FACTORS ASSOCIATED WITH THE UTILIZATION OF TRADITIONAL BIRTH ATTENDANTS (TBAS) AMONG PREGNANT WOMEN IN NIGERIAN RURAL COMMUNITIES

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Abstract

The objective of this study is to provide an alternative explanation for the utilization of traditional birth attendants (TBAs) and home delivery by pregnant women across Nigeria. The patronage of TBAs and home delivery is preferable to many Nigerian women in rural, despite the availability of orthodox clinics, health centres and hospitals across the country. Certain factors categorized as socio-economic/cultural have been identified to be the reasons why many patronize TBAs and deliver at home. These include low economic status, unavailability of health insurance/healthcare scheme, influence of culture and trust of the TBAs by the members of their communities, difficulty to access healthcare personnel and facilities, among others, also serve as major reasons for the preference of the utilization of TBAs and home delivery by pregnant women across Nigerian rural communities. Data from secondary sources was gleaned to ascertain the factors that encourage pregnant women in utilizing the services of TBAs across the country. Findings from literature revealed that the age of the women, level of income, level of education, proximity to and accessibility of medical personnel and healthcare facilities are the major reasons that women across the country patronize the services of TBAs. Recommendations proffered include that stakeholders should encourage a synergy between TBAs assisting in home delivery and the medical personnel in the healthcare facilities, the government and other stakeholders like social workers should facilitate the integration of TBAs into the modern healthcare system, ensure the proximity and accessibility of obstetric and gynaecologic services by the people by certifying the TBAs who are closer to the people.

Keywords: Home Delivery, Pregnant women, Skilled Birth Attendant, Traditional Birth Attendant, Utilization

Introduction

Globally, many countries have limited access to primary healthcare for residents (Rutherford, Dockerty, Jasseh, Howie, Herbison, Jeffries & Hill, 2009; World Health Organization [WHO], 2008). A combination of factors contributes to this condition, including socio-demographic characteristics of the population, lack of resources, challenges posed by the primary-care model, and government healthcare administrators'

failure to incorporate input from the community regarding healthcare needs (Higgs, Bayne & Murphy, 2001; Uneke, Ogbonna, Ezeoha, Oyibo, Onwe, Ngwu & Innovative Health Research Group 2009). As a result, many people suffer illnesses unnecessarily, and communities experience high mortality and morbidity rates from preventable causes (Irwin, Valentine, Brown, Loewenson, Solar, Brown & Vega, 2006). This unfortunate situation is the case among many African countries (World Bank, 2011). Compared to other countries, African countries bear a greater burden of disease and death from preventable and terminal causes. In fact, 72% of all deaths in Africa are the result of communicable diseases such as HIV/AIDS, tuberculosis, and malaria; respiratory infections; and complications of pregnancy and childbirth. Deaths due to these conditions total 27% for all other WHO regions combined (WHO, 2006). In addition, the WHO reported that 19 of the 20 countries with highest maternal mortality ratios worldwide are in Africa.

Data from a 2009 report from the World Bank (2011) indicated that the prevalence of HIV among people ages 15–49 in sub-Saharan Africa is nearly seven times of that in other areas of the world (5.4% compared to 0.8%, respectively). Similarly, WHO (2006) reported that Africans account for 60% of global HIV/AIDS cases, 90% of the 300-500 million clinical cases of malaria that occur each year, and 2.4 million new cases of tuberculosis each year. As of 2003, infant mortality rates were reported to be 29% higher than in the 1960s (43% up from 14%; WHO, 2006). Lack of safe drinking water (58% of the population) and access to sanitation systems (36% of the population) contribute to these poor health outcomes (WHO, 2006).

