FACTORS INFLUENCING UTILISATION OF TRADITIONAL BIRTH ATTENDANTS' SERVICES BY PREGNANT WOMEN AND NURSING MOTHERS IN IKOLE LGA OF EKITI STATE, NIGERIA

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ABSTRACT

Women and children die everyday from the scourge of maternal and infant/ mortality due to the poor primary health care system in most rural communities and as such, this study intends to explore factors influencing utilisation of traditional birth attendants' services by pregnant women and nursing mothers with children ≤ 5 years old in Ikole LGA of Ekiti State, Nigeria in a typical rural Yoruba community. A descriptive research design was employed for the study, using both quantitative and qualitative methods of data collection. The sample size was selected through random sampling technique and a total of 250 questionnaires were distributed to the pregnant women and mothers with children ≤ 5 years old, who were currently attending antenatal and/or postnatal with TBAs and were resident in the Ikole Local Government Area. 25 TBAs were interviewed in five selected communities in Ikole Local Government Area of Ekiti State for the study.

Findings revealed that majority of the pregnant women and nursing mothers had exclusively utilized TBAs facility while only. Consequently, the outcome of the study indicates that some women resort to TBAs assistance for spiritual reasons. Generally, the TBAs should be given more training to be aware that they are not "illegal," so that their work does not go underground and becomes dangerous. There should be an integration of TBAs and the health centres as it is practiced in China to deal with the spiritual aspect of health care delivery which makes many people patronize TBAs.

Key Words: Traditional Birth Attendant, Utilization, Socio-Cultural, Maternal health, Child Health, Ikole.

Word Count: 245

Background:

A Traditional Birth Attendant (TBAs), also known as a traditional midwife, community midwife or lay midwife, is a pregnancy and childbirth care provider. Traditional Birth Attendants provide the majority of primary maternity care in many developing countries, and may function within specific communities in developed countries (Aletor, 2007).

According to Goodburn (2001), throughout history, Traditional Birth Attendants have been the main health care providers for women during childbirth in Africa. They attend to the majority of deliveries in rural areas of developing countries. There is little doubt that they have a significant role when it comes to cultural competence, consolation, empathy and psychosocial support during pregnancy and labour, with important benefits for the mother and the newborn child (Smith JB; Edward and Gideon, 2000). It is now estimated that 85% of developing countries have some form of Traditional Birth Attendants training to enable them provide better maternal health services, thereby reduces maternal and infant mortality (Chana H, Schwab L, Foster L, 2012). Maternal and child healthcare system is an important segment of medical system in every society. This is as a result of large number of human population involved in this health sector, coupled with the significance of this group to the overall substance of human population (Ajala, 2011).

Specifically, writers have exposed the risk of childbearing and child health care in their various writings and research findings. The works of Owumi (1996) and Oke (1993 and 1996) are very significant in this respect. All these works and the annual reports of World Health Organisation (WHO) and UNICEF since 1970s show that there is high maternal and child mortality and morbidity especially in Nigeria in which the large population dwell in rural areas where there are little or no modern health care services.

Access to Traditional Birth Attendants services is determined by a variety of factors, including their availability within a reasonable distance and their affordability. The extent to which available services are utilized may also depend on perception of their quality, the availability of alternative options for health care, such as traditional healers or the purchase of drugs from the informal market and cultural factors (Abbas and Walker, Habib and Vaughan, 1986).

In many African countries, the intervention of Traditional Birth Attendants has been a key strategy to improving maternal and child health care. However, recent analyses (Sibley, L., Sipe, T. and Koblinsky, M. 2004) have concluded that the impact of training Traditional birth attendants on maternal and child health is low. An emphasis on large scale Traditional Birth Attendants training efforts could also be counterproductive, as it will hold back the training of the necessary numbers of medium level providers, particularly midwives.

The Problem:

Nigeria as a nation is blessed with both human and natural resources, yet women and children die everyday from the scourge of maternal and infant mortality (Ajala 2011). In Nigeria, one in every eight women dies while giving birth. Most of these deaths are avoidable as compared to the United States of America where only one in 4,800 obtains (Olusoga, 2010). Pregnancy which ordinarily should be a thing of joy is now a death warrant for most women due to the weak and poor primary health care system and less qualified staff in most rural communities. In the urban areas where some good health services are available they are too expensive or reaching them is too costly (Oluranti, 2009).

