[336] gives a detailed explanation of the historical context of the creation of TBAs (Kiswahili: *wakunga wa jadi*) among the Makonde of Tanzania. Before the 1970s, the concept did not exist. While there had always been women who had assisted pregnant women during childbirth, the term *mkunga wa jadi* only started to be used after the first women received official training. From the studies, it seems like there was no model for traditional birth attendants as is seen in other cultural and ethnic groups in Sub Saharan Africa. The TBAs as is seen in Tanzania by the medical practitioners are not skilled herbalists or practitioners of traditional herbal medicine but are normal women who have had experiences with childbirth and do not charge exorbitant fees much unlike the doctors. Edmund J. citing relevant sources is however of a different opinion stating in his article, that traditionally, the role of TBAs on reproductive health starts immediately after a woman becomes pregnant. These TBAs are consulted for any health problems occurring among pregnant women until during the first to second week after delivery.[337] TBAs have rich knowledge of herbal plants which are used for managing pregnancy and child

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[334]Ministry of Health and Child Welfare, Traditional Midwives Training Guidelines, Government of Zimbabwe, Harare, Zimbabwe, 1997. Retrieved May, 8 2018 fromhttps://www.hindawi.com/journals/janthro/2015/215909/ B45.

[335] Godfrey M. et al. *Dissatisfaction with traditional birth attendants in rural Tanzania*. International Journal of Gynecology & Obstetrics Volume 107, Issue 1, October 2009, Pages 8-11

[336]Langwick S.A. *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania*. Volume 39, Issue 2 May 2012 Pages 467-468 Retrieved May, 8 2018 from https://doi.org/10.1111/j.1548-1425.2012.01374_23.x.

[337] Swantz, L. 1966. Religious and magical rites of Bantu women in Tanzania. M. Phil. Thesis University of Dar-es-Salaam, Tanzania.

delivery[338]. Further, TBAs educate pregnant women on appropriate diet to take, pregnancy-related taboos and on how to take care of infants after birth. Most TBAs are known to have some knowledge of risk signs during pregnancy[339].

The Tanzanian Government promotes TBAs in order to provide maternal and neonatal health counselling and initiating timely referral, however, their role officially does not include delivery attendance. Yet, experience illustrates that most TBAs still often handle complicated deliveries. Maternal health has become an increasingly homogenized biomedical problem, with delivery with the help of a skilled health care provider being the advocated solution for safe delivery. The use of TBAs is no longer considered safe and therefore women are encouraged to go to health facilities.

In a study conducted in Dares Salaam, it is clear that the TBAs reportedly did not use any traditional tools or medicine during delivery. In general, their knowledge related to hygiene standards and risk signs, and the importance of referral was surprisingly high.[340]The Institute of Traditional Medicine (ITM, 2005) in Tanzania, on the other hand, has reported a total number of 80,000 traditional health practitioners including TBA in 2005.[341] Since more than 60% of child delivery in African countries south of the Sahara occur at home; it is thus very likely that there are many TBAs and there is a need to identify and train them in order to fill the gap of skilled birth attendants. This in turn will help African countries south of the Sahara to be closer to meet the 4th and 5th Millennium Development Goals.

Creation of dialogue, trustworthiness, patience, tolerance, willingness to collaborate, transparent and familiarity during training are keys when working with TBAs as partners in

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[338] Kayombo, E. 1997 Traditional birth attendants (TBAs) and maternal health care in Tanzania. In Issues and Perspectives on Health Care in Contemporary Sub - Saharan Africa by Studies in Africa Health and Medicine Volume 8. Ezekiel Kalipen and Philip Thiuri (eds.) The Edwin Mellen Oress Lewston, Queenston: Lampeter, 288-305.

[339] Cosminsky, S. 1983 Traditional midwifery and contraception. In : R. H. Bannerman, John Burton and Che'n Wen -Chieh (eds.) Traditional Medicine and Health Care coverage. World Health Organization, Geneva.

[340] Constanze P, Rosemarie M. 2003. Delivering at home or in a health facility? Health-seeking behavior of women and the role of traditional birth attendants in Tanzania. *BMC Pregnancy and Childbirth*, Vol. 13, No.1, 1

[341] Edmund J. Impact of Training traditional birth attendants on maternal mortality and morbidity in Sub-Saharan African countries .*Tanzania Journal of Health Research* Retrieved May 8, 2018 from http://dx.doi.org/10.4314/thrb.v15i2.7. Vol. 15, No.2

health care and share experiences.[342] TBAs are product of cultural system in community, and one of their roles is to protect culture from being invaded by other cultures.[343] The dilemma it seems remains the same. Due to the fact that knowledge is being lost and the true practitioners are gradually dying out what is seen in Tanzania is a watered down version of the TBAs than they were 15-20 years ago. In order for this institution to survive - and it must because only its survival can adequately weed the quacks from the true practitioners- there is a need for proper investigation as to the practitioners, sensitization in relation to hygiene and clean practices and finally regulation and policy.

Currently, Tanzania has an Act for the regulation of traditional health practitioners. The Act which was enacted in 2002 is The Traditional and Alternative Medicines Act, 2002. This Act delineates the following and ascribes meanings to clarify traditional health practice areas.

"Traditional health practitioner" means a person who is recognized by the community in which he lives as competent to provide health care by using plants, animal, mineral substances and other methods based on social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social wellbeing and the cause of disease and disability;

"Traditional medicine" means a total combination of knowledge and practice, whether applicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disease and which may rely exclusively on past experience and observation handled down from one generation to another orally or in writing;

"Traditional medicine remedy" means and includes any methods, processes, practices or any medicine consisting of a substance or a mixture of substances produced by drying, extracting, crushing or commuting, compressing natural substance of a plant, animal or mineral origin or any part of such substances;

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[342] Ibid.

[343] Cosminsky, S. 1983 Traditional midwifery and contraception. In : R. H. Bannerman, John Burton and Che'n Wen-Chieh (eds.) Traditional Medicine and Health Care coverage. World Health Organization, Geneva.

One thing is very absent or perhaps it is encompassed in the general definition of traditional medicine, a mistake that remains to be fatal. The word Traditional Birth Attendant is so conspicuously missing that it raises concerns. There is absolutely no provision for the aspect of traditional medicine that causes such high mortality especially in mothers and infants.

It is clear that the law is in need of an upgrade. For new terms to be defined and new circumstances be provided for. Perhaps the most striking of the law is Section 35 which provides inter alia

35.- (1) It shall be the duty of every traditional or alternative health practitioner registered under this Act to attend and treat their patients with clear knowledge, skills and light attitude.

(2) Every registered traditional or alternative health practitioner shall ensure that:

a) He is compatible with the traditional and alternative health profession;

b) His conduct does not amount to professional misconduct; No 23 Traditional and Alternative Medicine 2002

c) His conduct is commensurate to traditional and alternative health ethics and professional etiquettes;

d) He adheres to the secrecy and confidentiality aspects of his patients;

e) He transfers difficult cases to hospitals or other practitioners;

f) He has a good system of keeping records to all cases attended by him;

g) He observes cleanness of himself, appliances used and premises under which the service is rendered.

It is clear that either the minds of the draftsmen of this law did not avert to the fact that traditional birth attendants should be included or they just did not deem it particularly important. Apart from this provision and the other that provides penalties in the name of

suspension from practice this is all that can be boasted of in the extant law. The bulk of it is left for creating offices, Registration, procedures for such and dues to be paid. No proper groundwork or regulation is actually done and the law reads more like a set of guidelines rather than a law meant for enforcement. The Medical Practitioners and Dentists Ordinance[344], which was constituted before Tanzania's independence and is still in operation, hold exemplary status for traditional practitioners. Chapter 92.20,[345] states the following:

> Nothing contained in this ordinance shall be construed to prohibit or prevent the practice of systems of therapeutics according to native methods by persons recognized by the community to which they belong to be duly trained in such practice. Provided that nothing in this section shall be construed to authorize any person to practice native systems of therapeutics except amongst the community to which he belongs, or the performance of an act on the part of any persons practicing any such system which is dangerous to life.

5.2. REGULATION OF TRADITIONAL MATERNAL HEALTH CARE IN SOUTH AFRICA

Traditional healthcare practitioners play a significant role in South Africa's health care delivery, particularly in the potential positive impact of traditional health care therapeutics on HIV/ AIDS.[346] Traditional health care practitioners were the doctors of the day before the advent of orthodox medicine in Africa and it seems South Africa has been able to understand this and respect same as an integral part of their culture that cannot be easily eroded and shunned unlike other African countries. Hence, it seems that there is a more

[344]Tanzania laws. Chapter 409, Section 37 and Chapter 416, Section 53. Tanzania. See further http://apps.who.int/medicinedocs/en/d/Jh2943e/4.42.html

[345] Swantz L. *The medicine man among the Zamaro of Dar es Salaam.* Uppsala, The Scandinavian Institute of African Studies in cooperation with Dar es Salaam University Press, 1990.

[346] Roux- Kemp A. (2010) A Legal perspective on African traditional medicine in South Africa *The Comparative and International Law Journal of Southern Africa* Vol. 43, No. 3, pp. 273-291 Retrieved Oct.10 2018 https://www.jstor.org/stable/23253084 Retrieved Oct. 10 2018

holistic approach to traditional health practice and it is quite reminiscent of the approach taken by China and some other Asian countries in embracing the traditional way of living.

Currently there are over 200,000 traditional healers of different specialities across the country. About 60% to 80% of South Africans patronise traditional health care practitioners.[347] Traditional birth attendants (TBAs) are still frequently utilized in rural areas in South Africa, even when mothers have access to formal health care facilities.[348] A traditional birth attendant (TBA) is defined (based on the Traditional Health Practitioners Act) as a person who engages in traditional health practice and is registered under this Act.[349] The TBA in South Africa can be characterized as a middle-aged or elderly woman with no formal training, who acquired her skills through experience and attends to women during pregnancy.[350] TBAs are non-professionals who assist women during pregnancy and deliveries and in some cases advocate some form of family planning. The majorities of TBAs are females in most area. Some of the TBAs do not feel free to perform their duties because of the conflicts they encounter with orthodox medical personnel and fear of non-registration by the establishment[351]

A study was conducted in Abaqulusi, a sub-district of KwaZulu-Natal, Zululand Health District, in four rural communities. Prior to this, despite the concern from health professionals and nationals as well, about reduction of maternal mortality and morbidity through training of TBAs, there is no documented evidence about the practices of TBAs and their beneficiary activity in the community.

There has been very little research done in South Africa to describe the practices of TBAs and the advantages their practices may have in promoting safe motherhood. In most of these traditional rural societies, local women function as primary health care providers for

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[347] Sidely P.2004 South Africa to regulate healers *BMJ* Vol. 2; 329(7469): 758. Retrieved June 6, 2018 from 10.1136/bmj.329.7469.758-b
[348]Peltzer K, Henda N. 2006 Traditional birth attendants, HIV/AIDS and safe delivery in the Eastern Cape, South Africa - evaluation of a training program. *The South African Journal of Obstetrics and Gynaecology*
[349] Department of Health. Traditional Health Practitioners Act. Pretoria: Department of Health, 2004
[350] Nolte A. 1998 Traditional birth attendants in South Africa: professional midwives' beliefs and myths. *Curationis* 21: 59-66. Retrieved June 6, 2018 from https://www.ncbi.nlm.nih.gov/pubmed/11040590
[351]Dedeh. H. 2004 The practice of the traditional birth attendants during pregnancy, labor, and postpartum period in rural South Africa. LL.M Thesis , University of Kwazulu Natal Durban

their children, women, and their community. It is strongly believed that TBAs can greatly reduce morbidity and mortality associated with pregnancy, labour, and the postpartum period.