However, these poor health conditions also are due in part to the historical and current states of primary healthcare in Africa, and particularly in Nigeria (Asuzu, 2004; National Primary Health Care Development Agency, 2007; Tulsi Chanrai Foundation, 2007; WHO, 2008b). Over the years, international attention has been drawn to the global issue of limited access to primary healthcare for many populations. The outcome of this attention has been the initiation of numerous efforts to change this condition and develop modern and effective healthcare systems focused on preventing diseases (United Nations Population Fund, 2010); reducing disparity in health care (Andaya, 2009; Negin, Roberts & Lingam, 2010); improving access to healthcare (Bourne, Keck & Reed, 2006; Dresang, Brebrick, Murray, Shallue & Sullivan-Vedder, 2005; WHO Country Office for India [COI], 2008); promoting active community participation in healthcare planning (International Conference on Primary Health Care [ICPHC], 1978; International Conference on Primary Health Care and Health Systems in Africa [ICPHCHSA], 2008; WHO, 1974); and promoting overall health and well-being (Hall & Taylor, 2003).

Nigeria's continued reliance on the ineffective British system of healthcare (Ityavyar, 1987), governmental inadequacy (African Development Bank, 2002; Asuzu & Ogundeji, 2007), and a 3-year civil war (Uche, 2008; Uchendu, 2007) have left the Federal Republic of Nigeria in a state of political, economic, and social unrest, unable to accommodate a governmental infrastructure to satisfy the diverse cultural needs of its people (Hargreaves, 2002). Particularly strained is the nation's ability to provide access to effective healthcare for its growing population, especially in rural areas (African Development Bank, 2002). The socio-demographic characteristics of the population compound this condition (Labiran, Mafe, Onajole & Lambo, 2008). Access to healthcare remains inadequate in Nigeria; literature has demonstrated that health research in general

contributes to improved decision-making procedures for healthcare administrators and performance of national healthcare systems (Briss, Gostin & Gottfried, 2005). Specifically, community based research supports positive social change (Centre for Community Based Research, 2011). In addition, private-practice healthcare providers could implement aspects of the model appropriate for improving patient care in private-practice situations, especially, the maternal utilization of the services of TBAs.

Health care has encountered problems across communities that make up the Nigerian state, particularly with shortage of medical and health practitioners willing to work in the remote rural areas for various reasons such as very difficult terrain. The result is that health and medical services are not readily available, accessible and affordable to most of the population, particularly those in rural areas. The situation is compounded by prevailing high level of poverty leading to poor environmental and infrastructural conditions like shortage of good quality housing, lack of proper sanitation, lack of safe water supply, and inadequately functioning health and other systems. Furthermore, primary health care arrangement in the Nigerian setting is heavily anchored on western orthodox medical system that was imported into the country during the colonial period. This system does not yet have the best in terms of equipment (Nwankwo, Udeobasi, Osakwe & Okafor, 2007). That is why Ojeifo (2005) lamented that one of the problems is lack of basic medical equipment, which results in low patronage especially of rural health centers. It is also up against formidable odds of low number of adequately trained and skilled personnel, limited acceptance and challenges of poverty which hinder people from taking maximum advantage of its costly services to alleviate diseases and discomfort. Public enlightenment or health advocacy have also been weak and yet to make the desired impact. Dennill (1999) argued that poor governance by the ruling parties with lack of policies or unrealistic policies and legislations that fail to address the needs of the people negatively impact on health of the population.

In many countries, the healthcare system also includes the insurance agencies (social or private) that take decisions based on the type and extent of care to be administered. Large differences in healthcare systems exist between countries. These variations are even more evident between developed and developing countries. Numerous developed countries see the providing of healthcare as a social responsibility and provide universal coverage for its citizens, usually financed by the tax or social security system. For most less-developed countries, however, universal healthcare coverage is still more or less a dream. Consequently, many such countries have turned to the private sector for its healthcare needs, basic healthcare as well as health insurance. In low-income countries, private services are popular because they are often cheap (and) are adjusted to the purchasing power of the clients, as when partial doses of drugs are sold (Mills, Brugha, Hanson & McPake, 2002). The access to public healthcare is especially restricted in rural areas, so in rural areas the private sectors as well as traditional healing play a dominant role. This is in line with the study by Jerve, Krantz & San (2001), which concluded that the poor quality of curative services at the community level directly contributes to the phenomenon of high levels of self-medication and over-utilization of tertiary healthcare facilities and alternative medications.

