Traditional Birth Attendants and Maternal Mortality: A Study of Ohaji Egbema, Imo State, Nigeria.

[1]Ukpabi Monday Chidi and [2]Okpan Samuel .O
[1]Department of Sociology and Anthropology,
Imo State University
Owerri, Imo State, Nigeria

[2]Sociology and Anthropology Department
Evangel University
Okpoto, Ebonyi State, Nigeria
Email: Okpansam@yahoo.com

Abstract

Maternal and newborn morbidity and mortality continue to be a problem with a huge disparity between developed and developing countries. About 99% of maternal and newborn deaths occur in low and middle income countries, globally amounting to about 500 000 maternal deaths and 8 million peri neonatal deaths per year. In this settings Traditional Birth Attendants (TBAs), who are mostly women embedded in the community and its socio-cultural frame with no formal medical training and no connection to the formal health system, play a major role around childbirth. TBAs exist since centuries and still continue to be the major providers of care for families, in poor and remote areas where they assist up to 50 – 80% of deliveries. This paper therefore examine the role Traditional Birth Attendants play in maternal and child health in remote communities in the Ohaji-Egbema Local government and to come out with some policy recommendations that will help in achieving the Millenium Development Goals (MDGs) 4 and5.

Keywords: Traditions, Traditional Birth Attendants, Mortality.

Introduction

Rites, special places, special caretakers and tools for childbirth can be identified back to prehistory of mankind (Beausang 2000). Nowadays Traditional Birth Attendants (TBAs), who are community members with no formal medical training, still continue to provide numerous services around childbirth all over developing countries as traditional practitioners. They are mentioned in literature back to mid 19th century (Lang 2005) and have been involved in national and international health programs since that time, with a peak of interventions in the 1970s and 1980s. The enthusiasm declined in the 1990s with a debate on their cost-effectiveness and the missing impact of TBAs training to reduce maternal mortality. Data from the World Health Organization (Proportions of births attended by a skilled health worker WHO 2008) show, that worldwide 34%

of births, i.e. 45 million births, occur at home assisted by a TBA or family member or nobody at all. This scenario we find especially in developing, poor and remote areas. In some countries (Afghanistan, Bangladesh, Chad, Ethiopia, Laos, Mali, Nepal, Niger, Timor-Leste, Yemen) around 80% and even more of all births take place outside of the medical system. At the same time, these settings account for the highest number of morbidity and mortality of mothers and newborns worldwide.

The choice of mothers, not to have medical care by a Skilled Birth Attendant (SBA) for herself and her newborn, might be due to cultural beliefs, transport/mobility restrictions or financial barriers or simply by the fact, that access to the health system is limited because it cannot provide sufficient numbers of SBA and services (WHO Annual report 2007, 2008; UNFPA Towards MDG 5, 2006; WHO World Health Statistics 2008, 2008). From a public health view, it might therefore be crucial to rethink about the potential of TBAs to provide care, where the public health system is not able to scale-up human resources and make services/infrastructure available in future and to identify further need for research and interventions to improve the performance of TBAs. There is a broad spectrum of policies, descriptive literature and various analytical studies on TBA, as well as reviews and meta-analysis which are mostly about their effectiveness. However debate could not find a common ground so far and opinions and results on the impact of TBAs activities on maternal and newborn health continue to be conflicting. The aim of this paper is to identify factors sustaining the prevalence of TBA and existing roles of TBAs in Ohaji-Egbema Local Government Area's maternal and child health. A special focus was to identify the significant impact their roles have on the health of pregnant women and their newborns.

Conceptualisation of Key Concepts

Maternal Health: Maternal and child health refers to the promotive, preventive, curative and rehabilitative health care of mother and children. It also includes the subareas of maternal health, child health, family planning etc. Pregnancy is the vital event in the life of a woman. It needs special attention from the time of conception to the postnatal stage. Safe motherhood programme aims to prevent pregnancy related deaths and disability. The period of pregnancy extend from the

time of conception to 42days after delivery. During this period the progress is not the same therefore the total period of pregnancy is divided into three periods namely the antenatal, intra-natal and the postnatal periods. Each period has its own special features and specific risks. Antenatal provides care to the pregnant woman with the aim of ensuring maternal and foetal wellbeing. The safe motherhood programme aimed at achieving a maternal mortality rate of 2/1000 live births by 2000AD. On the other hand, Intra-natal care starts from starting of labour to delivery of the placenta. Its objectives are the conduct of aseptic delivery, watch for complications during labour, timely referral if complications arise and care of the baby at delivery. Personnel involved in intra natal care should be given under the watchful supervision of Doctors, Nurses, Midwives or trained Female health workers (Skilled Attendants). Postnatal care is the care of the mother and new born after delivery. Its components are to watch for complications in the post natal period that are likely to arise, Puerperal sepsis, thrombophlebitis, secondary haemorrhage due to retained placenta, urinary tract infections, breast abscess (Rahim, 2008). Skilled attendance is defined as the process by which a woman is provided with adequate care during labour, delivery and postpartum period and requires both a skilled attendant and an enabling environment. Skilled attendant refers exclusively to people with midwifery skills for example Doctors, Midwives and Nurses who have been trained to proficiency in the skills necessary to manage normal deliveries, diagnose, manage or refer complications. It is noted that the higher the proportion of deliveries attended by skilled attendants in a country the lower the country's maternal mortality ratio (Sibley, 2006). Therefore every pregnancy should culminate in healthy mother and healthy baby. We need to ensure that all women have access to high quality essential and emergency obstetric service along with provision for safe abortion and contraceptive services to reduce mortality due to unplanned pregnancies.