Most TBAs' training programmes have an antenatal care component, which all TBAs are expected to follow to identify pregnant women in their community, examine them, give them advice, and follow them up. Traditional Birth Attendants are trained to identify complications, provide immediate first aid, and know when and where to refer women for additional care. They are trained for appropriate referral of postpartum complications, such as haemorrhage, sepsis, peri-natal trauma, breastfeeding problems, and new-born complications.[352]

Furthermore, Dedeh, was of the opinion that the reason for the success was a willingness to work with professional health workers stating that traditionally in initiating safe motherhood in the community, the professional health care workers, most especially the midwife, is responsible for the task of training and providing support to Traditional Birth Attendants to enable them to carry out safe deliveries in the community where she lives. The TBAs assess the mother's overall health status and thus can identify factors which may adversely affect the pregnancy outcome.

Regulation of traditional healthcare practitioners in South Africa began in 2004[353], before then, traditional health care practitioners have operated freely without government interference. This was followed by another review of the regulation in the enactment of the Traditional Health Practitioners Act of 2007. Traditional health Care Practitioners in Africa belong to an umbrella associations such as Traditional Healers Organisation which has more than 29,000 members and National Unitary Professional Association for Traditional Health Practitioners of South Africa.

In 2014, the Traditional Health Practitioners Act 2014 was passed to standardise and regulate traditional healthcare practice. In 2015, more regulations were enacted give effect to the 2014 Act. A regulatory council is established under the Act to provide a regulatory

[352] Ibid.
[353] Traditional Health Practitioners Act 2004

framework. The Act also provides for the registration, categorisation into specialties and certification of traditional healthcare practitioners. Areas of specialization specified by the Act include: diviners (those who have a calling from ancestral spirits); herbalists (those practising herbalism); student trainees (those training to be a traditional healer); traditional birth attendants (TBAs); traditional tutors (a traditional healer trainer); and traditional surgeons (those who perform cultural operations such as circumcision). Some other criteria for registration and certification to practice as a traditional health care practitioner in South Africa include: being a South African citizen; provision of character references; and other proof of qualifications. Traditional healers have criticised the Traditional Health Practitioners Act 2014 asking for the government of South Africa to abolish the Act because it tramples on their right to practice. They are demanding instead that they as traditional health practitioners should be self-regulated.[354]

Perhaps the most impressive law of the different enactments of South Africa is the Traditional Health Practitioners Act No. 22 of 2007 as there is a definite defining of terms in such a manner that positions are clearly stated and delineated. It is perhaps the most advanced example in Africa and that is why the Act is preferred to the 2014 Act as a comparative model in this research. The Traditional Health Practitioners Act No. 22 of 2007 comes across as not just another law but one that was mindful of the different roles and niches that traditional health practitioners have carved for themselves over the ages.

The definition section defines the following terms amongst others

"**Traditional birth attendant**" means a person who engages in traditional health practice and is registered as a traditional birth attendant under this Act;[355]

"**Traditional health practice**" means the performance of a function, activity, process or service based on a traditional philosophy that includes the utilization of traditional medicine or traditional practice and which has as its object—

(a) The maintenance or restoration of physical or mental health or function; or

[354] Retrieved Oct. 10, 2018 from https://www.timeslive.co.za/news/south-africa/2018-09-21-let-us-regulate-ourselves-say-traditional-healers/
[355] Definition Section. Traditional Health Practitioners Act No. 22 2007.

(b) The diagnosis, treatment or prevention of a physical or mental illness; or

(c) The rehabilitation of a person to enable that person to resume normal functioning within the family or community; or

(d) the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death, but excludes the professional activities of a person practicing any of the professions contemplated in the Pharmacy Act, 1974 (Act No. 53 of 1974), the Health Professions Act, 1974 (Act No. 56 of 1974), the Nursing Act, 1974 (Act No. 50 of 1974), the Allied Health Professions Act, 1982 (Act No. 63 of 1982), or the Dental Technicians Act, 1979 (Act No. 19 of 1979), and any other activity not based on traditional philosophy;

"**Traditional health practitioner**" means a person registered under this Act in **one or more of the categories of traditional health practitioners**;

"**Traditional medicine**" means an object or substance used in traditional health practice for—

(a) The diagnosis, treatment or prevention of a physical or mental illness; or

(b) Any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug;

"traditional philosophy" means indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice;

"Traditional surgeon" means a person registered as a traditional surgeon under this Act;

-Traditional health practitioner" means a person registered under this Act in **one or more of the categories of traditional health practitioners**

It is clear to see by this definition that there are recognized categories of the law and each is alienated to stand on its own one of which TBAs stand on its own.

Section 49[356] prescribes offences and punishment ranging from suspensions to imprisonment same covers examination, diagnosis, prescription, impersonation are well covered and then some in this section.

The tone of the law is clear here and such is the fact that its citizens no matter the kind of health care chosen are adequately protected. It also provides in section 36 for continued education where the juniors have a sort of way either by apprenticeship or any other means to continue to learn from senior practitioners.

Referrals are also provided for, where the THP can refer patients to a hospital in cases of complications. This is very indicative as it shows most extraordinarily that a sort of fusion was sought to be created thereby making for a well-oiled machine in the Health Sectors in South Africa.

Though South Africa should be lauded for an exemplary show of integration and regulation of Traditional health practice it seems there is one place in which they seem to have fallen short. Documentation and its importance cannot be overemphasized. In fact, there is a dearth of literature concerning traditional birth attendants and in order to preserve knowledge that is being passed through the ages, proper documentation of practices should be done; sensitization of institutions with an aim geared towards extensive and incursive research into this basically unexplored labyrinth is needed.

This would bring about better regulations and policies because as we know the law should change with society, the law is dynamic and should be able to make provisions in terms of new discoveries and innovations in the health sector.

[356] Op cit.

5.3 REGULATION OF TRADITIONAL AND FAITH HEALING MATERNAL HEALTH CARE IN MALAYSIA

Malaysia a common law country like Nigeria is with a well-developed traditional health care system. Recent estimate on the maternal mortality rate of these jurisdictions is 40 deaths/100,000 live births in Malaysia. Traditional and complementary medicine in Malaysia is a combination of traditional Malay medicine, traditional Chinese medicine, traditional Indian medicine, homeopathy, Islamic medical practice and complementary therapies which is exclusive of medical or dental practices by orthodox medical and dental practitioners.[357] Traditional health care which includes maternal health care is regulated under the Malaysia Traditional and Complementary Medicine Act 2016. The purposes of the Act are:

- To ensure the high quality, effectiveness and safety of the traditional and complementary medicine practices.
- Determine eligibility requirements for each type of traditional and complementary medicine practices.
- Render compulsory registration of traditional and complementary medicine practitioners.
- Enforce the legislation.

Some significant provisions under this Act include: Professionalism of traditional and complementary medicine practices, provision on apprenticeship and training requirements, provision on the duty to refer patients to medical practitioners and dental practitioners where there is acute medical emergency or the condition of the patient is beyond the skill, competence or expertise of the traditional healer. The Act also makes provision for the prescription and recognition of practice areas of traditional health care practitioners from time to time, giving room for advancement and development.

The Act also permits the use of titles and abbreviations which must not cause the public to belief that a traditional and complementary health practitioner is an orthodox

[357] Raja R, 2015. An overview of traditional Malay medicine in the Malaysian healthcare system. *Journal of Applied Sciences,* 15: 723-727.

medical practitioner. This is very important when compared to Nigeria, where traditional health care practitioners affix to their names titles and abbreviations that are supposed to be exclusive to orthodox medical practitioners. Under the Act, there is provision for provisional registration and residency training of traditional health care personnel in recognized institutions.

5.4 SUMMARY AND CONCLUSION

The regulatory framework from three selected jurisdictions namely Malaysia, South Africa, and Tanzania were compared. The reason for selecting Tanzania and South Africa is because they are African countries having relatively similar culture to Nigeria. Although Malaysia is not a common law country it has a well-developed traditional health care system. Recent estimate on the maternal mortality rate of these jurisdictions is 40 deaths/100,000 live births in Malaysia, 138 deaths/100,000 live births in South Africa and 398 deaths/100,000 live births in Tanzania.[358] (CIA world fact book, 2018) While, it is not intended in this research to present these regulatory instruments as perfect in entirety, they are recommended as good models for the enactment of a holistic regulatory instrument for the regulation of traditional health care practices which includes the practice of TBAs and FBAs.

[358]CIA World fact book 2018

CHAPTER SIX

SUMMARY, RECOMMENDATIONS AND CONCLUSION

6.0 INTRODUCTION

Reproductive health of women and maternal mortality is one of the critical areas that have been a major global concern. There is no doubt that several studies have been carried out in other areas of reproductive health, however, very little have been done on legal regulation or enacting a specific regulation for traditional and faith based maternal practices in Nigeria. This study examines holistically the regulation of traditional and faith based maternal practices in Nigeria. In other to achieve the objective of the research, several related literature were reviewed in other to find out gap in knowledge. A qualitative approach was adopted for the study in order to bridge the gap in knowledge. Key informant interviews, in-depth interviews and focus group discussions with traditional birth attendants, faith birth attendants, pregnant women and mothers, community leaders and orthodox maternal medical practitioners such as doctors, nurses and midwives was adopted for data collection. The various data collected were content analysed. Other data gathered from legal frameworks of other jurisdictions were subjected to jurisprudential and comparative discourse.

6.1. SUMMARY OF FINDINGS

The right to health in all areas including maternal health is a fundamental part of human rights, particularly women's reproductive health rights. In Nigeria, there is an incessant rise in maternal deaths, and one noticeable cause of the high incidence of maternal mortality can be attributed to the frequent patronage of Traditional Birth Attendant (TBAs) and Faith Birth Attendants (FBAs) by expectant women during pregnancy. Although most of these attendants often serve communities that are remotely out of the claws of orthodox health care service, they are inexperienced and often engage in certain dangerous health care practices which make them prone to losing pregnant women. This problem therefore

prompts this research, calling for appropriate legislative and policy measures to protect the life of pregnant women and ultimately reduce maternal mortality in Nigeria.

In attaining the aim and specific objectives of this research as stated earlier, the researcher formulates and addresses the following questions:

i. What are the legal standards of practice for TBA's and FBA's in Nigeria?

ii. Is there a nexus between the high rate of maternal mortality and regulation or non-regulation of traditional, faith based and other maternal health care practices in Nigeria?

iii. Can a legal framework and other regulatory policies for traditional and faith based maternal homes and missions reduce maternal mortality, and ultimately improve maternal and women's reproductive health and rights in Nigeria?

OBJECTIVE ONE: Examine the factors responsible for the choice of maternal health service

Historically, women's main human resource for childbirth has been traditional birth attendants (TBAs). They are constant in various cultures, and play varying roles according to said cultures and times.[359] Traditional birth attendants are usually elderly women and sometimes men. They are known members of their community; they serve as an avenue of social support for women during childbirth. TBAs are respected in society for their skills; however, in such cultural settings as the Indian sub-continent, TBAs are considered low caste and have no reputable influence.[360]

Objective one examined and described the reasons for the patronage of TBAs and FBAs by respondents in the community. The findings revealed that several reasons are responsible for the patronage of TBAs and FBAs, such as poverty/socio-economic status, care and support obtained from TBAs and FBAs, free services or reduced charges.

[359]Bergstrom, S.,Goodburn, E. 2001. The role of traditional birth attendants in the reduction of maternal mortality op.cit.
[360] Ibid.