New data from Partnership for Maternal and Child Health (PMCH) shows that as the death toll in Nigeria is falling, the percentage of deaths that happen in the first month of life is increasing. Newborn deaths now make up 28% of all deaths under five years compared to 24% two years ago. 6 out of 10 mothers give birth at home without access to skilled care during childbirth and it is in the first few days of life when both women and newborns are most at risk (PMCH, 2012). Women in Sub-Saharan Africa mainly rely on traditional birth attendants (TBAs), who have little or no formal health care training. In recognition of their role, some countries and non-governmental organizations are making efforts to train TBAs in order to improve the chances for better health outcomes among mothers and babies (Mathur and Sharma, 2009).

Basically, one of the millennium development goals is to improve maternal health care. Despite much progress, achieving the Millennium Development Goals (MDGs) related to maternal and child health is considered unlikely, given that the majority of high-burden, priority countries in which Nigeria is not left out, are not on track to reach MDGs 4 and 5 (Ogunbode, 2010).

Therefore, against this background, this research work, having perceived this silent maternal and child health crisis attempts to uncover the factors influencing utilisation of traditional birth

attendants' services by pregnant women and nursing mothers with children ≤ 5 years old in Ikole LGA of Ekiti State, Nigeria.

Objectives of the Study

General Objective

The aim of this study is to assess factors influencing utilisation of traditional birth attendants' services by pregnant women and nursing mothers with children ≤ 5 years old in Ikole LGA of Ekiti State, Nigeria.

Specific Objective

1. Investigate the role of Traditional Birth Attendants in the provision of maternal and child health services.
2. Examine the socio-cultural factors influencing utilization of Traditional Birth attendant facilities in rural Ikole LGA.
3. Assessing the health care factors associated with access to traditional birth attendant care services and maternal and child health in Ikole LGA?
4. Evaluate the working relationship between Traditional Birth Attendants and the formal health system: By exploring the referral linkage between Traditional Birth Attendants and the formal health system.

Literature Review

There is a growing notion worldwide that the so-called modern biomedical approach to health care does not meet and address people's health needs adequately, but not exclusively in the non-Western world. Consequently, non-conventional therapies are increasingly demanded.

Global Overview of Maternal and Child Mortality

Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth. 99% of all maternal deaths occur in developing countries. Maternal mortality is higher in women living in rural areas and among poorer communities. Young adolescents face a higher risk of complications and death as a result of pregnancy than older women (Matic, S., Lazaarus, J. F., & Donoghoe, M. C, 2010). Between 1990 and 2011, maternal mortality

worldwide dropped by almost 50% maternal mortality is unacceptably high. In 2010, 287 000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been prevented (WHO,2012).

Improving maternal health is one of the eight Millennium Development Goals (MDGs) adopted by the international community in 2000. Under MDG5, countries committed to reducing maternal mortality by three quarters between 1990 and 2015. Since 1990, maternal deaths worldwide have dropped by 47% (Wilkinson, D. & Wilkinson, N. 2008)

Maternal deaths in Nigeria

An estimated 500,000 women die each year throughout the world from complications of pregnancy and childbirth. About 55,000 of these deaths occur in Nigeria. Nigeria, with only 2% of the world's population therefore accounts for over 10% of the world's maternal deaths.
In (2011), the World Health Organization and the Federal Ministry of Health of Nigeria reported that about 145 women die everyday in Nigeria as a result of causes related to childbirth. In terms of absolute numbers, Nigeria ranks second globally to India in number of maternal deaths. The risk of a woman dying from child birth is 1 in 18 in Nigeria, compared to 1 in 61 for all developing countries, and 1 in 29,800 for Sweden (FMOH report, 2012).

Factors contributing to the high maternal and infant mortality rates in Nigeria

There are several underlying factors that contribute to the high maternal and infant mortality rates in Nigeria. These include lack of antenatal care, a low proportion of women attended to by skilled birth attendants, and delays in the treatment of complications of pregnancy. In the case of post-neonatal mortality, malnutrition is a major factor, underlying about half of all infant deaths.

Other indirect factors that affect both maternal and infant mortality rates include maternal educational level, cultural practices, and poverty. There is a strong relationship between infant mortality and socio-economic status. Across Africa, the neonatal mortality rate per 1000 live births is 59 in the lowest income.

Traditional Medicine

Traditional medicine (also known as indigenous or folk medicine) comprises knowledge systems that developed over generations within various societies before the era of modern medicine. According to WHO (2004), traditional medicine is the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being (MacArthur, 2009). In some Asian and African countries, up to 80% of the population relies on traditional medicine for their primary

health care needs. When adopted outside of its traditional culture, traditional medicine is often called complementary and alternative medicine (MacArthur, 2009).