Traditional Birth Attendants: Traditional birth attendants provide the majority of primary maternity care in many developing countries, and may function within specific communities in developed countries. They provide basic health care, support, advice during and after pregnancy and childbirth, based primarily on experience and knowledge acquired informally through the traditions and practices of the communities where they originated (WHO, 2010). TBAs may not receive formal education and training in health care provision, and there are no specific

professional requisites such as certification or licensure. They often learn their trade through apprenticeship or self-taught. In many communities one of the criteria for being accepted as a TBA by clients is experience as a mother. Many TBAs are also herbalists, or other traditional healers. Sometimes they serve as a bridge between the community and the formal health system. Traditional birth attendants are often older women, almost past or close to menopause, young adults and men who must have borne one or more children themselves and are respected in their communities. They consider themselves as private health care practitioners who respond to requests for service. The focus of their work is to assist women during delivery and post-partum. According to (WHO 1992), traditional birth attendant is defined as a person who assists the mother during child birth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants. But in the contest of this paper and what is obtainable in Nigeria, a traditional birth attendant is a person (man or woman) who assists the mother or serves as an apprentice to other TBAs, during delivery, and must have acquired his or her knowledge and experience in delivery and is capable of delivering babies without assistance. They live in the community in which they practice and they are respected in that community. They operate mainly in a relatively restricted zones always limited to their own community and sometimes those close to them. Their roles include everything connected with the conduct of childbirth and this is where they hold most power and authority. Many of their beliefs and practices pertaining to the reproductive cycle are dependent upon religion or mystic sanctions. They are reinforced by rituals that are performed with traditional ceremonies which are intended to maintain the balance between the absence of ill health and state of ill health.

Due to the lack of education in some TBAs, the way many attended the delivery is risky for women and their babies, leading to poor health outcomes and even death (Mrisho., Schellenberg., Mushi., Obrist., Mshinda., Tanner., & Schellenberg, 2007). There are various types of traditional birth attendants, they are, trained TBAs, untrained TBAs, family TBAs, Full-time TBAs, Part time TBAs, TBA/Herbalists and Spiritualists. The traditional birth attendants make great impact in the rural community, they are very close to the people and the rural women believe and have trust on them so much that they cannot be easily abolished in the community. To this effect, measures

should be carried out to improve their skills for example health educating them, training, organizing seminars and the need for referral of complicated cases and at risk mothers.

Theoretical Framework

Two theoretical platforms, Conflict and Political Economy, complement each other as the anchoring point of this studyWhile Talcott Parsons' (1951) work on the sick role gave medical sociology a place in mainstream sociology, it was the work of Eliot Freidson (1952–2005) that gave medical sociology its critical dimension. 'Profession of Medicine' published in 1970 defined the boundaries of medical sociology, suggesting how sociological perspectives on the practice and profession of medicine as well as on health and illness could be examined.

By introducing a conflict perspective to the study of medicine and taking patients' perspectives seriously, the claims of the then powerful medical profession were interrogated. Freidson advocated a distinctive kind of medical sociology that applied structural perspectives to medical institutions and yet remained 'detached from medicine's own viewpoints and assumptions' (Conrad, 2007: 142).

Whereas structural functionalism views social hierarchy as a necessary, functional feature of a complex society wherein a universal value consensus ensures stability and social order, conflict theorists view competition between groups for scarce resources as the characteristic nature of social relationships. Social structures mean that access to resources is inherently unequal and those who benefit from the inequality will seek to maintain the hierarchy, and so conflict theorists anticipate that social change will occur through revolution rather than evolution. Blaxter (2004: 95) points out that conflict theory focuses attention on sources of ill health in the economic environment and on the competition of rival interests in the healthcare sector, and hence are preoccupied with the relationship between medicine and society. She suggests that this preoccupation has distracted research interest from the broader issue of the relationship between health and society. Political economy approaches to health have the class struggle for resources at the centre of analysis, and the influence of the approach has informed understandings of other social divisions as similarly conflict driven.

Analysis of the medical division of labour and iniquitous patients' outcomes in racialized groups interrogates another system of privilege and power. While analyses that include class, gender and racism in a single analytic framework are an ideal, the tendency to collapse all systems of inequality back to a class based understanding of power and inequality derives from the influence of the political economy approach to health. A political economy approach emphasizes that under capitalism a person's relationship to the means of production is central to understanding not only their position in the hierarchy, but also their prospects of wealth and health. The political economy which delineates members of society conditions the type and form of health care the members of a particular society may opt for, in most rural certain such as Ohaji/Egbema the people are mostly rural farmers with low income which are usually unable to afford the cost of western medical service thereby opt for the traditional methods which they perceive to be more affordable. Traditional birth attendants in some cases render their services without charge whereas the hospital will require the pregnant mother makes a certain deposit even before being admitted into the hospital, as we know capitalism is faceless. Political economists of health describe how capitalism's relentless pursuit of profit is regularly in direct contradiction to workers' health and how medicine is entangled in the capitalist system through its statutory roles and its relationships with a range of industries. Under highly developed (or late) capitalism, where all dimensions of life are dominated by the unregulated market, the welfare state and national health service is left with the unenviable and, by definition, impossible job of solving the health problems created by the pursuit of profit. However, the theory could be criticize for not taking into consideration social cultural believes and practices of a people which in any case do influence their choice of medical service, they believe system may construed society from seeking western medicine not on the bases of cost but as a matter of tradition.