Poverty

Poverty according to Advanced English Dictionary is a state of having little and no money and few or no material possession. There has been a constant rise in the incidence of poverty in Nigeria. According to National Bureau of Statistic (2010) about 112 million Nigerians live in poverty. According to the Medical Practitioners interviewed, poverty is one factor that hinders pregnant women from patronizing the orthodox medical centres despite knowing that delivery is safer in the hands of medical practitioners. Medical practitioners reiterated that the services of TBAs and FBAs are relatively cheaper than the orthodox. Sometimes their services are free and this alone is a big relief for pregnant women who are not financially buoyant to seek maternity services from hospitals. A respondent said:

> *I believe that some of the pregnant women who patronize the TBAs and FBAs do so because they cannot afford the services of the teaching hospitals, private and public orthodox medical centres. When issues are like this, pregnant women opt for places they can afford and these places happen to be the houses or centres of the TBAs and FBAs not regarding the associated risk involved in patronizing them (MEDICAL PERSONNEL).*

Many women living in low-resource and rural settings and even urban areas continue to seek the care of a TBAs and FBAs, despite the knowledge that a health facility delivery is often safer.[361] As earlier stated, poverty is seen as the major contributing factor to why these women cannot seek out adequate medical services.[362] This is supported by a medial practitioner who stated thus:

> *The economic condition of many Nigerian is quite low that they cannot afford the services of an orthodox medical centre. A large number of pregnant women have resolve to using herbs*

[361]Pyone, T. et al 2014. Changing the role of traditional birth attendants in Somaliland.op.cit.
[362]Owoseni, J. S. et al. 2014. Pregnancy care and maternal mortality in Ilesa, Osun State Nigeria.op cit.

and consulting unskilled birth attendants as regards their maternal issue. Their service fees when compared to the orthodox centres are cheaper. In some places, pregnant women do not have to pay. However, their patronage is associated with bigger risks such as the death of the patient (MEDICAL PERSONNEL).

The findings revealed that the most recurring reason pregnant women patronize TBA or FBA is because of their economic status. The findings further revealed that low income earners are more prone to seek the service of a TBA and FBA than high income earners. TBAs and FBAs consider the act of helping women deliver of their babies as a community responsibility and often demand little or no money as a reward for their service. Some average and high income earners also revealed that they have been faced with situations (when they have little or no money) where they had no option but to seek maternal assistant from a TBA or a FBAs. The findings revealed that the economic status of pregnant women has an influence on the maternal health care provider patronized. One of the respondents said:

Let us face reality; everything now has to do with money. The services I use here, I pay for. What happens if I do not have the money to pay for their services here? Obviously, I will go to places I can use their services. I basically believe people visit the TBAs and FBAs because their services are cheap.

Respondents revealed that the orthodox medical practitioner's fees are too high. Aside this, there is variation in the charges based on the gender of the baby. They alleged that the charges imposed are higher with emergency or complicated delivery. According to them TBAs and FBAs are more concerned about the safety of the mother and the child rather than fees. TBAs and FBAs treat pregnant women like their child or relative. They suspend any discussion on payments until after service is rendered. In some setting, the TBAs and FBAs are gratified just by giving items in kinds. Items such as, soaps, anointing oil and disinfectants are collected from the client to refill their old stock. A respondent stated that:

> *The use of a particular type of maternal health providers is dependent on the economic status I believe. Low income earners like me will consider the TBAs and FBAs because their services are cheap while the high income learners may consider the orthodox medical centres. The money involved matters a lot in this case.*

Another opined that:

> *When my wife was pregnant and due to deliver, we went to the hospital where we were charged ₦80,000. I am a junior staff at University of Ibadan with a monthly income less than that figure. I left there and went to where I can afford - I went to the mission house, I can't lie.*

Care and Empathy from TBAs and FBAs

The word support according to Livingstone (2008:666) relates to comfort, encouragement, backing and assistance. A Traditional birth attendant or Faith birth attendant is a person known within a geographical location or society to be responsible for the provision of care to pregnant women during antenatal, labour, delivery, puerperium and post natal periods in a traditional and religious manner respectively. The study revealed that TBAs and FBAs are very supportive to the pregnant women in their community. They provide encouragement, assistance, care, comfort and build up the strength of the pregnant women, their spouse and family members through their frequent visits and impromptu responses in terms of emergency care.

TBAs are more approachable and readily available than the orthodox maternal practitioners. They further reported that the care and support mostly given by the TBAs and FBAs helps the pregnant women through the pregnancy stage. Unlike the orthodox medical centres where appointment and consultation is by booking and payment of consultation fees, TBAs and FBAs are readily available, offer free services and are always on the lookout for pregnant women in need of assistance or their services in the

community. They claim that TBAs and FBAs are available for consultation even at odd hours and is one of the reasons their services are preferred to that of orthodox medical practitioners. The study revealed that they are closer to the pregnant women and their attitude makes pregnant women want to open up to them.

A married couple said:

> *I personally have a TBA and I consciously make use of their service because a part of me trusts their judgement. They are caring, simple and available. They most time take the patient as their relative and do everything within their might to ensure the patients safety (MARRIED COUPLE).*

Another also said

> *Previously, my wife and I visit an orthodox centre and make use of doctors and nurses. Their attitude most time to work is lackadaisical and uncaring. We had to switch to a Faith birth attendant and we love the care we get and the hopeful words that come out of her mouth (MARRIED COUPLE).*

Care is a resounding reason pregnant women patronize TBAs and FBAs. Pregnant women revealed that TBAs and FBAs show more care and empathy towards them than orthodox medical practitioners. Pregnant women revealed that TBAs and FBAs show genuine care as evident in the way these FBAs and TBAs relate with them verbally and non-verbally. A pregnant woman stated thus:

> *Orthodox medical practitioners are most times harsh in their words and actions. They can go as far as beating the patient in other to gain their cooperation. I have experienced both and I must confess that has influenced me to use mission houses frequently. This rarely happen when dealing with FBAs. I personally love being pacified (smiles) (PREGNANT WOMAN).*

Another respondent also said:

> *Most nurses are wicked and exhibits uncaring attitudes, I have not experienced one before but I have seen it happen to others. Sometimes if you wish to open up to them, you might need to think again. I am certain thing like this (Hostile attitudes) must have an influence in people visiting TBAs and FBAs because I am aware FBAs are not hostile, they take you as their daughters (PREGNANT WOMAN).*

Spirituality

According to WHO, list of the social determinants of health include the social gradient; stress; early life development; social exclusion; work; unemployment; social support; addiction; food; and transport.[363]However, the WHO list of social determinants of health may not be exhaustive without religion, as this is contrary to several research findings that religion is a significant correlate of health care utilization.[364] Several researches have demonstrated that religion has profound effect on the health care beliefs and health care seeking behaviours of people.[365]

The findings reveals that pregnant women visit TBAs and FBAs because they strongly belief that TBAs and FBAs are spiritual, making their services more holistic.

Avoidance of orthodox methods (use of injections and surgical instrument).

The study revealed that one reason they seek medical help from TBAs and FBAs is because of their dread for orthodox maternal practices. Often times, orthodox practices involves the use of needles, syringe, pills which pregnant women consider as irritants. Unlike the orthodox, pregnant women believes that TBAs and FBAs maternal health practice are pleasing. This was evident in a respondent's statement:

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[363] WHO, 2013

[364] Solanke, B. et al. 2015. Religion as a Social Determinant of Maternal Health Care Service Utilisation in Nigeria. *African Population Studies Vol. 29, No. 2*, p. 1868 http://aps.journals.ac.za 5/17/18 ; Mekonnen & Mekonnen, 2002; Benjamins .M et al 2005, op cit ;Gyimah, et al, op cit 2006; Benjamins, et al, op cit 2007)

[365] Ibid

I have a friend who gave birth to her four children in a traditional birth house. Each time I ask her for a reason she loves to give birth there, she says she dislikes hospital odours to say the least. Taking pills and impaling her with needles is a big NO (PREGNANT WOMAN).

Experience

Experience acts as a factor that prompts pregnant women to patronize traditional and faith health care service provider. Pregnant women tell of their positive experiences and that of other pregnant women that have influenced their decision to patronize. A pregnant woman stated thus:

I have always visited TBAs during period of child birth and I am satisfied with the way they performed their service (PREGNANT WOMAN).

OBJECTIVE TWO: Examine and assess the regulatory structures or regulatory measures for the practice of traditional and faith based maternal healthcare services in Nigeria.

Having established the fact that TBAs and FBAs are health care providers assisting majority of women in childbirth, if they are left unregulated, they could carry out their activities without due regard for quality and standards of technical competence which could result in maternal death, serious bodily injury, catastrophic destruction or deprivation of legal rights. On this basis, it is difficult to dispute the necessity and the value of some form of regulatory intervention in the health care service market.

This research was able to identify one National bill which is yet to be passed into law and three National policies. The National bill and policies examined include: Traditional Medicine Practice Bill 2004, Traditional Medicine Policy 2007, National Health Policy 2016, and National Reproductive Health Policy 2017. The research also discovered that in the various states, there exist different laws and regulation on traditional healthcare. The provisions of these laws and policies regulating healthcare practices in Nigeria are examined; chapter five discusses the inadequacies in the existing legal frameworks.

Presently, orthodox healthcare practitioners have legal standards of practice firmly established and regulated by common law, criminal law and the professional bodies for the different specialties in orthodox healthcare; TBAs and FBAs are loosely 'regulated' by different state laws under States' Ministries of Health. There are standards for practicing as TBA or FBA and these standards are basically established through regulatory mechanism solely designed to ensure the safety, efficacy and quality of traditional medicines and practices. Traditional Medical practitioners (TMPs) are controlled by different boards and committees established at the state and local government levels based on the guidelines proposed by the traditional medicine practitioners' council or Boards. For example in Oyo State, the government of Oyo state in government enacted a Law establishing the Oyo State Advisory Board on Traditional Medicine.[366] According to S.3 (2) (a) of this law, the Advisory Board on Traditional Medicine is

> *… an extra-ministerial department of the Ministry of Health", responsible directly to the Commissioner of Health.*[367] *The law also provides that the Commissioner may make regulations 'as may be deemed necessary or expedient.*

Some of the functions and powers of the Oyo State Advisory Board on Traditional Medicine are:

> *To standardise training in traditional medicine and the type of medical service to be rendered; to establish registration of offices for the purposes of registering traditional herbalists, birth attendants, and other practitioners in traditional medicine in clinics and hospitals within the State; to lay down conditions to be followed by traditional herbalists, traditional birth attendants and other practitioners in traditional medicine in clinics and hospitals within the State; to regulate the code of*

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[366]Oyo State Advisory Board on Traditional Medicine Edict No.1, 1996, an edict to provide for the establishment of the Oyo State Advisory Board on Traditional Medicine and other Matters Connected Therewith in Supplements to the Oyo State of Nigeria Extra-Ordinary Gazette No.2 Vol.22 of 9th January 1997

[367] S.3(2)(b)

conduct and practice of traditional herbalists or healers, birth attendants or other practitioners in traditional medicine in the State; to charge and collect fees for registration as traditional medicine practitioner and to review such fees; and to do anything generally which, in its opinion, shall ensure the achievement of the purposes of the law.[368]

The question that readily comes to mind is "what is the standard of practice and training envisioned by the drafters of the law? Is this standard the same as the standard expected of an orthodox healthcare provider? In reality, there is little or no oversight by the Board on the activities of traditional birth attendants. Going by our findings, only few of the TBAs interviewed have knowledge of the existence of the Board or any law relating to their practice. One of the TBAs stated thus:

> *There may be a form of regulations because at a point I was asked to fill a form and sign, the content of the form was read out to me of which I agreed and signed. The officer also told me of some benefits I will be entitled to as a result of my compliance. He actually fulfilled it once (around 2004) after then I have not heard from him or any other government officer again (TBA).*

Another respondent also stated thus:

> *The angle of developing a regulation for the TBAs and FBAs is an amazing development. However it is expedient for them (policy makers) to note that the people they are creating these policies for have little knowledge which will not make the regulations hard on the TBAs and FBAs (COUPLE CATEGORY).*

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[368]Ss. 10, 11

There is no provision or any guideline on penalty, discipline or sanction for erring practitioners. The Law establishing the Advisory Board on Traditional Medicine since 1996 has not been reviewed or amended by successive administrations.