Traditional medicine may include formalized aspects of folk medicine, i.e. longstanding remedies passed on and practiced by lay people. Practices known as traditional medicines include Ayurveda, Siddha medicine, Unani, ancient Iranian medicine, Irani, Islamic medicine, traditional Vietnamese medicine, traditional Chinese medicine, traditional Korean medicine, acupuncture, Muti, Ifá, traditional African medicine, and many other forms of healing practices (Prata, N; Sreenivas A, Vahidnia F, Potts M. 2009).

The importance of traditional medicines for humans as well as animals in Africa both now and in the past is enormous. Traditional medicine takes on a diverse and complex definition and though it involves some aspects of mind-body interventions and use of animal-based products, it is largely plant-based. Conventional medicine focuses on experiment and disease causing pathogens. Traditional medicine however postulates that the human being is both a somatic and spiritual entity, and that disease can be due to supernatural causes arising from the anger of ancestral or evil spirits, the result of witchcraft or the entry of an object into the body. It is therefore not only the symptoms of the disease that are taken into account, but also psychological and sociological factors. Thus the holistic nature and culture-based approach to traditional healthcare is an important aspect of the practice, and sets it apart from conventional western approaches (World Vision, 2011).

African traditional medicine practice includes diverse health practices, remedies, approaches, knowledge and beliefs incorporating plant, animal and mineral products, spiritual therapies and charms. Traditional healers utilise a variety of approaches to diagnose, treat or prevent illness (Leighton, C. & Foster, R. 2003).

Traditional Medicine In Contemporary Nigeria

Health is the most precious of all things and it is the foundation of all happiness. Traditional medicine has developed in various communities in Nigeria in response to the health needs of the people. There is the common saying that "what the toad will eat, God will not put on a tree." Even if such needs of the told develop or grow in space, they will surely come to the ground if they are to satisfy the needs of the toad (Ogundari, 2008). Many communities have, therefore, since creation, developed various traditional systems using locally-available resources for the alleviation of their health problems. As once noted some 13 years ago (Titiyal JS, Pal N, Murthy GV, Gupta SK, Tandon R, Vajpayee RB, Gilbert CE, 2006), traditional medicine is as old as the hills in Nigeria. The development of traditional medicine in Nigeria has led to various

categories of healers, the various healing methods, strategies and medicines or remedies now known. The British colonial masters brought in orthodox medicine and, today, both systems of medicine exist in the country; both have the primary objective to cure, manage or prevent diseases and maintain good health (Odusoga, 2010).

It is important to stress the relevance of traditional medicine to the majority of Nigerians. Most Nigerians, especially those living in rural communities don't have access to orthodox medicine and it is estimated that about 75 per cent of the populace still prefer to solve their health problems consulting traditional healers (Banerjee, M., 2000). Where such access exists, the rising cost of imported medications and other commodities used for medicines have posed a big problem. Besides, many rural communities have great faith in traditional medicine, particularly the inexplicable aspects as they believe that it is the wisdom of their fore-fathers which also recognises their socio-cultural and religious background which orthodox medicine seems to neglect (Bodeker, Gerard C: 2004). Recent reports show that more people in the world embrace traditional medicine. In 2011, the WHO published (WHO Policy and Activities in the Field of Traditional Medicine) that in China, the ratio of medical doctors to the population stood at 1:20,000 compared with traditional practitioners ratio of 1:2000, and in Swaziland, these figures are respectively 1:10,000 and 1:100.

Traditional Birth Attendants (TBAs):

Since the focus of this paper was to unearth the factors influencing utilisation of TBAs services, it is pivotal to discuss TBAs here. The World Health Organisation opines that a traditional birth attendant (TBA) is a person who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other birth attendants. In the northern parts of the country, TBAs are of the female sex only, whereas in some other parts both males and females are involved (WHO, 2004). TBAs occupy a prominent position in Nigeria today: as between 60-85 per cent of births delivered in the country and especially in the rural communities are by the TBAs. They have been seen to pro vide pre-natal and post-natal care and so combine successfully the duties of the modern-day mid-wife. Highly experienced TBAs have been recognised to assist in obstetric and paediatric care, as they man age simple maternal and babyhood illnesses (Peltzer, Preez, N. F., Ramlagan, S., & Fomundam, H 2008).

Because of their exposure and experience, and more particularly the TBA's concept of human reproduction, as exemplified by pregnancy and childbirth being normal biological functions of human life linked holistically to cultural/social practices, TBAs have been trained to assist in orthodox medicine practices at the primary health care level (Pickett, G. & Hanlon, J. J.,

2010). With their extra hands, a greater coverage of primary health care leading to improved material or child health and the lowering of maternal and child mortality and morbidity, have been achieved (Pickett, G. & Hanlon, J. J. (2010).