Review of Literature on the Nexus between Traditional Birth Attendance Roles and Maternal Mortality

Maternal mortality is an indicator of state of maternal health services, state of women, women's health and above all the development of a nation. Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes while maternal

mortality rate is defined internationally as the maternal death rate per 100,000 live births (WHO 1993). A late maternal death is the death of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of pregnancy. A pregnancy related death is death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the cause of death. Maternal mortality is divided into two major groups' namely direct and indirect obstetric death. Direct Obstetric Deaths results from obstetric complications of the pregnant state that is during pregnancy, labour and purperium. Most maternal deaths are related to obstetric complications like haemorrhage, sepsis, eclampsia, prolonged or obstructed labour and complications of abortion. Indirect Obstetric Deaths result from previous existing disease(s) that developed during pregnancy which were not due to obstetric causes, but was aggravated by physiological effect of pregnancy, example anaemia, HIV/AIDS and cardiovascular diseases, malaria to mention but a few (United Nation,1995). However, other predisposing factors to maternal mortality are ignorance, low socio-economic status, illiteracy, age and parity. Socio-economic and cultural factors had been documented to influence maternal mortality. This is dependent on the ability of the woman to command resources and make independent decision about her fertility. Where women are afforded a low status in the society, their health needs are often neglected and existing health facilities may not be accessed when in need. Illiteracy, social cultural barriers, to seek care at the time of emergency, acceptance of death as wish of God and concern that only female health care providers should attend to women's reproductive systems had also been implicated for maternal death (Castello, & Azad 2006). The risk of dying in pregnancy also depends on the number of pregnancies a woman had in her life time. The higher the number of pregnancies, the greater the risk of pregnancy related death.

Brief Overview of Roles of Traditional Birth Attendants in Nigeria

The most prominent argument as to how TBAs have been so beneficial to pregnant women in Nigeria centers on economic reason. Evidence has shown that out of pocket expenditure in poorest countries (Nigeria inclusive), is two to three times the total expenditure of government and irrational demand, commercial exploitation or defensive medicine are not unusual (World Health Report 2005). A study conducted by Imogie (2000) in Edo state of Nigeria, indicated that TBA-

provided maternal health services is free from inhibiting factors of prohibitive hospital fees, illegal fees and bribery.

The position of Imogie (2000) regarding cost is supported by a study in Bangladesh by Murakam (2003). In the study, report of interviews and various discussions with 60 women who had given birth in the last 3 months; 48 of their husbands; and 43 mother-in-laws, was analyzed. It was that TBA-provided maternal health service was selected by the respondents because of low cost. TBAs are sources of succor to pregnant women because their services are financially affordable unlike the orthodox medical services (Isenalumbe 1990). Financial affordability of TBA-provided maternal health care illustrates how popular the services are to pregnant women; therefore providing an easy access for the patronage of TBA-provided maternal health services.

Because TBAs are people mostly known in their communities and live in the communities where they practice (Itina 1997), it could be possible for the TBAs to have close proximity to the people whom they provide health care access. A qualitative study of delivery care services in West Java Province of Indonesia conducted in 2010 asserts that there are three main barriers to accessing modern maternal health care. The barriers are: physical distance, time and availability of care providers (Titaley, Hunter, Dibley, & Heywood, 2010). According to another study conducted on primary health care use among Nigerian rural population, it is stated that rural populations in Nigeria are underserved resulting into insufficient number of medical facilities and personnel. Rural population is now therefore unable to access modern health care. As a result of difficult access to healthcare personnel due to: high rate of absenteeism which occurs when health workers decide to seek greener pasture in terms of increased salary; and long distance to a health facility (Titaley, Hunter, Dibley ,& Heywood 2010,), women are dissuaded from accessing modern healthcare.

Furthermore, studies show that pregnant women believe that there are better accesses to TBAs compared to modern healthcare provider because of physical proximity that TBA services could offer as against modern health care which are not evenly spread in the rural areas (Imogie 2002, Titaley *et al* 2010). According to a paper presented at the 6th African population conference in

Burkina Faso, accessible distance and utilization of maternal health facilities decreases as the distance increases. This could translate to a fact that distances from health facilities are linked with utilization of maternal health services (Omotor 2011), hence, the extent to which modern maternal health care has been to the door step of rural people in Nigeria is low (Ayowumi 'nd'). Since pregnant women especially the ones in rural Nigeria do not have access to health facility (Titaley *et al* 2010,), TBA-provided maternal health services serve as a source of pregnancy care and child birth. For the notion that TBAs are accessible when they are needed, TBA-assisted maternal health services are endeared into the heart of the populace thereby ensuring social support from TBAs to pregnant women; moreover, among a sampled population of TBA users in a rural area in Nigeria, 52.4% of users asserts TBAs provide compassionate care (Ebuehi & Akintujoye 2012) thereby ensuring the basis for cultural affinity between TBAs and pregnant women. Another important reason for the benefit of TBA-assisted maternal care is seen to be culturally relative.