However, apart from governmental regulations, TBAs operate a unified association. To be a registered member, a TBA will be required to fill a form and attend their periodic meetings. The findings discovered that the trade association provides its members with the following: updates on the latest development, trainings and workshops to empower members, materials in kinds and financial assistance. Non-members of the trade association however are not entitled to these benefits. The most talked about benefit of the trade association according to the responses of TBAs and FBAs in the study is the support given to members when faced with cases of litigation from families or relations of pregnant women that died under their care. A respondent said thus:

> *We do not give support to people that are not part of us. A lot of them come around when they are faced with one challenge or the other. We encourage them to join us first then we can stretch out our arms of assistance (TBA).*

Another also reiterated that:

> *I know a lady who is part of us but she was not a member of the trade association. She assisted a pregnant woman with child delivery of which the process claimed the life of the mother. She was charged for manslaughter. She came to the association but she was denied support (TBA).*

Findings from the field work therefore reveal that the association of TBAs guide the activities of traditional birth attendants in some ways.

Unlike TBAs, the study reveals that faith birth Attendants and faith homes' supervision and regulation are under the control of the States Ministries of health. In Oyo State, going by

the provisions of the Hospitals (Private) Registration Law[369], private hospitals by its interpretation,

> *…includes any hospital, convalescent home, nursing home, clinic…, and any premises used or intended to be used for reception or treatment of persons… and for the reception of women in child-birth or immediately after child-birth… and whether or not any payment or reward is made or promised by or on behalf of any person so received…*[370]

Going by the provisions and interpretation section, faith birth homes and faith birth attendants are private hospitals, which according to s.3 must be 'duly registered by the Director of Medical services' and be under the day to day running management, control and supervision of a medical practitioner(herein after referred to as "the medical practitioner in charge"[371]. Other requirements include: adequate nursing staff, there must be a Matron or other person in charge of the nursing staff, who must be a qualified nurse and holds a diploma or certificate of training in nursing.

Conclusively, this research posits that while there are various 'laws' and policies regulating Traditional Medical Practitioners in general, there is no specific law or national policy addressing the specific practice of TBAs and FBAs. The basis for this conclusion stems from facts gathered from existing literature, previous research and responses from participants in this research. TBA and FBAs are role actors in maternal health care and major contributors to the increasing incidence of maternal mortality in Nigeria, thus the need for a specific National legislation and policy guidance for TBA and FBA practices.

[369] Hospitals (Private) Registration Law, 1998. CAP. 58. Laws of Oyo state 2000
[370] s.2 on interpretation
[371] s.4(1)

OBJECTIVE THREE: Investigate and document the historical development of regulatory structures and standards of practice for traditional and faith based maternal healthcare in Nigeria from pre-colonial to modern day.

Chapter three reports and documents the accounts on the historical development of the different healthcare practices and the forms of regulation. The research finds that there is a dearth of literature on the historical development of traditional healthcare and the practitioners in traditional Nigeria societies. There seems to be no information on regulation and control for standards and safety in these early traditional societies as every practitioner is left to the dictates of 'his conscience and moral compasses'. However, we want to differ on this and posit that, while there may not be written accounts of regulation of traditional health care institutions in early traditional societies, it would be presumptuous to assume that there was no form or system of regulation. We align with the thought that in early traditional societies, traditional authority remains a relevant vital social control platform.[372]

The emergence of modern medicine not only relegated the traditional healthcare practices, the introduction of other religion such as Christianity and Islam also contributed to the demonization and retardation of traditional healthcare practices. The emergence of orthodox medical practices brought with it the regulation of its professionals but this did not extend to traditional healthcare practices. Before the Medical and Dental Practitioners Act of 1963, there were regulations on the conduct of medical and dental practitioners by the Medical Practitioners Disciplinary Board in the Colonial Department of Health under the General Medical Council of England. During this period however, there were no regulations for traditional or indigenous health care practice in Nigeria.

Though informal interaction between the Government and traditional medicine practitioners can be traced back to the 19th century, formal legislation promoting traditional medicine dates to 1966 when the Ministry of Health authorized the University of Ibadan to conduct research into the medicinal properties of local herbs. Efforts to

[372]Maternal health in Nigeria: a statistical overview, June 2012. Global One 2015.op.cit..

promote traditional medicine continued throughout the 1970s in the form of conferences and training programmes.

In 1973, Lagos Ministry of Health, in conjunction with the Department of Chemistry, University of Lagos, Nigeria sponsored an International Scientific conference in traditional medicine and medical therapy. In 1979, the Federal Ministry of Health organized the very first nationwide seminar on Traditional Medicine, an intensive training exercise, where both orthodox and traditional medical practitioners participated actively. In the 1980s, policies were established to accredit and register traditional medicine practitioners and regulate the practice of traditional medicine.

Later in 1984, the Federal Ministry of Health set up the National Investigation Committee on Traditional and Alternative Medicine (NICTAM). A National Committee on the training of Traditional Birth Attendants was also inaugurated in 1987. In 1988, the Federal Ministry of Science and Technology inaugurated a committee mandated to undertake research and development on alternative medicine.[373]

Presently, orthodox healthcare practitioners have legal standards of practice firmly established and regulated by common law, criminal law and the professional bodies for the different specialties in orthodox healthcare; TBAs and FBAs are loosely 'regulated' by different state laws under States' Ministries of Health

OBJECTIVE FOUR: Consider those factors influencing non-implementation and non-compliance with these regulatory standards for TBA's and FBA's.

According to UNICEF, every day, Nigeria loses about 145 women of childbearing age, many of the half million women per year who die in childbirth are attended by TBAs or FBAs. In a study carried out in 2008, 62% of all births in that year took place in the home

[373]Borokini, T. and Lawal I. 2014. Traditional medicine practices among the Yoruba People of Nigeria: a historical perspective. op.cit.

in Nigeria, clearly suggesting a strong cause of Nigeria's high maternal mortality ratio.[374] In addition, the findings of this research, the responses of participants, particularly pregnant women who shared from their personal experiences and what they knew about others, establishes the fact that there is a nexus between the high rate of maternal mortality and the non- regulation and ill-regulation of TBAs and FBAs. One of the respondents said:

> *The government should organize orthodox medical practitioners to frequently see to things that happen in the Tradition birth centres and faith birth centres. I believe that will help reduce maternal mortality caused by TBAs and FBAs (Pregnant Women/Mothers Category).*

The World Health Organization (WHO) in the year 2004 stated that research does not support the hypothesis that training TBAs could contribute to lowering the Maternal Mortality Rate (MMR), predominantly because the government is not involving TBAs in the formal health care system. Medical practitioners revealed that maternal mortality can also result from late referral from TBAs or FBAs. Some TBAs and FBAs prefer to test their birth delivery skills on pregnant women who partake in home delivery or those who are comfortable with their practice. The users of TBAs / FBAs are prone to maternal complications. These complications if not handled properly could result in maternal death. TBAs / FBAs are more likely to probe further into the nature of the complication despite their lack of knowledge on the issues with hope that their skills can provide solutions to these complications rather than referring the pregnant women promptly to medical centres where they can receive the necessary treatment they need. Medical practitioners further attested to the fact that most referrals they receive from TBAs / FBAs occurs when the patients are in critical conditions tending towards maternal mortality. Medical personnel stated that:

> *I believe in recent times, the government at federal, state and local government level teach TBAs and FBAs on easier methods to handle delivery cases in their local areas with a*

[374]UNICEF. Dec., 2008. *The state of the World's children 2009: Maternal and New Born Health*. op.cit.

> *clause that they should refer the more complicated birth deliveries to the skilled birth attendants. Most patients referred to me by a TBA or FBA are usually in a critical condition, possibly the TBA or FBA tries to carry out the delivery and he/ she encounters a complex situation beyond the level of their competence. When issues like these arise, they (TBAs and FBAs) then start to refer patients. Most times the referred patients die before getting here (MEDICAL PERSONNEL).*

Another also said:

> *I receive a lot of referral cases from TBAs and FBAs as regard maternal child delivery. I must commend them on that they have been really helpful as a referral agent although this one thing I have against them. Most of their (TBAs and FBAs) referrals are usually the late types of referral. Most time, referred patients arrived in extreme critical conditions. You can always tell because once they arrive, you may have to suspend whatever thing you are doing and focus more of your energy keeping them alive (MEDICAL PERSONNEL).*

The above quote proves that TBAs and FBAs are living up to the expectation of acting as referral agent however; there is a need to ensure that the referrals are prompt as late referral often results in the death of the pregnant woman.

There are a lot of communities (especially those located within the rural and semi-urban) where the presence of skilled medical personnel are absent. These communities are further characterized with a low standard of maternal care and a great proportion of deliveries are assisted by untrained medical personnel (TBAs and FBAs) under little or no supervision. According to the interviewed medical personnel, these communities are prone to have a high incidence of maternal mortality. They attributed this to the untrained personnel deficiency in basic knowledge of prenatal care, hazardous procedures and practices during labour, poor nutrition and infection. All these affect maternal and foetal health and are

strong precursors for maternal morbidity and mortality. The fact that medical personnel considers untrained staff as a factor responsible for the increased rates of maternal mortality in Nigeria is expressed is expressed by a medical practitioner:

> *I think their delivery practices are being modified; it used to be very crude. They use to commit all atrocities in the process of delivering babies. Some of them will keep the patients in prolong labours for such a long time until the uterus tears or in the process of pushing the baby out, they could stand on the woman's abdomen or they would cause a lot of tear - very wide tear where you then have fistula - vesico vaginal fistula, if these aren't managed well result in the death of the pregnant women (MEDICAL PERSONNEL).*

Most of the interviewed TBAs affirmed that there are regulations regarding registration with the state and local government traditional medicine boards/council. The research findings however confirm that there are numerous factors influencing the non-implementation and ill regulation of the current regulatory regimes for Traditional Medical Practices in Nigeria. Some of the factors identified include: lack of training, lack of supervision, lack of equipment, and inconsistent government promises.