In the light of shortage of medical and health practitioners willing to work in remote and rural communities for various reasons such as difficult terrain, the mortality rate has remained on the increase. All women need maternity care in pregnancy,

childbirth and after delivery to ensure optimal pregnancy outcomes. Skilled attendant at every child birth is one of the affordable measures which is now being advocated for and adopted by many countries in order to reduce maternal mortality. Despite the level of advocacy, it is observed that some women still utilize the services of TBAs in both the urban and rural areas. However, the challenge now is implementing effective and affordable interventions so that progress towards the reduction of maternal mortality can become a reality. Considering the high level of poverty and non availability of medical personnel in most rural communities, the traditional birth attendants (TBAs) are faced with the challenge of attending to pregnant women.

It is in this light that this work examines the prevalent factors associated with the utilization of the TBAs in rural Nigerian communities. The work focused on data from national and international agencies. In addition, textbooks, journal articles and magazines also served as sources of data to the work. The challenge now is implementing effective and affordable interventions so that progress towards the reduction of maternal mortality can become a reality.

An Overview of Traditional Birth Attendants (TBAs)

The reduction of maternal mortality has been a major concern in many developing countries. Every day, approximately 830 women die from preventable causes related to pregnancy and childbirth and 99% of all maternal deaths occur in developing countries and more from rural area (WHO, 2015). One of the major reasons for maternal death especially in developing countries is that women are left in the hands of unskilled birth attendants at pregnancy and childbirth (Jokhio, Winter, Cheng & Engl, 2005). World Health Organization (WHO) reported that, the high number of maternal deaths in some areas of the world reflects inequities in access to health services, and highlights the gap between rich and poor. Many women in developing countries like Nigeria do not have access to skilled care during pregnancy and childbirth thus such women rely on traditional birth attendants for care. Also, it has been reported that many of the practices of these traditional birth attendants (TBAs) are detrimental to the health of mothers resulting in many complications and ultimately maternal death, as many of them are not skilled (Adeniran, 2012). The World Health Organization (WHO) defines a skilled attendant as "an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to be proficient in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. While, a Traditional Birth Attendant (TBA), is a person who provides basic pregnancy and birthing care and advice based primarily on experience and knowledge acquired informally through the traditions and practices of the communities where they originated (WHO, 2010).

Many traditional midwives are also herbalists, or other traditional healers. In many countries, TBA training has been used as a means of extending health services to underserved communities especially in developing nations with the hope of decreasing mortality and morbidity (Sibley, Sipe, & Koblinsky, 2004; Mhame, Busia & Kasilo, 2015).). They sometimes serve as a bridge between the community and the formal health system, and may accompany women to health facilities for delivery. Around the world, one third of births take place at home without the assistance of a skilled attendant

(Bergström & Goodburn, 2001). Skilled attendants assist in more than 99% of births in more developed countries while 51% of women in low-income countries benefit from skilled care during childbirth (Wikipedia, 2012). The vast majority of the 4 million neonatal and 500,000 maternal deaths each year occur in resource-poor countries where traditional birth attendants (TBAs) participate in 43% of deliveries. There are re-emerging birth complications with the resurgence of home births attended by TBAs, who are now excluded from the health system in countries like Sierra Leone (Fofanah, 2010). The care given during the prenatal, intranatal and postnatal periods and the environment in which the women find themselves to a very great extent can determine the state of the health of women (Imogie, 2011). Pregnant women need adequate care and protection.

Theoretical Orientation

The Health Belief Model (HBM) was adopted as the theoretical framework for the study. The model was put forward by Irwin Rosenstock and his colleagues in 1966 (Becker, 1974). This socio-psychological model upholds that healthy people seek to avoid illness. According to Ogden (2007), the health belief model is a preventive action taken by women to avoid reproductive health problem.