Types of Traditional Birth Attendants

The role of the Traditional Birth Attendants usually reflects the culture and social structure of her community. In some communities, a Traditional Birth Attendants may be a full-time worker who can be called upon by anyone and who expects to be paid either in cash or in kind (Holly et al 2008).

There are predominantly two kinds of Traditional Birth Attendants: a woman who practices midwifery (full-time or part-time) by assisting anyone who calls upon her service; and the family Traditional Birth Attendants' who deliver only the babies of her close relatives or friends in the community (Kale, 2011). For the purpose of this study, Traditional Birth Attendants are defined as a person (normally a female) who assists anyone who calls upon her service. The Traditional Birth Attendants who has received formal training through the modern health sector to upgrade her skills is defined as a trained Traditional Birth Attendants, whereas those who have not received any training or received training and not received any refresher course for the last ten years are defined as untrained Traditional Birth Attendants (Kamal, 2009).

In others, she may be a woman's elderly relative or neighbour who does not make a living from her work and will only assist in a birth if the mother is a relative or the daughter or daughter-in-law of a neighbour or close friend. She assists in childbirth as a favour or good deed and does not expect to be paid, but may receive a gift as a token of appreciation. A third type of Traditional Birth Attendants is the family birth attendant who only delivers babies of her close relatives (Bolatito, 2008).

Socio-Cultural Factors Contributing To Seeking Traditional Birth Attendants Care:

A number of studies within Nigeria, Africa region, and globally, cite a number of reasons for seeking Traditional Birth Attendants care. These include: cost, proximity, lack of trust in nurses and doctors, history with the Traditional Birth Attendants, affordability, accessibility, reliability, privacy, and desire for sincere attention (Izugbara and Ukwayi, 2004).

Another important consideration is that users do not see a risk in using the Traditional Birth Attendants' facilities, that is, they are not necessarily aware of the advantages of delivering within the health facility. In terms of Antenatal Care (ANC), according to the NDHS (2008), the majority of women in Nigeria do attend Modern Health Centres. This fact is confirmed in the

study by Ogbu and Orugwu (2010), which found that even when women lived 5km or more away from the health centre, the majority still attended Antenatal Care at the health centre. Sometimes, many women attend the Antenatal Care, but later deliver at home or with the Traditional Birth Attendants. This is important because how women can be reached through Antenatal Care and encouraged to deliver in a facility could be a key intervention in addition to understanding how Antenatal Care can be incorporated to include elements of safe delivery that empowers the mother to make a decision in how care is administered, even by the Traditional Birth Attendants (Courtright P, Charambo M, Lewallen S., 2002).

Even though the majority of hospitals with maternity in Nigeria have a waiting ward, many women still choose not to stay because of the unpredictability of time in how long they will wait. They also cite that costs for food, transport, and the requisite family member or guardian to assist them due to shortage of staff are hindrances in waiting at the hospital (Fiedler, J. L. 2011). In addition to practical issues Traditional Birth Attendants care might be favoured for its flexibility and the possibility of companionship in labour. According to a study in Zambia concerning pregnant women and their needs, both emotional and physical, at least three or four women in addition to the Traditional Birth Attendants were present during labour in the home. Yet, this experience was not replicable in the hospital setting because of strict policies on numbers of companions (Digambar et al., 2011).

Theoretical Framework

The study made use of Structural Functionalist and Social Action Theory. Structural Functionalist Theory explained that health care delivery system in Nigeria comprises of different healthcare providers, who are organized to see the actualization of the health security of the citizenry. The application of structural functionalism to this study helped us to determine what, if the subsystem is dysfunctional and its attendant implication on the maternal and child health care delivery system. For instance, what happens when the Traditional Birth Attendants do not remit its part of the contribution where there are no adequate Modern healthcare facilities? On the other hand Social action refers to an act which takes into account the actions and reactions of individuals (or 'agents'). According to Max Weber, "an Action is 'social' if the acting individual takes account of the behaviour of others and is thereby oriented in its course". It is important in any study of disease management among the Yoruba to investigate the persistence of their belief and also to examine the effect of such beliefs on curative measures likely to be adopted. It is further averred that action is influenced not only by the situation but by the actor's knowledge of it. It is for this reason that knowledge of available means and perceived efficacy of action play

important role in determining what course of action to take in improving or maintaining maternal and child health.

Methodology

Quantitative and qualitative research methods were adopted in the study. The study respondents consisted of clients and TBAs that were drawn from the five selected communities within Ikole LGA. The sample of 250 pregnant women and mothers with children ≤ 5 years old, who were currently attending antenatal and/or postnatal and were resident in the Ikole Local Government Area and 25 TBAs on whom in-depth interview were conducted.