Training of TBAs and FBAs

TBAs and FBAs make use of crude, obsolete methods and practices. TBA and FBA practices according to the pregnant women need an upgrade. They agreed to the regulation of TBAs and FBAs but reiterate that for regulation to be effective, it is important for the government to assist in training so as to improve the maternal skills of TBAs and FBAs by educating them on symptoms and signs of maternal complications, new methods of addressing maternal complications and safer child delivery practices. A medical personnel state that:

> *It is imperative that TBAs and FBAs be brought into the system and taught newer and easier approaches in the act of child*

> *delivery. Whether we like it or not, orthodox practitioners cannot attend to every delivery cases hence the need to teach the lower cadre (unskilled birth attendants) the easier processes and ask them to refer the more difficult ones (MEDICAL PERSONNEL).*

Training TBAs and FBAs as suggested by pregnant women is evident in her statement:

> *I think government should educate TBAs and FBAs more in the act of birth delivery, teach them what to look out for and what to do….*

The TBAs complained that the state boards do not supervise, follow up or check on their practices after registration. This confirms a failure in one of the duties of the boards which is to supervise and regulate the conduct and practice of TBAs and other Traditional medicine practitioners in the states. Another factor identified is the non-training and infrequent training of TBAs. From the interviews, some TBAs claimed they have never received any form of training or update on their practice from the boards. The few that attested to have benefitted from trainings organized by the boards alleged that the trainings were not frequent. This is contrary to the provisions of the law which stipulate that the boards shall standardize trainings and lay down conditions to be followed by TBAs and other practitioners in traditional medicine. Illiteracy of practitioners and conflicting notions of standards of practice is another factor interviewed TBAs view as reason for not complying with the regulatory standard of the board. Majority of the TBAs are not literate, neither do they have any formal training; they claim to have obtained their knowledge of traditional medical practices through informal means from parents or other traditional medicine experts. A respondent stated that:

> *The government should organize orthodox medical practitioners to frequently see to things that happen in the Tradition birth centres and faith birth centres. I believe that will help reduce maternal mortality caused by TBAs and FBAs (PREGNANT WOMAN/MOTHER).*

Another also said:

> *Another item on the list to consider before regulation is the supervision of these TBAs and FBAs. Teaching them is not enough, there is need to regularly check on them. It is easy for them to forget whatever they have learnt if they do not have anyone to frequently check and assess their level of development in the skills they have obtained (MEDICAL PERSONNEL).*

The introduction of regulatory standards by the state board according to the TBAs is strange and foreign to many of them. They further complained that instead of the board to set standards and conduct training within and in accordance with their mode of practices, they are introduced to standards and practices that are difficult for them to comprehend. This findings buttress existing literatures and report on the outcomes of the numerous training programmes that have been organized for TBAs and FBAs both at the national and state levels. Reports have it that majority of the TBAs and FBAs after receiving training on new practices and standards reverts after some time to their old ways of doing things.

Equipping of TBAs and FBAs

TBAs and FBAs do not possess modern technological equipment needed to carry out on demand test or assessment of pregnant women. Their assessment of pregnant women is mostly based on their sense of feeling and assumption, which is not always accurate. Government should assist them with modern equipment for safe maternal practices. A respondent stated thus:

> *…Aside imparting them (TBAs and FBAs) with knowledge, the government can also help them with easy to understand and operate equipment because they are most times making use of improvised equipment (PREGNANT WOMAN).*

Inconsistent government promises

In Nigeria, TBAs and FBAs are persons with little or no knowledge about conventional medical practices but they are however sound in the use of traditional medicine and religious doctrines respectively. TBAs and FBAs acknowledged that there is a form of regulation by government which comes with some incentives for adhering (incentive such as training, provision of medical items and equipment). They admitted that the incentives are a form of motivation to adhere to the regulation. However, since the government is not consistent with the incentives, they also do not see the need to take the regulation seriously. TBAs and FBAs referred to government inconsistent promises as a reason for their nonchalant attitude towards existing rules and 'regulations'. This is buttressed by the following quotes:

> *We were given a sheet of paper with some information to provide answers to. At the end we appended our signature on the paper and we were addressed by a government official that we will be entitled to the certain items from the government as long as we make sure we do what we agreed to do. Till this moment as I speak with you we have not heard from the government so tell me why we should also be encourage fulfilling my part of the bargain (TBA).*

The quote above shows the need for government to be consistent with promises made and policies embarked upon. TBAs and FBAs who have registered through government training programmes do not feel obligated to the rules and 'regulation' because these trainings and incentives promised by Government are not consistent. The study identifies lack of incentives as a contributor to the nonchalant attitude of TBAs and FBAs to rules and efforts of government towards regulating and standardising their practice, which we posit has an indirect effect on the high rate of maternal mortality recorded among pregnant women who engage their services.

The issues that result in non-compliance with regulatory standards have been identified, what then can be done to ensure compliance? Medical practitioners believe there is need

for TBAs and FBAs to be regulated. By regulation, they mean there must be a rule that oversees the activities of unskilled birth attendants. They agree that just like the orthodox medical practitioners, unskilled birth attendants should owe a duty of care to the pregnant women that patronize them. However, the regulations for TBAs and FBAs should not be as stringent as that of the orthodox with too much regulations and paper works because it may result in the TBAs and FBAs going into hiding. They are also of the opinion that before any regulation is made; policy makers should involve and get the input of unskilled birth attendants in the development of these regulations. This is necessary in order to combat non-compliance with these regulatory standards. A respondent said:

> *For the proclaimed regulation to be effective there must be need to involve the TBAs and FBAs in the process of planning, organising, management and implementation of the regulation activities (MEDICAL PERSONNEL).*

Another respondent also reiterated by stating thus:

> *Regulating the activities of the TBAs and FBAs is a good development. My concern is that they must not be too stringent like that of the orthodox medical practitioners or else, they will be go dark (I mean go into hiding) (MEDICAL PERSONNEL).*

The result shows that TBAs and FBAs are open to any regulation that will help improve their practice. They are also ready to be familiar with such regulation, if it exists. They stated expressly that for any regulation or legal framework on their practice to be effective, it is important that they are informed and involved at every stage of its development through Enlightenment campaigns. A traditional birth attendant said:

> *The government should call us and tell us exactly what they want from us. We are always ready to comply as long as it does not affect our business. In fact, we should be carried along all through the whole process so that any rule we think will be hard for us to comply, we will point out for them to adjust for*

us. They should also try and spread it across to others in other location, we will do that among our members here (TBA).

The quote above shows the need to enlighten and involve TBAs and FBAs in the development of any proposed regulation they will be subjected to. This will give them a sense of 'participation' and obligation to adhere to the regulation and also ensure compliance.

For the development of a functional and effective legal framework, there is need to hold meetings with policy makers, TBAs and FBAs to discuss challenges initiating the development of a legal framework, reasons for the need of a legal framework, plans about the developments of a legal framework and suggestions of TBAs and FBAs on the proposed framework. The finding revealed that there is need for meeting and consultation between policy makers, TBAs and FBAs on the development of a legal framework for traditional and faith based maternal practice in Nigeria. One of the respondents spoke thus:

There is a need for a meeting generally devoted to the discussion of this issue (legal framework for traditional and faith based maternal practice in Nigeria) and it must be one that involves a representative of the TBAs, FBAs and the government so that all parties involved might reason together and arrive at a conclusion.

Another respondent also said:

Let us meet with whoever is coming up with such program, we hear what they have to say and they hear what we have to say then we reach a conclusion. I think that should be considered fair (TBA).

And yet another spoke:

At some point in the past, we have been harassed over some regulations we were not informed about. It was so annoying

then, it is important we all meet on what is new so we have no excuse when the consequences come up (TBA).

The above quote shows the need to remove the communication barrier that prevents TBAs and FBAs from receiving new policies that are relevant to their practice. It is evident that a legal framework may drastically reduce maternal mortality in Nigeria but there is a need to consult, meet and discuss the whole processes involved with relevant stake holders. The importance of meetings and consultation is expressed in the definition by Livingstone[375] stating that a meeting is a gathering of a group of people with the aim of discussing matters of concern, such as achievements, challenges and implications for improvements. Similarly, according to Sahlstedt[376], it is an effective strategy in enhancing team building, boosting individual morale and building a good working relationship. Furthermore, the American Management Association[377] also confirms that holding workplace meetings has the advantage of finding complete resolutions of conflicts, proper follow ups, better understanding of complex problems, consensus and better decision-making.

Unlike TBAs, the issue on non-implementation and non-compliance by FBAs is different. In this research, it was found that there is a proliferation of faith based maternal homes. Many of these homes are not registered and do not meet the requirements of the law for registration which provides that such private hospitals shall be under the day to day management, control and supervision of a registered medical practitioner. Also, many of the FBAs are not qualified nurses, though some claim to have Matrons and Nursing sisters who from time to time over see the activities in the homes. Most of the FBAs are women with little or no formal training but who through practice and pupillage have mastered the art of assisting pregnant women in the process of childbirth. Also, many of these faith based homes lack suitable and sufficient equipment.

Disappointedly, the penalty for failing to comply with the provisions of the law is an offence for which any person or company shall be liable on summary conviction to a hundred Naira fine or to imprisonment for three months or to both such fine and

[375] Livingstone (2008).
[376] 2012, p. 93
[377] American Management Association. (2005)

imprisonment. In the case of a continuing offence to a further fine of twenty naira for each day during which the offence continues.[378] The study further reveals that many of the FBAs are not aware of any law regulating the homes or their practice. Some allude to the fact that some people sometimes come from the state secretariat to inspect the homes. Another major observation is that FBAs see their practice first as service to God, service to the faith and gratuitous service to humanity. Many of the older *Iya Agbebi's* are oblivious of the legal consequences that may arise from the practice.

There is a nexus between non- regulation, inadequate regulation of maternal health care and increase in incidence of maternal mortality. This research finding reveals that the presence of quacks among FBA can be attributed to inadequate regulation and non-regulation which directly or indirectly contributes to the high incidence of maternal mortality in Nigeria. This position has been established by extant literature of many qualitative and quantitative researches.[379]

For effective compliance with standards, there must be frequent training and update on issues pertaining to their practices, the regulatory bodies must also involve TBAs and FBAs in setting attainable operational standards for their practice. There must also be regulation in order to protect the people from abuse, exploitation and other forms of harm.[380] Aside all these, there is frequent need for monitoring, evaluation and periodic review of the standards.

Objective Five: Compare regulatory standards with that of other jurisdictions in order to propose draft model legislation for the regulation of traditional and other alternative maternal health care practices in Nigeria.

The comparison of the three selected jurisdictions namely: Tanzania, South Africa and Malaysia are contained in chapter five of the thesis. In this research, the comparative study

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[378] Hospitals (Private) Registration Law, 1998. Op cit

[379]Walraven, G. and Andrews, W. 1999.The role of (traditional) birth attendants with midwifery skills in the reduction of maternal mortality. op.cit.

[380]Liberman, J. 1970. The Tyranny of experts: how professionals are closing the open society. op.cit.

of the regulatory framework from three selected jurisdictions, namely; Tanzania, South Africa and Malaysia brings to fore the adaptable prospects of having a specific framework for the regulation of TBAs and FBAs in Nigeria. This reason for selecting Tanzania and South Africa is because they are African countries having relatively similar culture to Nigeria. Malaysia on the other hand, is a common law country like Nigeria with a well-developed traditional health care system.

South Africa

In South Africa, there is a Traditional Health Practitioners Act, 2007.[381] This legal framework contains provisions to ensure efficacy, safety and quality of traditional health care services, management and control, registration, training and conducts of traditional health care practitioners. The Act specifically provides for educational standards and continuing education through training of students by accredited institutions and recognized traditional medicine tutors. Other provisions include Disciplinary inquiries and investigations by the Traditional Health Practitioners Council of South Africa. The Act also contains some general and supplementary provisions relating to practice. One of the peculiar attributes of this Act is that it recognizes the different traditional specialties and provides for their individual registration.

The Act specifically defines traditional health care practice as the performance of a function, activity, process or service based on a traditional philosophy that includes the utilization of traditional medicine or traditional practice. The Act also provides a definition of a traditional birth attendant. Some of the peculiar provisions of the Act are the following:

(a) It clearly excludes traditional health practitioners from engaging in the professional activities of professions like nursing, pharmacy, dental technician and all other activities not based on traditional philosophy.

[381] Act No. 22, 2007. Government Gazette, 10 January 2008.

(b) The Act provides the meaning of unprofessional conducts as any act or omission that is improper, disgraceful, dishonourable or unworthy of the traditional health profession.

(c) It states that the objects of the Traditional Health Practitioners Council includes: promoting public awareness, ensuring quality of health services within the traditional health practices, protecting and service the interest of members of the public who use or are affected by the services of traditional health practitioners and also ensuring that traditional health practices complies with universally accepted health care norms and values

(d) The Act provides for investigation of complaints and charges of misconduct. An Investigating Officer is authorized to enter and search premises for the purpose of investigation.