The modern maternal healthcare so stated has not been in tune with the culture of the people. Jordan (1987) asserts that formal maternal health care services that exist is more likely to focus on medicalised view of child birth. He further states that this conflicts with and is at times antagonistic to the more traditional view that childbirth, been a natural event is best managed by family and community people (Jordan 1987). Evidence shows that modern maternal healthcare is not so much in parallel with socio-cultural reality of pregnant women in Nigeria as this is evident in the fact that TBAs are part and parcel of rural areas of Nigeria (Itina 1997, Imogie 2000). Over a long period of time, it has been shown that Nigerian women have had to rely on TBAs for assistance and advice during pregnancy because their services are seen to be culturally acceptable (Okafor & Rizzuto 1994, Babalola & Fatusi 2009, Ebuehi & Akintujoye 2012).

Even beyond the shores of Nigeria, a study in Afar Regional State of Ethiopia asserts that TBA provided maternal health care is very popular with the sampled population, because TBAs provide social support, cultural competence and psychosocial supports for the mothers and babies (Yousuf, Mulatu, Nigatu, & Seyum 2010). Also, to be noted is the notion that childbirth, been a natural phenomena, should be welcomed by a pregnant woman's kin and kith and such occasions are better handled by people who are culturally-acceptable and viewed as expert in child delivery and who

are not far from the place of abode of the pregnant woman, because of the need for convenience of home delivery (Isenalumbe 1990).

Despite the affordability, accessibility and cultural acceptability of TBA-provided maternal health care, which is further enhanced by its high patronage, evidence has shown that many of its practices have been shown to have an adverse effect on the health of mothers unlike the modern healthcare (Imogie 2000). When analyzing the cost-benefit importance of TBA-provided maternal health care, one should examine its impact on mothers and newborns. One problem is that TBA services have provided pregnant women and the community at large with acts that can potentially lead to an increase in maternal mortality. There is evidence that TBA-provided maternal health care has negative impacts on maternal health. A descriptive study undertaken as part of a preliminary part of safe motherhood campaign in Akwa-Ibom state of Nigeria, posits that 72% of maternal mortality occurred among women who were either registered for hospital antenatal care or were registered but nevertheless attempted deliveries with TBAs (Itina 1997). The growing link between maternal mortality and TBA-provided maternal care has resulted in a number of studies. Researchers have revealed that TBA-provided maternal health care has not proven to reduce maternal mortality and in many cases, it increases vulnerability of pregnant women and or their newly-born to infections (Ofili & Okojie 2005).

It is important to recognize the correlation between accessibility of TBA-provided maternal health care on one hand and accessibility to modern maternal health facility on the other hand. Studies have proven that some pregnant women would still patronize TBAs even if and when modern health facility is at their door step (Imogie 2000, Titaley *et al* 2010). These studies suggest that accessibility can be explained in so many ways than physical proximity alone. In a country like Bangladesh, that has seen considerable rise in investment in maternal healthcare in recent time, its healthcare facilities has been made more accessible (Population Action International 2010), yet evidence shows that TBAs are still very much prevalent (Rowen, Prata & Passano, 2009). TBAs are accessible not simply because they are beneficial to pregnant women but due to the conditions over which pregnant women have no control.

The accessibility of TBA-provided maternal health care is not an end in itself but a response to a failed modern maternal health care system in Nigeria. Access and utilization of quality health services is debatable as a result of a weak primary health care system coupled with constrained health resources (UNICEF nd). Hence, less than 20% of health care facilities in Nigeria offer emergency obstetric care for women and only about 35 per cent of deliveries are attended by skilled birth attendants (UNICEF nd). Evidence suggests that the environment that societies create for these women subject the women into poor reproductive health and unsafe motherhood (World Health Report 2005). This unsafe motherhood is mostly prominent in rural areas (Aguilar, Kintanar, & Tiampo 1999). Rural areas usually lack adequate medical facilities coupled with no adequate number of medical personnel that are trained in modern medicine and midwifery (Aguilar Kintanar, & Tiampo 1999). This unsafe motherhood occurs before a pregnancy occurs and is further made worse once pregnancy and child bearing have begun simply because of health system constraints (Garg *et al* 2006). Therefore, patronage of TBA-provided maternal health care by pregnant women is in response to the failed health system which is more pronounced in the health inequity suffered by women. Although, there has been some increase in health system expansion in Nigeria, yet only 39% of births are assisted by a skilled health care provider while just 35% are delivered in health facilities (National Population Commission (NPC) and ICF Macro 2009). The difficulties women face in accessing health facility may seem to have led many into having distrust for modern maternal health care hence a reliance on maternal health care as provided by TBAs. While these feelings of distrust for modern maternal healthcare persist, it has come to be seen as an established view that now makes TBA-provided healthcare seem more to be traditionally in tune with cultures of the society.

However, that a lot of women patronize TBAs is deeply rooted in the adverse socio-cultural and economic environments of the society. That TBA-provided maternal health care is traditionally appropriate and culturally regarded as been provided by experts does not mean that TBAs are knowledgeable enough to be regarded as experts in maternal health care provision. Among a sampled population of TBA users, 34.4% as against 3.2% believe that TBAs are not knowledgeable enough to cope with complications and or adverse effects of child birth in women (Imogie 2000). Further evidence also shows there seems to be consensus that TBAs are generally

not able to handle most potentially fatal complications (Bergstrom & Goodburn 2001, Itina 1997). A typical TBA is an illiterate (WHO 1986, Imogie 2000, Ofili & Okojie 2005, Titaley 2010) and may lack the potential to recognize birth complication. Therefore, TBA-provided maternal health services are unsafe to health of mothers and their babies and neither has it contributed to decrease in maternal mortality (Ofili & Okojie 2005).