The quantitative data will be computer processed and analyzed with statistical package for Social Science (SPSS v18.0). Chi-square and Correlation analysis will be used for the objectives stated above to explore the relationship between the variables. It also will be used to involve the use of descriptive statistics such as frequency distribution tables, percentage distribution and Pearson chi-square and Pearson correlation while the qualitative data will be analyzed through manual content analysis to identify the impact of TBAs on maternal and child health.

Findings and Discussion

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Age Years	Frequency	Percentage %
≤ 20	17	6.8
21 – 30	75	30.0
31 – 40	81	32.4
41 – 50	77	30.8
Total	250	100
Educational Level		
No formal Education	26	10.4
Primary Education	54	21.6
Secondary Education	112	44.8
Tertiary Education	58	23.2
Total	250	100
Ethnic Group		
Yoruba	211	84.4
Igbo	20	8.0
Hausa	10	4.0
Others	9	3.6
Total	250	100
Religion		
Traditional belief	9	3.6
Christianity	224	89.6
Muslim	17	6.8
Total	250	100

Monthly Income		
≤ 10,000	56	22.4
11,000 – 20,000	71	28.4
21,000 – 30,000	49	19.6
31,000 – 40,000	37	14.8
41,000 – 50,000	21	8.4
51,000 – 60,000	11	4.4
61,000 – and Above	5	2.0
Total	250	100

Source: Fieldwork: (2012)

Table 4.1.1 above shows the socio-economic and demographic characteristics of respondents, who are currently attending antenatal and/or postnatal care with TBAs in the study, Nigeria. For the age distribution, the data shows that the respondents age range between 14-50 years which is in line with reproductive age for women. While the majority of pregnant women and mothers between ages 31-40 years and 41-50 years 32.4% and 30.8% constitute the highest, meaning that in the rural area, older women are indifferent to family planning. Those below 20 years constitute 6.8%.

Data on educational attainment of the respondents revealed that the population consists mostly of mothers with little education. Respondents with no education constitute 10.4% while 21.6% and 44.8% had primary and secondary education respectively. Respondents with tertiary education 23.2% are slightly higher than primary education. This shows that many TBAs clients in Ikole LGA did acquire formal education.

The majority of the respondents 84.4% were Yoruba, followed by Igbo 8.0%, Hausa 4.0% and 3.6% were from other ethnic groups in Nigeria. This finding was expected because the study was conducted in the Yoruba speaking community. The proportion of the Yoruba women attending antenatal and postnatal was higher compared to other ethnic groups. The religion affiliation of the respondents' shows that majority of them are Christians 89.6% followed by Muslim 6.8% and 3.6% of the respondents claimed to be Traditional worshipers.

An examination of the monthly income reveals that the population consists of low income earners. The figure shows that majority of the respondents earned between the average income of ₦11,000 – ₦20,000 28.4%, those with income below ₦10,000 were 22.4%. pregnant women and mothers with income between ₦21,000 - ₦30,000 and ₦31,000 – ₦40,000 constitute 19.6% and 8.4% respectively while income earner between ₦61,000 and above were 2.8%. This shows that the pregnant women and nursing mother may not have enough financial capability to attend modern health centre. The pregnant women and nursing mothers with low income, that had

little or no support from their husbands would surely prefer TBAs facilities to health centres due to the low cost.

UTILIZATION OF TBA FACILITY/TBA FACILITY PARONIZED

Nature of Utilization	Frequency	Percentage %
Exclusive	226	90.4
Non exclusive	24	9.6
Total	250	100.00
The TBA Patronized		
Faith Based Clinic	210	84.0
Herbalist home	6	2.4
Alfa home	17	6.8
Others	17	6.8
Total	250	100.0

Source: Fieldwork, (2012)

The table above shows the frequencies and percentages of respondents that had exclusively used the services of Traditional Birth Attendants in their communities. 90.4% of the respondents agreed that they had exclusively utilized the TBAs' services while 9.6% of the respondents had never had exclusively utilization of TBA in their locality. This percentage shows that they also make use of other health facilities with TBAs' health services.

The highest percentage of the respondents that had used TBA services patronized Healing Church (84.0%) while 2.4% of the respondents visited herbalist home, those that patronized Alfa home were 6.8% and 6.8% of them visited others, which could be homebirth or other places. Despite the high level of awareness about maternal and child high mortality rate, the number of the respondents that made use of TBAs' facilities was still high. The reason for this is not far fetched; public health care facilities that are supposed to provide basic prevention and health promotion services that include immunization, health education, promotion of adequate nutrition and management of malaria, diarrhea, acute respiratory infection and other common illness are not available, which makes the rural dwellers make use of the available health facilities such as TBAs (Simpson 2004). This is corroborated by the interview of a TBA;

> *People prefer home delivery with the availability of TBA or delivery in the TBAs centres instead of doctors Health Centres is too costly. If any woman wants to deliver in general hospital now, she must prepare up to ₦20,000 if not more without complication but if it by caesarean, it will cost nothing less than ₦50,000 unlike here, we collect just ₦1,000 and less and at the same time, medical staff at the health centres easily,cut and stitch, which people are not comfortable with: they prefer to deliver without stitches.* (IDI/TBA/Ijesa-Isu /April 19, 2012).