Tanzania

Tanzanian's National law on traditional health practice is known as the Traditional and Alternative Medicine Act of 2002[382]. This Act is a very comprehensive with provision for the promotion, control and regulation of traditional and alternative health practice. One feature of the Act is that it applies to all traditional and alternative health practitioners and their aides irrespective of whether they are registered, enrolled or not. The Act just as the South Africa legislation defines 'traditional health practitioners' to include any one who provides health care 'using other methods based on social, cultural and religious background as well as knowledge, attitudes and beliefs…' This specific provision unlike the Nigerian regulations can be implied to cover the activities and practices of FBAs. Other special features of the Act are:

(a) A registered traditional birth attendant is a member of the Traditional and Alternative Health Practice Council.

[382] Traditional and Alternative Medicine Act, no. 23, 2002: Act of the Parliament of the United Republic of Tanzania Gazette.

(b) A legally qualified person from the Attorney General's Chambers is also a member of the Council.

(c) The functions of the Council apart from monitoring, regulating, promoting, implementing and supporting the development of traditional medicine includes protecting the society from abuse of traditional and alternative health practitioner.

(d) The Act provides for standing committees which includes academics, professionals and researchers.

(e) The Act specifies the qualification of a traditional health practitioner as distinct from that of an alternative health practitioner.

(f) The Act provides for provisional registration and full registration upon the fulfilment of certain requirements.

(g) The provision of the Act also includes deregistration and removal for professional misconduct and conviction.

(h) The Act stipulates conducts that amounts to non-adherence to professional ethics and etiquettes.

(i) The Act also identified practices that are likely to be dangerous to health or life.

(j) The Act specifies the duties of traditional and alternative health practitioners to include confidentiality, good system of record keeping, personal cleanliness and cleanliness of premises and appliances.

(k) Finally, the Act specifically states that illegal practicing and illegal registration are offences liable on conviction to a fine and imprisonment.

Malaysia

Traditional health care in Malaysia is regulated under the Traditional and Complementary Medicine Act, 2016.[383] The Act regulates traditional and complementary medicine services

[383] Traditional and Complementary Medicine Act, 2016, Laws of Malaysia Act 775

in Malaysia. The Act provides a definition of the practice of traditional and complementary medicine to include prevention, treatments and management of illness according to traditional Malay medicine. It also recognizes traditional Chinese medicine, traditional Indian medicine and Islamic medical practice excluding medical and dental practices. Similar to the provisions of Tanzania's Traditional and Alternative Medicine Act, the Malay Act provides for the protection of patients information. Some of the significant provisions of the Act include:

(a) Provision on apprenticeship and training requirements

(b) Professionalism of traditional and complementary medicine practices.

(c) Provision on the duty to refer patients to medical practitioners and dental practitioners where there is acute medical emergency or the condition of the patient is beyond his skill, competence or expertise. This provision creates and maintains relations between traditional and orthodox medical practices.

(d) Provision on the prescription and recognition of practice areas from time to time.

(e) Provisional registration and residency training.

(f) Non-registration and practice either directly or indirectly is an offence liable on conviction to fine and imprisonment. A subsequent offence attracts a higher fine and longer term of imprisonment.

(g) The Act permits the use of titles and abbreviations which must not cause the public to belief that a traditional and complementary health practitioner is an orthodox medical practitioner.

(h) The Act prohibits a traditional health care practitioner from making any spurious claims, false or misleading representation in any advertisement whether on print, social or commercial media.

(i) Other provisions include incorporation of practice as a limited liability company, prescription of mandatory practice standards and practice codes, prosecution and

punishment, provisions on implied guarantee to patient, patients' rights and compensations for loss or damage. The Act also provides for joint liability, vicarious liability, dispute resolution and a self-regulatory framework by body of practitioners of a recognized area of practice.

This exploratory comparative study of the fore-going legal framework exposes the distinct provisions of these regulatory instruments. This research finds that the current regulatory framework including the proposed Traditional Medicine Practice Bill on traditional health care practice in Nigeria falls short of these standards provisions and thus requires a review. In addition, there is need for an all- embracing national legislation to ensure more effective maternal health care services that will subsequently reduce the high incidence of maternal mortality in Nigeria.

6.2 CONCLUSION

The purpose of this research is to examine the regulation and legal framework for traditional and faith based maternal practices in order to establish the nexus between ill regulation and the high incidence of maternal mortality in Nigeria. Based on the interpretation of our findings, it has been discovered that, there is significant nexus between inadequate regulation of traditional and faith based maternal healthcare practices and maternal mortality in Nigeria.

The research reveals that traditional birth attendants and faith birth attendants play a significant role in the provision of maternal health care and deliveries. They provide services to pregnant women in rural, semi urban and urban areas. Maternal health care practices with traditional birth attendants are without any formal regulation, while faith birth attendants are partly regulated under subsidiary legislations of states under the State Ministry of Health.

There is a general lack of adequate supervision in terms of standards and quality of services rendered. Women are exposed to risks in the hands of charlatans and incompetent traditional and over-zealous faith based maternal carers and midwives. They are subjected to all sorts of unorthodox practices which may not be unconnected to maternal deaths and mortality as a result of complications during and after child birth.

Finally, it is also evident in our findings that, there is significant relationship between regulation of maternal practices and maternal morbidity and mortality. This finding is asserted because of the proliferation of non-regulated traditional and ill regulated- faith birth homes

6.3. RECOMMENDATIONS

After a careful exploratory study into the legal framework for the regulation of traditional birth and faith based maternal practices in Nigeria, the following recommendations are proposed:

i. Government should enact a national legislation on traditional medicine with specific and more detailed provisions on traditional and faith birth attendants detailing services and standards.

ii. There should be a specific national policy on maternal health care focusing on TBAs and FBAs towards addressing standardization of practice and ultimately reducing the risk and rate of maternal death in Nigeria.

iii. States should review their anachronistic laws and enact specific laws for the regulation of faith birth attendants and traditional birth attendants including home deliveries.

iv. There is a need to scrutinize and systemically investigate the activities of faith birth attendants and faith birth homes by social science researchers and other academics.

v. Government should endeavour to provide more health delivery services at affordable prices to the people in order to encourage them to patronize modern maternity and antenatal services than as they currently patronize traditional birth attendants and faith birth attendants.

vi. Government should scrutinize the various existing traditional birth attendants' and faith-based birth attendant centres to make sure they carry out maternal health services in a more decent and professional environment.

vii. There is a need for a comprehensive registration and licencing system of TBAs, FBAs including the maternal homes and centres by appropriate

oversight authorities like the State Ministries of Health and Traditional Medicine Boards.

viii. There should be proposed before the National Assembly a model draft legislation for the regulation of traditional and other faith based maternal health care practices in Nigeria

ix. Finally, recognizing the importance and contributions of TBAs and FBAs in the provision of maternal healthcare. Government, society and all other stake holders should develop a positive attitude towards TBAs and FBAs by acknowledging their relevance and provide the appropriate legal environment for safe maternal health care services.

6.4 MODEL LEGISLATION FOR REGULATION OF TBAs AND FBAs

Below is the model legislation that could serve as the beginning of a proper legal framework for regulating traditional and faith birth attendants. It is the recommendation of this research, that, efforts should be made into translating this law to the indigenous language of the major ethnic groups in the country so as to make the laws easily understood by the people at the grass root level who would be the major beneficiaries of the law.

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APPENDIX

A Bill

For

AN ACT

TO REGULATE AND CONTROL THE PRACTICE OF TRADITIONAL AND FAITH BIRTH ATTENDANTS TO PROMOTE SAFE MATERNAL CARE AND REDUCE MATERNAL MORTALITY IN NIGERIA

Commencement (…………)

ENACTMENT:

Short Title: This bill may be cited as the Traditional and Faith Birth Attendants Regulatory Act, 2019

The object and purpose of the law is

a) To provide a framework for regulation and standardization of traditional reproductive health services
b) To promote health and safe motherhood
c) To reduce maternal mortality and morbidity in Nigeria.
d) To provide a database for registered traditional birth attendants
e) To encourage collaborative health care practices between TBAs and FBAs

Application of the Act

The Act applies to

- Traditional Health Practitioners
- Traditional birth attendants
- Faith birth Attendants

Prosecution

The Nigerian Police Force and the National Agency for Food, Drugs, Administration and Control where applicable in terms of jurisdiction may prosecute under this Act

Interpretation

"Abortion" means the ending of a pregnancy due to the removing of an embryo or foetus before it can survive outside the uterus or the use of herbs to intentionally expel the embryo or foetus before it can survive outside the womb or fallopian tube.

"Adolescent" means someone below the age of 18.

"Antenatal Care" means a kind of preventive healthcare. Its main goal is to provide regular check-ups including correct diagnoses in pregnancy that allow doctors or midwives to treat, prevent and manage potential health problems throughout the course of the pregnancy and to promote healthy lifestyles that will eventually benefit both mother and child after birth.

"Caesarean Delivery" means any delivery involving the cutting up or making of incisions on the abdomen for the purpose of delivering a pregnant woman.

"Contraception" means the deliberate and wilful act of using local methods or drugs either oral or intra vaginal insertions to prevent the normal process of fertilization from taking place thereby stopping the occurrence of pregnancy following unprotected sexual intercourse.

"Health Care Provider" means any person or institution recognised by a community; village, Local-government, state or a recognised authorised body for regulation; to render maternal health care services.

"Informed Consent" means consent given freely by a patient, after the patient has been duly informed and made aware of all the implications of the said consent. Said consent must be obtained without force, inducement, threats or undue pressure.

“Maternal Care” covers all aspects of caretaking of a pregnant woman, covering from the time of conception, through all trimesters, childbirth and till 90 days after birth

“Maternal Morbidity” refers to any health condition; disease (physical, emotional or psychological) caused or aggravated by pregnancy or pregnancy related complications whether life-threatening or otherwise that can affect or have a significant impact on the quality of life of the woman, during or after pregnancy.

“Maternal Mortality” means the death of a woman while pregnant or within 42 days of the termination of the pregnancy, delivery or loss of the pregnancy from any cause related to or aggravated by the mismanagement of the health care provider but not from any accidental or incidental causes.

“Minor” for the purposes of this Act, a minor means someone below the age of 18.

“Practitioner” for the purpose of this act means a traditional birth attendant or faith birth attendant.

“Pregnancy” the state of carrying a developing embryo or foetus in the womb or any other part of the reproductive system and is indicated by positive results on a urine test, blood test, ultra sound or X-ray and usually lasts for a period of 9 months

“Quack” refers to a person who dishonestly claims to have specialized and experiential knowledge and skill in the provision of maternal services.

“Reproductive Health” means the complete state of physical, mental and social well-being and not merely the absence of disease or infirmity, the ability to have a safe and satisfying sex life, capability to reproduce and the freedom to decide if, when and how often to do so.

“Skilled Birth Attendants” means an accredited health professional such as a midwife who has been trained to proficiency in the skills needed to manage an uncomplicated pregnancy, childbirth and the immediate postnatal period.

“Termination of Pregnancy” for the purpose of this Act means the separation or expulsion of the contents of the uterus by any herbal means either orally taken or by intra vaginal insertions by a pregnant woman before the foetus has become capable of sustaining an independent life outside the womb

Traditional Birth Attendants” means any local midwife, either male or female who has no formal type of training but have local knowledge of herbs and their uses and use this knowledge to help with delivery. For the purpose of this Act, any birth attendant apart from Skilled Birth attendants and other orthodox maternal healthcare providers.