Although, TBA-provided maternal health care may not have been significantly proven to reduce maternal mortality, however the services have been established to improve maternal outcome such as screening at risk mothers and providing family planning information for pregnant women (Yousuf *et al* 2010, Evidence Update 2010). A prospective study in Nigeria studied changes in maternal mortality rate following trainings of 75 TBAs within a 10 mile radius of a referral hospital. The result of the study asserts that maternal deaths dropped by 50% (30 t0 15) in 3 years following the training (Brennan 1989 cited in Bergstrom & Goodburn 2001). Training TBAs may therefore enhance their potentials in reducing the high number of maternal mortality.

However, a review of evidence by Bergstrom and Goodburn (2001) asserts that training programmes for TBAs are grossly expensive that the government of less developed countries cannot afford to shoulder the cost in a sustainable manner (Bergstrom and Goodburn, 2001). Furthermore, a meta-analysis review by Cochrane asserts that there remains insufficient evidence to establish the potentials of TBAs to reduce perinatal mortality; and reported evidence that have associated a link between TBAs and reduction in maternal mortality are said to be mixed with methodological flaws and inconclusive findings (Sibley *et al* 2012). Hence, this paper is focused towards identifying factors sustaining the prevalence of TBA and existing roles of TBAs in Ohaji-Egbema Local Government Area's maternal and child health.

Materials and Methods

The study was carried out in Ohaji-Egbema, Imo State, Nigeria, in 2016. It adopted a cross sectional survey design. According to 2006 National Population figure, the area covering Ohaji-Egbema has a total population of 182,538. The target population for this study were adults male

and female aged 18 years and above. The multi stage sampling method that involves successive random sampling was employed in selecting communities, households and respondents in the study. The multi – stage design was very relevant because the study population was very large and made up of several clusters like towns, streets, and households.

The multi – stage sampling technique made up of cluster, simple random sampling, and systematic sampling techniques were adopted in selecting the sample for the study. First Imo state was clustered into three senatorial districts. Then using the random sampling technique, Orlu senatorial district was selected. The LGAs in the selected cluster were numbered and then with the application of the simple random sampling technique, one LGA was selected – Ohaji-Egbema. This was done by first numbering all the elements in the sampling frame out of which the above named LGA was selected through the balloting method. Furthermore, the communities in Ohaji-Egbema were numbered and through the aid of the balloting method of simple random sampling technique, five communities were selected namely Ilie, Umuokanne, Umuagwo, Oloshi, Umuapu, autonomous community respectively. Then the villages in the selected five autonomous communities were numbered and through the balloting method of the simple random sampling technique one village was selected from each of the five autonomous communities namely; Ubeke, Umuobogwo, Umuezenwere, Oforola and Umualum villagess respectively. Finally, households in the selected streets were numbered and the systematic sampling technique was employed to select every Kth household in the sampling frame from which an adult was selected as a respondent for the study. The sequence continued until a total of three hundred and ten were drawn from the streets. However, only persons of 18 years and above were allowed to participate.

A sample size of (310) was selected using the Fishers, Laing, Stockel, and Townsend (1998) statistical formula and was used for the study and the major instrument for collecting data was questionnaire. A uniform set of questionnaires validated were administered to all the respondents. The researcher got approval from the respondents before administering the questionnaires. Quantitative methodologies are complemented with qualitative work, including in-depth interviews with TBAs, medical professionals, NGOs and opinion leaders. Some focus group discussions were also organized among women who were attended to by TBAs on their views on

the work of TBAs. Four sessions of In-depth interview (IDI) were conducted with four female TBAs, purposively selected based on their knowledge of the subject matter, two medical nurses and director of an NGO that specialized on Women Reproductive Health Rights. The interviewees gave their consent before the in-depth interviews were conducted.

Data Analysis

Out of the (310) questionnaires distributed, (256) were correctly filled and returned, giving a response rate of 96 percent. Data were analyzed using Statistical Package for Social Sciences (SPSS). Descriptive statistics such as frequencies and percentages were used to analyze the quantitative data. For the qualitative data, in-depth interviews were subjected to manual content analysis. However, illustrative quotes were identified and organized under distinct themes.

Results

Socio-demographic Attributes of Respondents

This section presents the socio- demographic attributes of the respondents. The attributes are age, gender, marital status and educational qualification of respondents.

Socio – Demographic characteristic	***Frequency (F)***	***Percentage (%)***
Age		
18 – 28	16	6.3

29 – 39	18	7.0
40 – 50	44	17.1
Above 50	178	69.5
Total	**256**	**100**
Gender		
Male	21	8.2
Female	235	91.7
Total	**256**	**100.0**
Marital Status		
Single	59	23.0
Married	109	41.8
Widowed	88	34.4
Total	**256**	**100.0**
Educational qualification		
Primary	76	29.6
Secondary	161	62.9
NCE/OND/ HND	7	2.7
University degree or higher	12	4.7
Total	**256**	**100.0**

Source: Field Survey 2016

Table 1 clearly indicates that majority (69.5%), of respondents were aged 50 and above and that while (91.7%) of the respondents are females. The number of female respondents who participated in the study outweighs the male respondents because many of the males who declined to participate felt it was a female issue. In terms of marital status, most of the respondents are married (41.8%). The educational qualification of the respondents' shows that majority of them have secondary education (62.9%), while 29.6% of them have primary school.