REASONS FOR PREFERRING TBAs TO MODERN HEALTH ENTRES

Reasons	Frequency	Percentage %
Experiences from Previous Services	22	8.8
Competency of TBA	36	14.4
Efficacy of medicine given by TBA	32	12.8
Spiritual Reason	135	54.0
All of the above	21	8.4
I don't know	4	1.6
Total	250	100.0

Source: Fieldwork, 2012

The above finding depicts that 8.8% of the respondents chose experiences from previous birth and diseases as a major reason for preferring TBAs to modern health care; 14.4% of them were of the side that the competence of the TBAs made them preferred it to modern health centres. Furthermore, 12.8% of the respondents said that efficacy of the medicines given at the TBAs gives them (TBAs) preference over modern health centres. The highest number of the respondents (54.0%) was of the opinion that they preferred using TBAs to modern health centres purposely for spiritual reason while 8.4% of them chose all the options. and 1.6% of the respondents did not know.

The finding above is corroborated by the in-depth interview conducted with TBAs in the selected communities. TBAs are generally older women who "care" about younger women in the community. They also take care of those women that are not able to pay for delivery and are therefore also seen as benevolent members of the community. Below is a claim about attending to spiritual issues that may occur;

> *We the TBAs are capable to address the spiritual issues that women may have. For cases of witchcraft, for example, only the TBA can address this problem. There are some problems/complications that can only be addressed by the TBA especially those involving witchcraft. For instances, a woman was brought to me three months ago by one of her relatives that she got married for over 14 years with no child. When I tried to understand the cause, it was the mother-in-law that was behind the scene in which no hospital can understand. As I am talking to you now, the woman is pregnant"* **(IDI/TBA2/Ijesa-Isu Ekiti/ May 4, 2012)**

EFFICACY OF THE MEDICINE GIVEN AT THE TBAs CENTRES

Efficacy of the medicine given by TBA	Frequency	Percentage %
Efficacious	198	79.2
Not Efficacious	47	18.8
No Comment	5	2.0
Total	250	100.0

The table above depicts that 79.2% of the respondents believed in the efficacy of the medicine given by the TBA while 18.8% of them did not believe in the efficacy of the medicine. Only 2.0% of them did not have any comment. The result signifies that majority of the respondents believed in the efficacy of the medicine given at the TBAs centres. Among those respondents that utilized the TBAs, there were some who still patronized other health facilities such as modern health care service. This is corroborated by the interview of a 43-year old woman found at one of the TBAs centres;

> *Though, I attend antenatal care at both health centre and TBA based on the instruction given by my husband but herbal concoction is the best therapy for me during pregnancy because I so much have strong belief in its efficacy. It makes me stronger and keeps me going throughout the nine months. More so, I had never experienced any complication, stillbirth or pre-term birth since I have been using herbal medicine (IDI/Mother/Ijesa-Isu/April 19, 2012)*

The TBAs believe in the efficacy of medicine given to their clients. In order to ascertain this, a traditional birth attendant at Ijesa-Isu Ekiti, during the in-depth interview stressed that:

> *There are certain care and advice that I offer to my clients. Anyone of them that follows the prescription and advice will not have complication whatsoever, either during antennal, delivery or postnatal. She supported her claim by some incantations;* ***A ki ngbebi ewure, a ki ngbebi aguntan, ewe kii jabo lara igi ko pagi lara, irawe kii dajo ile ko sunke*** *meaning that nobody does delivery for goat and sheep, so safe delivery is sure for her clients (IDI/TBA/Ijesa-Isu/April 19, 2012).*

FACTORS INFLUENCING UTILIZATION OF TRADITIONAL BIRTH ATTENDANTS

Factors considered before utilizing preferred TBA?	Frequency	Percentage %
The cost	20	8.0
Efficacy	36	14.4
Proximity	12	4.8
Religious Belief	124	49.6
Experience	29	11.6
Others	29	11.6
Total	**250**	**100.0**

Source: fieldwork (2012)

Table 4.3.1 indicates what the respondents considered before utilizing TBAs health services. The above shows that 8.0% of the respondents considered cost of service; 14.4% of them utilized TBAs based on the efficacy of the services rendered by the TBAs whereas 4.8%, which is the lowest percentage utilized TBAs services because of its closeness to their residences. Furthermore, 49.6%, which is the highest percentage of the respondents utilized TBAs due to their religious belief. This is attached to spiritual belief of the respondents. 11.6% and 11.6% of the respondents utilized TBAs due to experience and other issues respectively.