The health belief model states that the perception of a personal health behavior threat is itself influenced by at least three factors; general health values; which include interest and concern about health; specific health beliefs about vulnerability to a particular health threat; and beliefs about consequences of the health problem. Once an individual perceives a threat to his/her perceived benefits, then that individual is most likely to undertake the recommended preventive health action. There, may be some variables (demographic, socio-psychological, and structural) that can influence an individual's decision (Glanz, Lewis and Rimer, 2002).

There are key descriptors which further emphasizes the model and which will therefore be used to describe the relevance of the model to the work.

i. Perceived seriousness – This refers to the belief a person holds concerning the effect of a given disease or condition would have on one's state of affairs. These effects can be considered from the point of view of the difficulties that a disease would create, for instance, pain and discomfort, financial burdens, difficulties with family, relationships, susceptibility to future conditions. It is important to include these emotional and financial burdens when considering the utilization of traditional birth attendants or modern health care facilities.

ii. Perceived benefits of taking action – This implies taking action toward the prevention of disease or toward dealing with illness is the next step to expect after an individual has accepted the susceptibility of a disease and recognized it is serious. The direction of action that a person chooses will be influenced by the beliefs regarding the action. Therefore, the faith that most pregnant women has on. TBAs largely influence their decision to utilize their services as against health care centres.

iii. Barrier to taking action – Action may not be taken, even though an individual may believe that the benefits of taking action are effective. This may be due to barriers. Barriers relate to the fact that the characteristics of a

treatment or preventive measure may be inconvenient, expensive, unpleasant, painful or upsetting. These characteristics may lead a person away from taking the desired action. In application, although the benefits and importance of utilizing modern health care is evident, there are various hindrances such as poverty, awareness and the likes which must be addressed to promote action.

iv. Cues to action – An individual's perception of the levels of susceptibility and seriousness provide the force to act. Benefits (minus barriers) provide the path of action. However, it may require a 'cue to action' for the desired behavior to occur. These cues may be internal or external.

v. Perceived susceptibility – Each individual has his/her own perception of the likelihood of experiencing a condition that would adversely affect one's health. Individuals vary widely in their perception of susceptibility to a disease or condition. Those at low end of the extreme deny the possibility of contracting an adverse condition. Individuals in a modern category admit to a statistical possibility of disease susceptibility. Those individuals at high extreme of susceptibility feel there is real danger that they will experience an adverse condition or contract a given disease.

The Roles of Traditional Birth Attendants (TBAs) in Nigeria

Ichizie (2005) indicates that in developed countries, some traditional or lay mid-wives are becoming increasingly vocal in support of their right to practice without formal regulation, advocacy for woman's right to choose her place of birth and attendants. They see their role to include promoting change in societal attitudes towards birth, and favouring the 'art' of midwifery founded on maternal or compassionate instinct, rather than over-medicalization of this natural event. He added that traditional birth attendants are often older women, respected in their communities. They consider themselves as private health care practitioners who respond to request for service. The focus of their work is to assist women during delivery and immediately post-partum. Frequently their assistants include helping with household chores.

Ichizie (2005) further opined that traditional midwives provide basic health care, support and advice during pregnancy and after childbirth, based primarily on experience and knowledge acquired formally through the traditions and practices of the communities where they originated. They usually work in rural, remote and other medically underserved areas. TBAs may not receive formal education and training in health care provision, and there are no specific professional requisites such as certification or licensure. A traditional birth attendant may have been formally educated and has chosen not to register. They often learn their trade through apprenticeship or are self-taught; in many communities one of the criteria for being accepted as a TBA by clients is experience as a mother. Many traditional midwives are also herbalists, or other traditional healers. They may or may not be integrated in the formal health care system. They sometimes serve as a bridge between the community and the formal health system, and may accompany women to health facilities for delivery.