Figure 1: Distribution of Respondents on why they utilize TBA

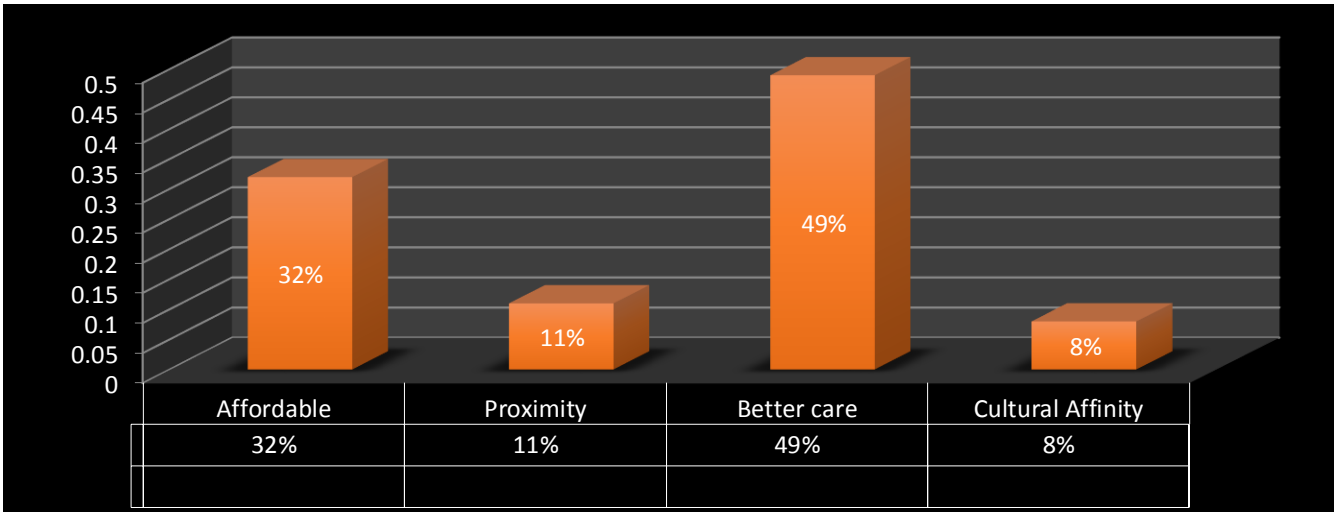

Figure 1 above shows the distribution of respondents on why they patronize TBA's within the community. Majority (49%) of the respondents are of the view that they utilize TBA's service because they render better care to them during child birth. (32%) of respondents are of the view that they utilize TBA because they are more affordable than orthodox TBA services. A few (11%) suggested that it is because of their proximity as most of TBA providers reside within the village. This means that a very high percentage of respondents are of the view that traditional birth attendance provide them with better care during child birth. However, results from the in-depth interviews conducted show contradicting responses from the respondents on why they utilize TBA's services. One of the female respondents interviewed described TBA as follows:

> *Traditional birth attendants treat the pregnant women with a sense of community and family member, "you see they will pamper, pet and even pray for the women in labour, tell me which nurse that has such time." Their services are not only affordable as in some cases they are family members but they also stay very close so you don't need to start looking for means of transportation to take a pregnant women to hospital during labour at mid- night. (Female, 32 years, Farmer).*

However, another respondent refuted this assertion arguing that:

> *It is penny wise pound foolish, she stated that they spend small at the short run and spend huge at the long run especially when there is a complication which usually force them to hospitals. (Female, 25 years, Nurse)*

Figure 2: Distribution of Respondents on the extent skilled TBA's are accessible in orthodox Health Centres