The above statement is corroborated by the interview of a 47 years old woman;

> *The major reasons I can see that make women prefer TBAs is the mothers' negative perception of healthcare workers. It is like, in hospitals, they won't give you required attention; they're carefree, they're careless, they're insolent, they're this, they're that.* **(IDI/Mother/Ikole Central/May 9, 2012)**

Conclusion

In this study, it was sought to gain further knowledge on the barriers that women encounter in accessing maternal health care services their reasons for choosing to attend TBAs in Ikole LGA of Ekiti State. In many countries, TBAs are an important source of social and cultural support to women during childbirth and because of economic constraints, and the difficulty in posting trained professionals to rural areas, many women will continue to deliver with TBAs. However, there is no conclusive evidence that trained TBAs can prevent maternal deaths unless they are closely linked with the health services, and are supported to refer women to functioning hospitals providing essential obstetric care. The role of TBAs should not be ignored but TBA training should be given high priority and precedence given to other programme options that are based on stronger evidence of effectiveness including the provision of essential obstetric care and of a skilled attendant at delivery.

The attitudes of health workers and the poor relationship between TBAs in the cluster and the health facility are alarming. Some investigation is also required in this area to see how to best broker a relationship between TBAs and the health system, as the ultimate goal in the redefinition of TBA roles is to engage them as a key liaison between the two. Assessing appropriate supervision of TBAs is also a critical issue.

RECOMMENDATIONS

In light of the literature review and study evidence, TBAs still have an important role to play at the community level. At present, based on the discussions and experiences of women clarified in this study, several recommendations can be considered in line with current government policy towards TBAs.

1. The TBAs should be given more autonomy and assistance by the local, state, federal and even International health organization. All TBAs, regardless of status should be assisted by government in the provision of health equipment. The TBAs that have not been trained should be urged to participate in training programmes or activities, while they should continue to have government links. Funding the TBAs is important as they should be aware that they are not "illegal," and so that their work does not go underground and becomes dangerous.
2. It is apparent that TBAs have low level of health officer's supervision at the moment. Government should increase the level of supervision by community nurses, midwives at the health centre, or other additional health staff that might be able to assess the record keeping, practices, and needs of TBAs.
3. One of the major barriers faced by women was lack of transport to the health facility. In this regard, government should also seek the support of individuals in the rural areas by funding community level initiatives around the maternal and child health. Local government authorities should be involved in managing basic facilities within the community such as motorable roads linking the rural and interior local areas to urban centres.
4. As noted by the women in IDIs, they would go to the health facilities if they could. Hence, it is important that new facilities are constructed in accessible areas. It would be important that government ensures that maternity services are available in the rural areas.
5. There should be improvement on information flow and education on best childcare practices to mothers. From the qualitative findings, it is evident that most mothers correctly perceived

health workers in the health centres as wicked and not caring but alternatives available to them in terms of health care expose children under age five to risk of morbidity and mortality.

6. Female education was associated with patterns of maternal health care service use. Education levels of women need to be improved. In the sample studied, most of the women had either none or just primary education. Education affects maternal health care service use by changing ideas about maternal health and attitudes toward risk prevention by using the maternal health care services.

REFERENCES:

Abbas; Walker; Habib and Vaughan, 1986. "Health Mothers, Health Child: An information Guide" *family care International Inc.* New York, USA.

Ajala, 2011. Maternal and Child health status: where there's no tradition of traditional birth attendants: Southwest, Nigeria. In: *Safe Motherhood Initiatives: critical issues, Eds*, Blackwell Science, Oxford, 147-154.

Aletor M, Maine D. and Vaughan R, 2007. Why perinatal mortality cannot be a proxy for maternal mortality. Studies in Family Planning.

Banerjee, M.,2000. Whither indigenous medicine. http://www.india-seminar.com/2000/489.html.

Bodeker, Gerard C., 2004. Traditional health systems and national policy. http://users.ox.ac.uk/~gree0179/

Bolatito, 2008. Impact of traditional birth attendant training in Nigeria: a controlled study. *J Midwifery Womens Health*; 46: 210–216.