It is estimated that between 60% and 80% of all deliveries in developing countries occur outside modern health care facilities, with a significant proportion of these being attended to by TBAs (Tsui, Wasserheit & Haaga, 1996). TBAs deliver the majority of women in Nigeria as in other developing countries. A study carried out in eastern

Nigeria, showed that although 93% of rural women registered for prenatal care, 49% delivered at home under the care of TBAs (Imogie, 2012). Similarly, a study of 377 women who delivered before arrival at the hospital in Ogbomosho, southwestern Nigeria, revealed that 65% of the mothers had been delivered by a TBA, while, 73.7% had sought help from them for retained placenta with bleeding (Fajemilehin, 1991). In Chanchaga LGA of Niger State in north central Nigeria, 84% of households interviewed utilized the services of a TBA or village health worker (Itina, 1997). In a study done in Edo State, south Nigeria, to assess the role of TBAs in health care delivery, respondents believed that TBAs could play meaningful roles in family planning, screening for high-risk pregnant mothers, fertility/infertility treatment, and maternal and child care services.

Training for Traditional Birth Attendants (TBAs)

It has been presumed that many traditional midwives are also herbalists, or other traditional healers (Mhame, Busia & Kasilo, 2015). In many countries, TBA training has been used as a means of extending health services to underserved communities especially in developing nations with the hope of decreasing mortality and morbidity (Sibley, Sipe & Koblinsky, 2004). They sometimes serve as a bridge between the community and the formal health system, and may accompany women to health facilities for delivery (Wikipedia, 2012). In a study in Edo State of 45 TBAs, which assessed the services provided by them and their management practices (ie, management of complications, umbilical cord care, and infection control methods), findings revealed their unsafe practices. It was recommended that a more holistic training program including monitoring and supervision should be provided to them (Ofili & Okojie, 2005).

However, several efforts to formalize the role of TBAs in maternal and neonatal health programs have had limited success. TBAs continued attendance at home deliveries suggests, however, their potential in influencing maternal and neonatal outcomes (Imogie, Agwubike & Aluko, 2002). A South African study to evaluate the training of TBAs in human immunodeficiency virus/acquired immunodeficiency syndrome care and service delivery revealed that after the training, significantly more TBAs conducted prenatal checkups, assessed the baby's position in the uterus, and took the mother's and baby's pulse, and fewer TBAs conducted abnormal or complicated deliveries. Investigators concluded that training of TBAs can increase their knowledge, improve their attitudes, and reduce risk practices (Peltzer & Henda, 2006).

Socio-Cultural Factors that Encourages the Patronage of Traditional Birth Attendants (TBAs)

The factors that stimulate or encourage the utilization of the services of TBAs are all-encompassing, ranging from the economic, socio-cultural, and others. A study carried out by Ebuehi and Akintujoye (2012), revealed the following factors encourage the utilization of the services of TBAs, and these include that:

i. TBA services are cheaper and more affordable to the people than conventional orthodox maternity services.

ii. TBA services are more culturally acceptable in the environment than conventional orthodox maternity services.

iii. TBA services are closer and more accessible to the residents than hospital services, which most times are located quite distantly from the residents.

iv. TBAs provide more compassionate care than orthodox health workers, in the way they handle their clients, and,
v. TBA service is the only maternity service that most residents in the rural areas know, as compared to their knowledge of conventional orthodox maternity services.

Similarly, a qualitative study conducted in Zambia by Sialubanje, Massar, Hamer & Ruiter, (2014), showed that several factors make many women patronize TBAs, and these include: perceived poor quality of maternal healthcare services (MHS) due to negative staff attitudes towards pregnant women, a shortage of qualified staff and a lack of drugs and supplies necessary for emergency obstetric care, social and cultural norms, women's low social status and lack of decision-making autonomy prevented women from utilising facility delivery services in rural Zambia. While, a study in Indonesia by Titaley, Hunter, Dibley & Heywood, (2010), showed that the community had positive attitude towards TBAs and perceived their role as essential for providing MHS. Women preferred services of the TBAs because they were available and easily accessible, affordable and pragmatic. Moreover, the community believed that TBAs had enough midwifery knowledge, skills, and that they were trustworthy. However, these factors may differ from one socio-economic, cultural and geographic context to another, as is observed.