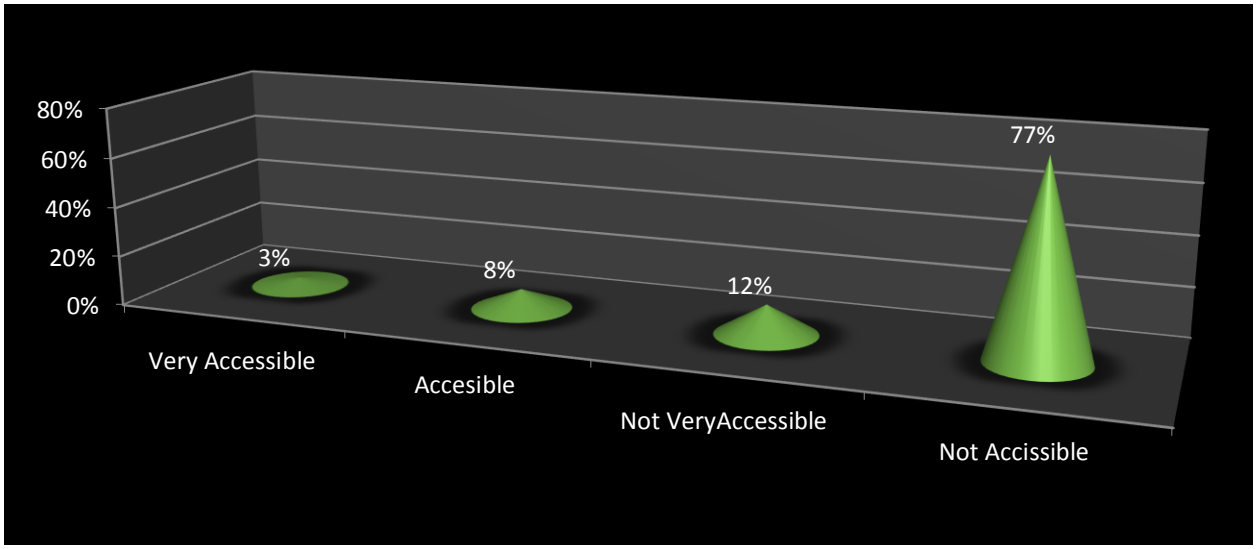

Figure 2 shows the distribution of respondent on extent skilled TBA practitioners are accessible to pregnant women within the communities. Findings reveal that majority of the respondents are of the view that skilled TBA practitioners (77%) are not accessible within the study area. However, only (3%) said they are very accessible within the study area.

This is in agreement with the view from in-depth interview respondent who elaborated thus:

> *We don't even have a functional general hospital within the LGA not to talk of our community. The governor during his first term commenced the construction of general hospitals within the LGA, but till date it is yet to be completed. The health centres are mere buildings without any medical equipment or personal so you don't even think of going there except you wish to die. It is not just accessible when you also consider the cost of attending to some of these private clinics, hmmm they will cut your head with their bill.*
> *(Female, 32 years, Farmer)*

Another respondent agreed with the view above when she stated that

> *It is not accessible, they don't have doctors and is also too far as one will have to travel to Owerri to be sure of getting such services and due to the large number you may not even be attended to on the day you came. Do you know a pregnant women can die due to their lack of doctors and equipments. So why taking the risk when you have*

a TBA available. (Female, 23 years, Trader)

Figure 3: Distribution of Respondents on if their aware of the risk associated with TBA's

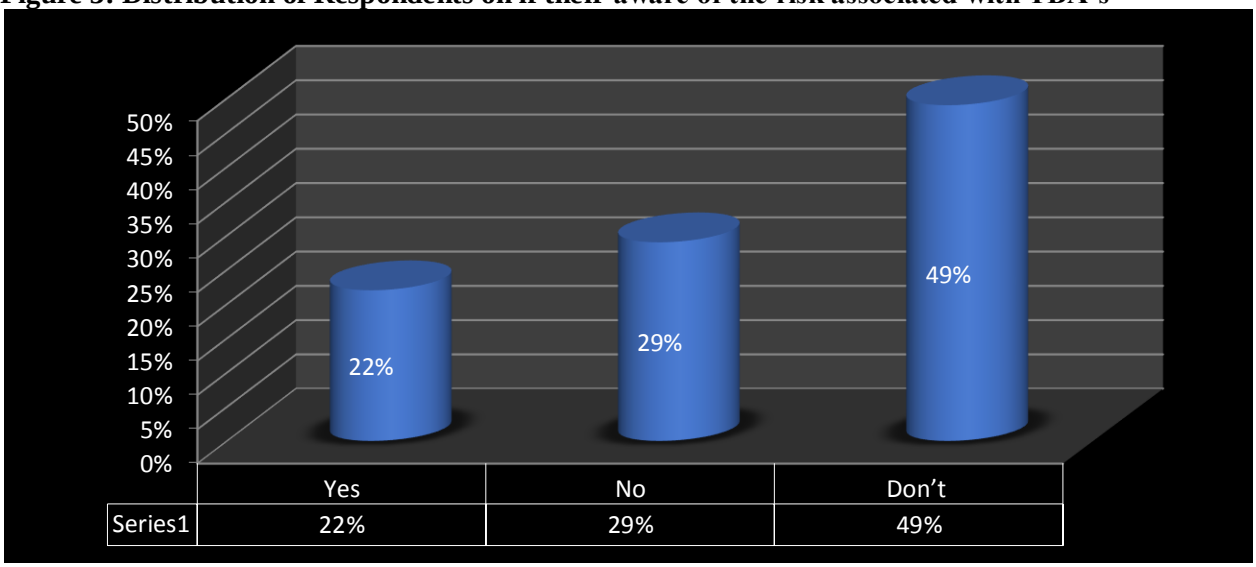

Figure 3 above shows the distribution of the respondents on if their aware of the risk associated with TBA. Overwhelming majority of the respondents (49%) maintained that they don't know if there are any risks associated with TBA within the study area. While only (22%) are aware of the fact that they are risk associated with TBA utilization in the study area.

An In – depth interviewee stated thus;

Am not aware of any risk, my mum thought me this trade and her mum thought her it has been the profession of our family right from origin so I do it well. For me nothing like complication, what do you even mean by death, (it was explained as risk such as bleeding, irregular shaped baby etc,). (loughs at the explanation). Go and ask them nobody I attended to has ever had such, they eat well and it does not happen to them. (Female, 69 years, TBA practitioner)

However another respondent has a contrary view;

Let me inform you, when you ask them such question they will never agree to it because is a threat to their trade they will rather conceal the truth so as to sustaining their profession. It is only when it has gotten

out of hand they will scamper soliciting for assistance from us. In some cases either the baby will die or the mum while sometimes both. In fact I don't know why they are still been utilized in this 21st century. (Female, 29 years, Nurse)

Figure 4: Distribution of Respondents on if their aware that TBA could lead to high mortality rate.