Chana H, Schwab L, Foster L, 2012. With an eye to good practice: Traditional Healers in rural communities. Uganda

Courtright P, Charambo M, Lewallen S., 2002: Collaboration with African traditional healers for the prevention of blindness. World Scientific Publishing Co Ltd, Danvers, Massachusetts, United States of America.

Digambar A.Chimankar and Harihar Sahoo. 2011. Factors influencing the Utilization of Maternal Health Care Services in Uttarakhand. *Ethno Med,* 53: 209-216.

Federal Ministry of Health FMOH 2012.Road map for accelerating the attainment of the millennium development goals related to maternal and newborn health in Nigeria. Abuja, FMOH.

Fiedler, J. L. 2011 A review of the literature on access and utilization of medical care with special emphasis on rural primary care. *Social Science and Medicine,* 15, 129–142.

Goodburn, A, 2001. An evaluation of a knowledge and practices of trained traditional birth attendants in Bodinga, Sokoto State, Nigeria. Journal of Tropical Medicine and Hygiene.

Holley etal, 2008. Revisiting the exclusion of traditional birth attendants from formal health systems in Ethiopia. *Discussion Paper Series.* 2008;3: Discussion Paper No. 003/2008.

Izugbara and Ukwayi, 2004. "Factors Influencing Prenatal Care Use Among Low Income African Women". *Population Reference Bureau,* Ghana.

MacArthur C. 2009. Traditional birth attendant training for improving health behaviours and pregnancy outcomes.

Mathur HN, Damodar and Sharma PN, 2009. The impact of training traditional birth attendants on the utilisation of maternal health services. J. Epidemiology and Community Health. 33,142-144.

NDHS, 2008. *Nigeria Demographic and Health Survey 2008.* Abuja, Nigeria: National Populaton Commission and ICF Macro.

Odusoga M.D, 2010. What in the world is being done about TBAs? An overview of international and national attitudes to traditional birth attendants. Midwifery.

Ogbu O. M and Orugwu A.A, 2010. Strategies for reducing maternal mortality in developing countries: what can we learn from the history of the industrialized west? Tropical medicine and international health 3,771-82.

Ogunbode O., 2010. Contemporary Obstetrics and Gynecology for Developing Countries. Benin City: *Women's Health and Action Research Centre*, 2003, PP. 514-529.

Ogundari, 2008. Traditional birth attendants, HIV/AIDS and safe delivery in the Eastern Cape, South Africa – evaluation of a training programme. *S Afr J Obstet Gynaecol.* 123:140–145.

Oluranti A. A., 2009. Social background, customs and traditions. In: Maternal and child health around the world, Eds H. M. Wallace and G. J. Ebrahim, London: The Macmillan Press Ltd, 71-75.

Olusoga, Ojo, M.B, 2010. Impact of training on the performance of traditional birth attendants. Journal of Family Welfare 4,32-35.

Owumi B. E, 1996. Society and Health: Social Patterns of Illness and Medical Care. In: Adewale E Oke, Benard E Owumi Eds.: *Readings in Medical Sociology*. Ibadan: RDMS, pp.196-208.

Peltzer, K., Preez, N. F., Ramlagan, S., & Fomundam, H. 2008. Use of traditional complementary and alternative medicine for HIV patients in KwaZulu-Natal, South Africa. BMC Public Health, 8, 255.

Pickett, G. & Hanlon, J. J., 2010. Public Health Administration and Practice. St. Louis imes Mirror/Mosby College Publishing.

Prata, N; Sreenivas A, Vahidnia F, Potts M, 2009. Saving maternal lives in resource-poor settings: facing reality. Health Policy 89 (2): 131–48

Sibley, L., Sipe, T. and Koblinsky, M. 2004. Does Traditional Birth Attendant Training Increase Use of Antenatal Care? A Review of the Evidence, *J. Midwifery Women's Health, 49,*298-305.

Simpson, 2004. The role of traditional birth attendants in the reduction of maternal mortality. *Studies in HSO and P.* 17:85–89.

Smith JB; Edward and Gideon, 2000. Management of Childhood Pneumonia by traditional birth attendants. Bulletin of the World Health Organisation.

WHO, 2004. Guidelines on Registration of Traditional Medicines in the WHO African Region. Traditional Medicine Programme Department of Essential Drug and Medicines Policy Geneva. WHO Regional Office for Africa, 2004 AFR/TRM/04.1

Wilkinson, D. And Wilkinson, N. 2008. HIV Infection among patients with sexually transmitted diseases in rural South Africa. International Journal of STD AIDS, 9, 736-39. http://dx.doi.org/10.1258/0956462981921486

World Vision, 2011.: Ethiopia: Trained traditional birth attendants easing delivery, Maternal Health Task Force, Hamlin Fistula Hospital, MHTF blog, accessed