“Traditional Birth Practices” means any type of practice involving the use and knowledge of herbs and other methods apart from orthodox practices that are learnt in a period of apprenticeship that spans from the time of pregnancy to 42 days post natal.

PART II: ESTABLISHMENT AND RESPONSIBILITIES OF THE TRADITIONAL MATERNITY PRACTICE CARE REGULATION BOARD.

1. (a) There is hereby established a body corporate to be known as the Traditional Maternity Practice Care Regulation Board hereafter referred to as “The Board”

   (b) There is hereby established for each state a Traditional Maternity Practice Care Regulation Board with presence in every local government

2. The term of office for the Board is four years.

3. Members of The Board shall be appointed by the President upon the recommendation of the Minister for Health.

   i) The members of the board shall comprise the following

      a. A Director-General who must be a certified traditional medicine practitioner and known in nothing less than two States of the country for his or her practice and success. To qualify, such person must have practiced traditional medicine for at least 20 years and by virtue of his or her

experience, ability and specialized knowledge is fit to head the board in the opinion of the Minister for Health.

b. A traditional Birth Attendant with specialised experience of not less than 10 years

c. A member of the Nigerian Bar Association with a degree or diploma in African Philosophy

d. A public health physician

e. A Permanent Secretary of the Ministry of Health or representative

f. Director of Nursing and midwifery in the Ministry of Health

g. Representative of the Minister of Women Affairs

h. Two representatives of Non-Governmental Organisations working in areas of Reproductive Health

i. Representative of the Traditional Medicine Advisory Board with speciality in traditional birth attendance.

j. An academic expert/researcher in reproductive health or a member of WORDOC with expertise in reproductive health.

k. A traditional ruler or historian.

l. A member of the Nigeria Police Force not below the rank of Superintendent.

m. A member of the Traditional Medicine Advisory chosen by the board to act as Registrar.

n. A member of the National Agency for Food, Drug, Administration and Control of rank not lower than a Deputy Director.

o. A Researcher from the Institute of African Studies.

3. The Board shall be responsible for the approval and appointment of the members of the State Committees.

4. The Functions of the Board are:

   a) Promote and develop interest in traditional health practice by encouraging research, education and training:
   b) Ensure that traditional maternal health practices complies with universally accepted health care norms and values.
   c) In consultation with the Minister, determine policy, and in accordance with policy determinations, make decisions regarding matters relating to education, educational framework, fees, funding, registration procedure, code for professional conduct and ethics, disciplinary procedure and scope of traditional maternal health practice.
   d) Managing and maintaining a credentialing programme where all individual traditional birth practitioners are licensed and given statutory certification for legitimate practice.
   e) Registration and assessment of Traditional and Faith birth attendants in each state;
   f) Conduct investigative inquiry into traditional maternity practices in all states in conjunction with the State Board.
   g) Monitor the levels of ante-natal and post natal care relating to Traditional birth attendants in any community.
   h) Developing methods of evaluation and conducting training of attendees to recognise dicey situations and give quick emergency response.
   i) Seal up illegal premises being used by non-registered traditional birth attendants and faith birth attendants.
   j) Monitor the activities of Traditional and Faith Birth Attendants and providing maternity services in each state.
   k) Establish minimum hygiene and health hazard safety standards as requirements for successful licensing and practice.

l) Advise the Federal Government on the financial needs and the need for investment in the traditional maternity health sector.

m) Take stock of maternal mortality in every state and keep proper annual record of such mortality and render same to the Ministry.

n) The Board must in the interest of the public act as a liaison between traditional maternal health practitioners and other health professionals registered under any law.

o) Publish and educate members of the society on scope and functions of the board, the right to choice of healthcare and the board's commitment to the reproductive health and reduction maternal mortality

p) Collate, analyse and publish information in journals, periodicals and websites in relation to reproductive health and maternity services annually.

q) Oversee activities of states and receive annual reports from same.

r) To view traditional practices from experts in states and organise training and hybridization of practices.

s) Organize regular seminars and lectures and public enlightenment programmes at local government and state levels in order to improve and promote reproductive health and maternity care awareness in the State.

t) Submit an annual report on all member states to the presidency with a copy each to the Ministry of Health and Ministry of Women Affairs.

u) Carry out any other activities as dictated or instructed by the Minister of Health under the direction of the presidency.

5. 1. The Board shall have the Power:

a. To sue and be sued.

b. To conduct inspections and assessment of the level of hygiene and care given in Traditional and Faith Birth Attendant homes.

c. To report offenders of this Bill to the Police

d. To convene inquiry tribunals into any suspicious activities that in the opinion of the chairman may pose a threat to the maternal health of women in the society.

e. To revoke approvals and licenses given prior.

f. To conduct investigations into safe herbal medicines used by traditional birth attendants

g. To create a list of approved medicines which have been seen to not be harmful in any way to the health of both the mother and the child

h. The Board shall liaise

i. To create offices necessary for the purposes of carrying out its functions.

6. 1. The committee shall hold meetings at least once every 3 months at a place and time communicated by the Director-General. Such notice must be given to all members of the board at least two months and a day before the meeting by way of a circular or memo, email and text message.

2. Without prejudice to section 6(1) of this bill, a special meeting may be convened by the Director General whenever the need arises or at the instance of four members of the board. However, no meeting can be convened without the express permission and approval of the Director-General. Any such meetings and resolutions taken will be null and void.

3. A quorum at the board meeting shall be nothing less than one-third of the members including the Director-General. Where the Director-General is absent then one of the members would be elected to take the place of the Director-General for the sake of the meeting.

4. The registrar shall be in charge of taking the minutes of the meetings and shall keep a minute’s book in his or her custody at every time.

a. The registrar shall be the accounting officer and take proper records of all financial transactions, assets and liabilities of the board.

b. All financial statements in respect of the financial year are submitted no later than two months to the end of each year.

c. The registrar shall also keep accounting records and submit same for auditing from time to time

5. The board shall have the power to regulate its own procedure including the power to evolve its rules as regarding the proceedings as long as such rules are not inconsistent with the general objects and purposes of this bill.

7. A member of the Board shall be expected to vacate office where:

a) He or she has been diagnosed with a mental illness that prevents the person from carrying out his or her duties to the satisfaction of the Board.
b) He or she has been convicted of an offence and sentenced to imprisonment.
c) He or she ceases to hold the necessary qualification for his or her designation or appointment
d) Tenders a resignation letter in writing to the Chairman of the Board.
e) He or she dies before the expiration of his/her term of office.

Source of Funds for the Board

8. The funds of the Board shall consist of:

a) Money approved and passed as budget by the National Assembly.
b) Fees raised by the Registrar in the performance of his or her functions under this Act.
c) Penalties contemplated by the Board.
d) Other fees including donations given by the public.

1. The Board may with the approval of the chairman administer invest any monies, which is not required for immediate use, with an approved institution.

PART III REGISTRATION OF TRADITIONAL BIRTH ATTENDANTS AND CENTRES

9. Any person wishing to be registered as a traditional birth attendant must apply on a prescribed form TRF A1 the Schedule to this Act.

1. The application form must be submitted to the registrar and approved by the Director-General.

2. The application must be accompanied with the requisite fees stipulated by the Table of fees as may be determined by the Board from time to time.

    a. Fees decided by the board may be appealed by Traditional Birth Attendant to an Appeal Committee set up by the Board.

3. The registrar shall keep a book of records for the registration of Traditional Birth Attendants.

    a. The book of records shall be made available in both soft and hard copies and stored in appropriate storage devices for safekeeping.

4. The registrar shall enter the name of the person who meets the requirements contemplated in Part A, B and C of the Schedule to this Act.

PART IV – SAFE REPRODUCTIVE AND TRADITIONAL MATERNAL HEALTH PRACTICES

10. Every traditional birth attendant must be registered with the board in order to be able to give maternity services in any given state.

1. Failure to register according to the stipulated process in Part III shall result in

    a. Immediate shut down of the premises.

    b. Prosecution according to the provision of this Act

2. Any traditional Birth Centre that fails to register as an on-going concern with the board upon conviction is guilty of an offence and its principals are liable to a term of 7 years imprisonment or fine of N25,000,000.

11. Every traditional and faith birth attendant shall undergo a training and education under and experienced birth attendant and shall apprentice for a term of not less than 5 years before he or she can be approved as a birth attendant.

a) Without prejudice to the above, apprentice shall undergo trainings in care and hygiene organised by the regulation committee.

12. Every student birth attendant or trainee must be registered by the registrar with the following

a) A valid driver's licence or

b) National Identification Number

c) Application form TRFA2

13. Every traditional and faith birth attendant shall have a clean surrounding and maintain hygienic conditions in the premises chosen as an operational base. All specific requirements are highlighted in Part A of the schedule.

2. Every birth attendant in providing services shall

a) Advise every patient of the need to register with an orthodox hospital in case of emergency situations.

b) Use only approved herbal medicines in the right amounts as have been approved by the board.

c) Monitor the mother from the time of knowledge and have a detailed history from the time of the first trimester to the time of birth.

d) Only use sterilized objects and shall take proper cognisance of hygiene in any investigation from the ante-natal period to labour and to the post-natal period. All objects are further listed in PART B of the Schedule.

e) Have the contact of an orthodox medical practitioner in the event of complications arising from the pregnancy, where the patient does not have any or where the registered hospital is too far from the location of the birth premises.

f) Shall utilize help services and seek professional help where it seems to the Traditional Birth Attendant that management of the pregnancy or labour has become complicated.

g) Shall abandon all customs and beliefs not approved by the board or that which can potentially harm the child and the mother.

h) Shall only prescribe medicine and foods that have been approved by the board after it is shown that such prescriptions are harmless and only serve to protect both the mother and child during and post pregnancy.

14. No person not being approved by the board after fulfilling all the compulsory training requirements shall engage in Birth attendant or the ante-natal and post-natal care of a pregnant woman.

1. Any person who contravenes the provision of Section 9 is guilty of an offence and liable for a term of imprisonment of 4 years with no option of fine.

2. Any person that colludes, plans, agrees with another person or takes part in the contravening of Section 9 shall also be guilty of conspiracy and liable to a term of two years for the conspiracy.

a) If found guilty for both conspiracy and the act, then shall be liable to a term of 6 years without the option of a fine

3. Anyone who makes claims in order to intentionally, wilfully and calculatingly deceives the Board, and by so doing obtains a license, upon conviction is guilty, of an offence and liable to a term of 3 years imprisonment.

4. A person who is not registered as a traditional birth attendant or trainee in the terms of this Act is guilty of an offence if he or she

a. For gain practices as such
b. Physically examines anybody
c. Performs any act of diagnosing, treating or preventing any physical defect, illness or deficiency in respect of a pregnant woman.
d. Prescribes or provides traditional medicine, substance or potions
e. Uses the name of a student or trainee or a traditional birth attendant and maternity care provider to lead persons into believing and by so doing diagnose, treat and prescribe medicines for an expectant mother or provides any other reproductive health care.

15. No traditional birth attendant shall train, use or engage the services of quack nurses in procuring maternity services.

1. Any nurse or orthodox maternity care chosen by the birth attendant must be taken from a pre-approved list of professionals supplied by the board.

2. If for any reason, the birth attendant chooses someone outside the list, the birth attendant must have proof that said person has been certified by the necessary regulation authorities to practice and provide maternity services.

3. Any Traditional or Faith Birth attendant that contravenes section 15 of this Act will be guilty of an offence and liable to a term of 3 years imprisonment.

4. Any person that colludes, plans, agrees with another person or takes part in the contravening of Section 15 shall also be guilty of conspiracy and liable to a term of two years for the conspiracy.

16. Every Traditional Birth Centre where a structure is put up specifically of Traditional Birth attendant, must be inspected and then registered by the Board.