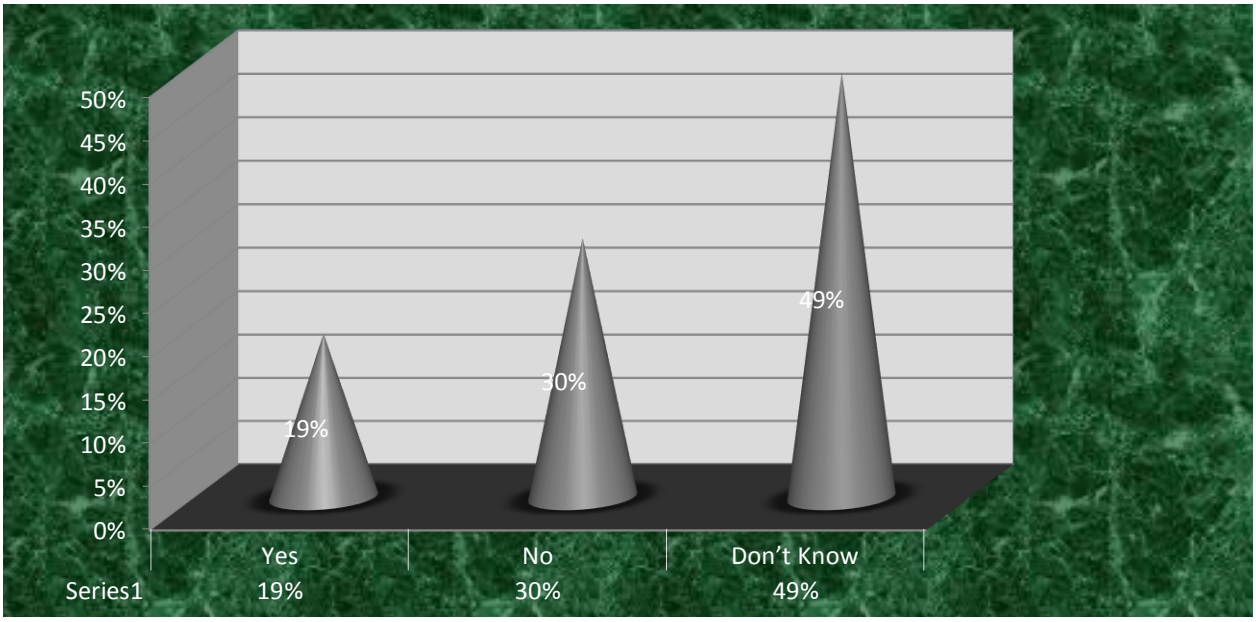

Figure 4 above shows if the respondents are aware that TBA could lead to high mortality rate within the study area. Findings reveal that majority of the respondents are of the view that they don't know (49%) that TBA could lead to high mortality. However, (30%), said they are aware it could lead to high level of mortality. One of the In –depth interviewee responded thus;

Like I told you before we don't kill people we only deliver them Of their babies. There is no mortality not to talk of high one. Am A professional. Biko (please) stop this kind of question is not good. You can even scare some pregnant women. Ask around all these children you see running around were delivered by us.(Female, 62 years, TBA practitioner)

However there is a contradiction to this view;

Don't mind these illiterate women, do they keep records even. The problem is that their not adequately informed about this practice, our organization is making frantic efforts to enlighten them. It has

led to unnecessary death and complications it has to stop.

Conclusion

Despite the efforts of the Government to provide quality health programmes with the establishment of safe motherhood and other laudable systems, some pregnant women still patronize traditional birth attendants in the state. TBAs are readily economically and physically accessible in the communities but are not without limitations. They may not be very aware of danger signs and may not refer at risk mothers. This may have led to increase in maternal mortality in our communities and nation.

Recommendations

The effort to increase access to trained birth attendants which was initiated by World Health Organization, through the launching of the Safe Motherhood Initiative, which aimed at ensuring women have a safe pregnancy and childbirth should be strengthened. Attention to maternal health which was demonstrated in 2000 when 147 heads of state and government and a total of 189 nations in total signed the Millennium Declaration, in which the proportion of births assisted by trained birth attendants became an important indicator to measure the progress of improving maternal health, should be maintained.

- The cost of orthodox medicine was in addition to indifferent care attitude towards the patience by the care provides as factors that compel pregnant women to patronize TBA, efforts should therefore be made to include most rural dwells on the national health insurance scheme so as to reduce cost for them, meanwhile care givers needs to be retrained towards human feelings.
- A partnership initiative should be put in place by involving health professionals and traditional birth attendants through improving Maternal Health Programme, under this scheme the midwives and traditional birth attendants were expected to work together.
- Different strategies be carried out to improve community awareness and utilization of the health professionals in addition to the traditional birth attendant. Efforts to strengthen the partnership program would appear to be a beneficial intervention.

- Advocacy, dissemination, and monitoring of activities of the TBAs should be carried out regularly. Local stakeholders, such as community leaders and full community participation should be encouraged to develop this program.

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