Problems Associated with Patronage of Traditional Birth Attendants (TBAs).

Several studies have shown that the increased maternal and infant mortality rate is blamed on many deliveries that took place at home with the help of untrained attendants (Chou, Inoue, Mathers, Moller, Oestergaard & Say, 2012; Monjok, Essien, Smesny & Okpokam, 2010; and, Lawn, Lee, Kinney, Sibley, Carlo & Paul, 2009). Also, deliveries that are conducted by TBAs have been shown to be associated with four times higher maternal and infant morbidity and mortality when compared with deliveries supervised by midwives and other health professionals (Opiah, Osayi, Afolayan & Adeyanju, 2010). The practice of traditional birth attendant has caused a lot of havoc on the health of mother and child. Despite the introduction of modern health facilities, safe motherhood initiative program, free medical services etc., statistics showed that majority of children are born by TBAs both in rural and urban areas. The majority of deliveries are being carried out by TBAs which indicate that several deliveries still occur outside hospitals and health facilities (Ofili & Okojie, 2005; Ebuehi & Akintujoye, 2012; and M'Cormack-Hale & Beoku-Betts, 2015).

Strategies for Effective Utilization of Traditional Birth Attendants (TBAs)

Addressing the issue of maternal mortality and utilization of TBA services needs a collaborative effort of the health care and other service providers like social workers to ensure that maternal health care is easily available. The cultural beliefs of our contemporary society will make it obvious that some women will still utilize the TBA care and also because of various factors outlined. Thus, the urgent needs to address identified challenges as well as inform women on the need to use modern healthcare. Also, where TBAs are the only means of care, the identified TBAs should be trained on early recognition and referral through effective collaboration and support of the society as a whole is needed (Ogunyomi & Ndikom, 2006). Albeit, certain strategies to curtail the problems associated with the patronage and utilization of TBAs, with regards to maternal

and infant mortality, needs be activated and appropriated because the TBAs play central roles in the present state of maternal and child health in Nigeria (Awotunde, Awotunde, Fehintola, Adesina, Oladeji, Fehintola & Ajala, 2007). The following strategies, among others, will enhance the services and utilization of TBAs in Nigeria:

a. Health centres, clinics, cottage hospital or maternal/delivery homes should be available in every community, especially, in the rural areas. These facilities should be close to the people, and should have qualified nurses and midwives (and possibly doctors) on standby, that will take care of patients in emergency situations, especially pregnant women (Eze, 2010; Okonofu, 2010).

b. There should be community-based training institutions that will train TBAs to provide them with the required training and adequate information, as well as, to give them a legal status.

c. There should be an improvement to the publicity given about TBAs, especially, from the medical/orthodox birth attendants. The perception of TBAs at present is considered as important for providing and achieving equitable health care. Apparent discrimination may lead to those in need of care (pregnant women), refraining from seeking it.

d. There is, therefore, the need to improve the educational and socio-economic status of women in order to allow them to access quality health care services that will safeguard their well-being. Inculcating compassionate care into orthodox healthcare delivery will go a long way to improving uptake of orthodox health care delivery.

The Roles of Social Workers in Enhancing the Utilization of Traditional Birth Attendants (TBAs)

Social workers as professionals are holistic in the services they render to the society, encompassing every area of life, aiding adequate functioning. Compton (2010) opined that social work is a process that operates to assist individuals or groups in increasing their control over their own lives through making satisfying choices, coping satisfactorily with the results of their choices and their lives events, working to provide the society changes that makes available to individuals and groups, the societal resources and support necessary for the selection of meaningful alternative and for the making of meaningful choices. That is to say, that the social work profession enables the individual or group to build their capacity (ies) to function appropriately. Community health is an area of specialization in social work profession, and a social worker in this area is regarded as a medical health practitioner, medical social worker or community health developer. The social worker is seen in this area as a multi-purpose worker and a change agent that plays the role of an educator, mediator, administrator, organizer, facilitator and an advocate. The social worker plays these roles for the optimal functioning of the individual client and the meaningful, genuine and sustainable development of the health sector at the community level, functioning as a health personnel or community educator (Omuruyi, 2001).