17. All premises used as a Traditional Birth Centre must strictly comply with the provisions of PART A, B, and C of the Schedule of this Act.

18. Every traditional birth centre shall have a prescribed form for registration found in Table 1.1 of the Schedule to this Act.

19. Every traditional birth attendant shall submit a list of trainees/student to the board.

PART V – THE RIGHTS, DUTIES AND OBLIGATIONS OF A WOMAN SEEKING THE SERVICES OF TRADITIONAL BIRTH ATTENDANTS

20. From the commencement of this Act, every expectant mother shall ensure that they attend ante-natal clinic and deliver their baby (ies) at a registered Health Care Provider or a Traditional Birth Centre providing maternity services.

21. All expectant mothers must from the time of knowledge of pregnancy, be registered at a Traditional Birth Centre or Registered Health Care provider.

22. Where an expectant mother is registered at a traditional Birth Centre she must have as an alternative a preferred Health Care provider in the eventuality of an emergency.

23. Every expectant mother shall submit to checks and examinations given by the traditional or faith Birth Attendant in charge.

1. Every expectant mother shall keep the centre appraised of any issues that might affect the pregnancy once it is noticed.

2. The husband of an expectant mother is expected to leave contact information with the Centre.

24. No husband of an expectant mother shall prevent, hinder or do anything to deny an expectant mother from choosing an alternative in Traditional or Faith Birth Centre offering maternity services.

25. No relative of an expectant mother shall prevent, hinder or do anything to deny an expectant mother from choosing an alternative in Traditional or Faith Birth maternity services.

26. In cases of emergency, choice as to preferred procedure exclusively belongs to the expected mother.

1. Where the expectant mother is unable to choose, recourse must be made to her list of preferred choices which she filled in the prescribed form in Table 1.1.

2. Where recourse cannot be made to the prescribed choice, then the husband of the expected mother may make the choice with the interest of the expectant mother as priority.

27. Anyone who violates the provisions of sections 14 and 15 shall be liable upon conviction to a fine of N150, 000 naira.

Where the violation leads to complications in the birthing of the child, the person liable shall;

a. Pay all the hospital bills and any other costs arising from the complication.

b. Be liable to claims of damages arising from the complication upon conviction.

28. Where a death occurs, the Traditional Birth Centre shall report same to the Board within one week of the occurrence.

Failure to report same shall result in a fine of N100,000 and a suspension from practice till the board can properly ascertain cause of death

29. The board shall investigate adequately the cause of death of the expectant mother, to exonerate the Traditional Birth Centre of all claims of negligence.

Where the Board fails to launch a proper inquiry to deaths, they can be held as necessary parties in a suit of negligence.

PART V – LIMITATIONS OF A TRADITIONAL BIRTH ATTENDANT

30. No traditional birth attendant/centre shall with the use of herbs or any other such procedures terminate or cause an abortion of a pregnant woman

A traditional birth attendant may refer all cases of planned abortions to a Health Care provider where after consultation with the pregnant woman, the traditional birth attendant is of the opinion that

a. The continued pregnancy would pose a risk of injury to the woman's physical or mental health, or

b. There exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality.

31. A traditional birth attendant that procures an abortion for a woman and directly contravenes Section 30 of this Act is guilty of a felony and upon conviction liable to a term of 14 years imprisonment with no option of fine.

Any person that agrees, colludes, plans, schemes with a traditional birth attendant to cause a miscarriage or abortion to a pregnant woman is guilty of a felony and upon conviction liable to 14 years imprisonment.

32. A traditional birth attendant shall first submit all herbal preparations made for ingestion to the National Agency for Food, Drug, Administration and Control (NAFDAC) through the Board.

Without prejudice to Section 32, a traditional birth attendant may procure for use already pre-approved preparations by NAFDAC.

33. A traditional birth attendant shall notify the board where a minor or adolescent seeks traditional birth maternity services.

34. A traditional birth attendant shall not prescribe traditional contraceptives to a minor except

1. Where the minor is a married woman
2. with the express permission of parents or guardians.

35. Anyone in contravention of section 29 is guilty of an offence and upon conviction is liable to a fine of N50, 000.

36. A traditional birth Centre shall ensure the privacy and confidentiality of its patients to the exclusion of everyone else.

Where permission is given by the expectant mother, information may be given to any person of choice as stipulated by the expectant mother.

37. All records must be kept by the traditional birth attendant and must be available from time to time for inspection by the Board.

38. Where a person registered by the board, after an inquiry is found guilty of improper or disgraceful conduct that is not compatible with the profession, such a person is liable to the following penalties:

a. A caution or reprimand by the board.

b. Suspension for a particular time from practice.

c. Removal of his or her name from the register.

d. A prescribed fine.

e. Payment of costs incurred as a result of misconduct.

f. Restitution of monies paid by the complainant to the registered practitioner.

39. Where inquiry is done by the board and it appears to the board that the traditional birth attendant is innocent, then the complainant shall:

a) Bear all costs incurred by virtue of the inquiry.
b) Refund all monies lost by the practitioner as a result of the inquiry.

40. Where death occurs as a result of gross negligence, recklessness and disregard for life, upon conviction, the practitioner would be guilty of manslaughter.

a) Recourse shall be made to the appropriate law of the state where a practitioner is guilty of manslaughter as prescribed in Section 40.
b) There may be recourse also to death as a cause of action in order to seek for compensation upon the death of a pregnant woman where it is clear that the death arose as a result of negligence, recklessness or carelessness on the part of the practitioner.

SCHEDULE

PART A

PREMISES

1. Spacious, clean and safe environment
2. Well lit environment
3. Clean and potable water
4. Clean toilets and bathrooms

PART B

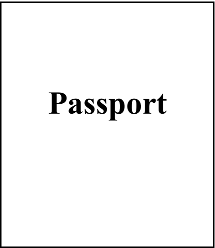
FACILITIES

1. Proper waste disposal
2. Delivery room
3. Recovery rooms

PART C

EQUIPMENT

1. Aprons
2. Surgical gloves
3. Sterilizers
4. Wash hand Basin
5. Mucus extractors
6. Weighing Scale
7. Cotton wool, gauze and clean towels
8. Sterilized forceps.



Forms

TRFA1

Intention to register as a traditional birth attendant

TRADITIONAL MATERNITY PRACTICE CARE REGULATION BOARD. FORM TRFA1	APPLICATION FOR REGISTRATION
ALL NON COMPLIANT APPLICATION WILL BE REJECTED PRINT AND RETURN ORIGINAL FORM TO REGISTRAR IN YOUR STATE	Official use only Date Received: ___________________ Receipt No: ______________________ Amount Paid: ____________________ State/Local Government: __________

Title:

____

First Name:

____

Last name (Surname):

____

Age:

____

Sex:

____

Nationality (specify if more than one):

____

Marital Status:

____

State of Origin:

____

Address:

____

Phone Number(s):

____

Email address (if any)

____

Identity Card No:

____

Primary Education	**Secondary Education**	**Tertiary Education**	**Traditional Birth Training**
Duration	**Duration**	**Duration**	**Duration**
Certificates Awarded	**Certificates Awarded**	**Certificates Awarded**	**Certificates Awarded**

Name of Traditional Birth Centre: ____

Location: ____

Specialty (specify if you also produce herbal preparations):

____

Years of Active Practice:

____

The following shall be submitted in lieu of the application

1. Proof of payment of the registration fee
2. Copy of birth certificate or Affidavit of birth
3. Highest Certification level attained
4. Voters card or National Identification Card or Driver's license or international Passport

I ________________________________hereby certify that all the information and documentation provided and submitted by me are true and correct.

Signature____________________________

Date______________________________

FORM TRFA2

Passport

Student/Trainee Registration Form

TRADITIONAL MATERNITY PRACTICE CARE REGULATION BOARD. FORM TRFA2	STUDENT APPLICATION FOR REGISTRATION
ALL NON COMPLIANT APPLICATION WILL BE REJECTED PRINT AND RETURN ORIGINAL FORM TO REGISTRAR IN YOUR STATE	Official use only Date Received: ___________________ Receipt No: ______________________ Amount Paid: ____________________ State/Local Government: __________

First Name: ____

Last name (Surname): ____

Age: ____

Sex: ____

Nationality: ____

Marital Status: ____

State of Origin: ____

Address: ____

Phone Number(s): ____

Email address (if any): ____

1. Training Institution/ Name of registered trainer: __________________________________

   ____

2. Residential
   Address____
3. Purpose of Application

   ____
4. Kind of skill to be
   Acquired____
5. Have you been accredited or trained before?

Yes	No

6. If yes give details of training ____
7. Duration of training ____
8. Tutor or Trainers qualification ____
9. Contact Details

CONTACT PERSON 1	Title:	
	Full Name:	
	Occupation:	
	Contact No:	
	Cell No:	
	Office Address:	
	Email Address:	
CONTACT	Title:	

PERSON 2	Full Name:	
	Occupation:	
	Contact No:	
	Cell No:	
	Office Address:	
	Email Address:	

The following shall be submitted in lieu of the application

5. Proof of payment of the registration fee
6. Copy of birth certificate or Affidavit of birth
7. Highest Certification level attained
8. Voters card or National Identification Card or Driver's license
9. 2 passport photographs

I ________________________________hereby certify that all the information and documentation provided and submitted by me are true and correct.

Signature____________________________

Date______________________________

Passport

APPLICATION FOR TOXICITY SEARCH WITH NAFDAC

TRADITIONAL MATERNITY PRACTICE CARE REGULATION BOARD. FORM TRFH1	APPLICATION FOR TOXICITY SEARCH
ALL NON COMPLIANT APPLICATIONS WILL BE REJECTED PRINT AND RETURN ORIGINAL FORM TO REGISTRAR IN YOUR STATE	Official use only Date Received: ________________ Receipt No: ___________________ Amount Paid: _________________ State/Local Government: _________

Name of Researcher: ______________________________________

Speciality: ____

TMPCR Registration Number: ______________________________

Name of Preparation/Herbal Medicine: _______________________

Components:

1. ________________

2. ________________

3. ________________

4. ________________

5. ________________

6. ________________

Contact Address: ____

Mobile No: ____

The following shall be submitted in lieu of the application

1. 5 bottles of the herbal medicine
2. TMPCR Registration certificate
3. Receipt of fees
4. Two passport photographs
5. Photographs of preparation steps
6. Local Government Identification Number

I ________________________________hereby certify that all the information and documentation provided and submitted by me are true and correct.

Signature____________________________

Date______________________________

TABLE 1.1

Name of Traditional Birth Centre

EXPECTANT MOTHER REGISTRATION FORM

Name	
Date of Birth	
Address	
Mobile No	
Date of Registration	
Next of Kin	
Contact of Next of Kin	
Husbands Mobile No.	
Emergency Contact	
Expected Due Date	

For official use only	
Preferred Health Care Provider:	
Preferred Alternative Procedure:	
Gestation weeks:	

REPORT OF DEATH

Name of Traditional/Faith Birth Centre

TRADITIONAL MATERNITY PRACTICE CARE REGULATION BOARD. FORM TRFD1	REPORT OF DEATH
PRINT AND RETURN ORIGINAL FORM TO REGISTRAR IN YOUR STATE	Official use only Date Reported: ________________ Cause of Death: _______________ TBC: _________________ State/Local Government: _________

Name of Traditional/Faith Birth Centre

Name of Deceased	
Time of Death	
Cause of Death	
Preferred Procedure	
Name of Next of Kin	

I ______________________________ (senior traditional birth attendant in charge) hereby certify that all the information and documentation provided and submitted by me are true and correct.

Signature_______________________

Date___________________________