Social workers in the maternal and child care units provide psycho-social support, health and behavioral assessment, as well as, responding to issues that emerge during the period from pre-pregnancy through an infant's first year of life. They work to support women and families as they navigate medical challenges, process complex information about pregnancies and neonates (birth to age one) and also access community

support, nurturing and providing hope for families as they move towards their future. Social workers, in partnership with other professionals involved in multi-disciplinary intervention, ensure that:

a. There is an adequately resourced facility.
b. A functionally designated transport system.
c. There are personnel that are trained to utilize protocols for identifying complications that are specific to the setting.
d. There is a unified records system.

The roles of social workers are flexibly versatile, but emphatically concentrated in impact upon any specific case in hand, with the results most times, holistically beneficial to the clients (in this case, the pregnant women and their children before, during and after pregnancy) and satisfactory to the social caseworker.

Recommendations

The following recommendations were made to curb the problems associated with the utilization of traditional birth attendance among pregnant women:

- Good referral training for TBAs allowing them to act as intermediaries between the community and the modern health care system. This training will improve collaboration, increase the number of referrals and improve communication.
- All stakeholders should encourage a synergy between TBAs assisting in home delivery and the medical personnel in the healthcare facilities. That is, the government, non-governmental organisations (NGOs), social workers and other stakeholders should facilitate the integration of TBAs into the modern healthcare system; ensure the proximity and accessibility of obstetric and gynaecologic services by the people by certifying the TBAs who are closer to the people.
- There should be education of the public and also the women on utilizing skilled birth attendants, capable of averting and managing complications during pregnancy, childbirth and postpartum period. Improvement of access to hospitals both in rural and urban areas.
- Policymakers and maternal health advocates must understand the causes of increase maternal mortality rates within the country and make effort to formulate health policies that will reduce the factors.
- Funding agencies and non-governmental organizations (NGOs) could also help to donate funds to make maternal health an urgent health priority and make financial support to be dedicated to this effort.

Conclusion

The activities of traditional birth attendants in most communities especially in the rural areas are highly recognized. Utilization of the services of TBAs depends on individuals and household factors as well as factors operating at the community or policy level. There are numerous problems that arise when there is no proper utilization of the services of TBAs, but each depends on locality, region or country. The TBAs are

believed to be presently serving an interim function in reproductive health care in Nigeria in the absence of a better and affordable alternative to the people.

Lack of proper utilization of the services of TBAs especially in the rural areas where there are no health centres may result in maternal death during pregnancy and increased health complication in mother and child. Presently, there has been increasing debate over the usefulness of TBAs in maternal health care. Opponents of TBAs care are of the view that TBAs have done little to improve maternal health. They opine that TBAs have frustrated laudable efforts made by the government to reduce maternal mortality, while proponents have expressed the need for sustained partnership with TBAs as a strategy to improve access to basic maternity care in rural areas thereby reducing maternal mortality.

The World Health Organization in 2010 identified and developed five mechanisms for TBA integration: training and supervision of TBAs; collaboration skills for health workers; inclusion of TBAs in facility-based activities; systems for communication between TBAs and Skilled Birth Attendants SBAs. TBAs must be provided with appropriate knowledge, easy access to health personnel and quality and regular supervision; all three components enable training to become a tool for TBA integration into the health care system. The referral training for TBAs allows them to act as 'intermediaries between the community and the formal health care system'. Training that advocates collaboration and regular involvement in clinic duties, increases the number of referrals and improve communication.

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