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The Impact of Traditional Birth Attendants on Maternal and Child Health In Ikole LGA of Ekiti State, Nigeria

Owoseni Joseph. S.
Department of Sociology, Ekiti State University, Ado Ekiti -Nigeria
e-mail : owoshynahi@yahoo.com

Owumi Bernard. E. (Ph.D)
Department of Sociology, University of Ibadan- Nigeria
e-mail : bowumi@yahoo.com

Traditional Birth Attendants have been assisting the pregnant women and children mostly in the rural areas. This study intended to explore the impact of traditional birth attendants on maternal and child health in Ikole LGA of Ekiti State, Nigeria. The study adopted the use of functionalist theory and Social Action theory in explaining the impact of TBAs on maternal and child health and the factors influencing the utilization of TBAs facilities respectively. 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.

Findings revealed that 90.4% of the pregnant women and nursing mothers had exclusively utilized TBAs facility. Also, majority of the respondents believed that TBAs have helped them solved their health problems and ensured safe delivery.

Consequently, the outcome of the study indicates that some women resort to TBAs assistance because they believe in the efficacy of the TBAs especially for spiritual assistance. 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, Impact, Maternal health, Child Health, Ikole.

Word Count: 259

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).

For most families, Traditional Birth Attendants are a cheaper option than domiciliary professional midwives and will often accept payment in kind. Mothers in rural areas especially in Southwest of Nigeria prefer to give birth at home because most Traditional Birth Attendants do not charge anything for deliveries and are willing to make house visits, which allow the mother the privacy that many prefer (Oladeji, 2008). Usually, pregnant women will inform their closest adult relatives (spouse, mother, siblings, or in-laws) once they realize that delivery is imminent, who will then contact the Traditional Birth Attendants. A husband, for example, will then look for a female relative to take care of his wife until the Traditional Birth Attendants arrives (Chalmers 2003,).

It was argued in Owumi (2002), Bearer (1994) Paolisco and Leilie, (2005) that Africans and other parts of the developing world treasure motherhood and attach such a high premium to children to the extent that women have little control over their reproductive and maternal health. This was consequently led to high fertility rate within the continent, thus endangering the health of the mothers and children because the higher the number of births per woman the higher the maternal mortality rate (Turmen, 1993) especially in a developing nation where the health facilities and nutritional

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49 requirements are poor. It is established that the risk of maternal death increases when women have children when they
50 are less than 18 years of age or more than 36 years of age (Ajala, 2011). Maternal and child healthcare system is an
51 important segment of medical system in every society. This is as a result of large number of human population involved
52 in this health sector, coupled with the significance of this group to the overall substance of human population (Ajala,
53 2011). Specifically, writers have exposed the risk of childbearing and child health care in their various writings and
54 research findings. The works of Owumi (1996) and Oke (2010) are very significant in this respect. All these works and the
55 annual reports of World Health Organisation (WHO) and UNICEF since 1970s show that there is high maternal and child
56 mortality and morbidity especially in Nigeria in which the large population dwell in rural areas where there are little or
57 no modern health care services.

58 In addition to attending deliveries, Traditional Birth Attendants also help with initiating breastfeeding; providing
59 health education on Sexually Transmitted Infections (STIs), reproductive health and nutrition; visiting mothers during
60 and shortly following delivery where they educate them on the associated danger signs; and accompanying referrals to
61 the health facilities for complicated deliveries (Oladeji, 2009). In many African communities, Traditional Birth Attendants
62 are highly respected; they perform important cultural rituals and provide essential social support to women during
63 childbirth (Chen 2004). In all cases their beliefs and practices are influenced by local customs and sometimes by religion
64 (Bullough 2000). The workload of Traditional Birth Attendants varies considerably from place to place and among
65 individuals. NGOs working at community level in resource poor countries, for instance Bangladesh, frequently include
66 Traditional Birth Attendants training in their activities. In recent years the value of Traditional Birth Attendants training
67 has been increasingly questioned although there are still many groups who remain enthusiastic (Campero, 2009). There
68 often appears to be little common ground between the proponents and opponents of Traditional Birth Attendants
69 training (Thaddeus S and Maine D 2010).

70 In many African countries, the intervention of Traditional Birth Attendants has been a key strategy to improving
71 maternal and child health care. However, recent analyses (Sibley L Sipe T, Koblinsky M. 2010) have concluded that the
72 impact of training Traditional birth attendants on maternal and child health is low. An emphasis on large scale
73 Traditional Birth Attendants training efforts could also be counterproductive, as it will hold back the training of the
74 necessary numbers of medium level providers, particularly midwives. The main benefits of training Traditional Birth
75 Attendants appear to be improved referral and links with the formal health care system, but only where essential
76 obstetric services are available. Some studies have observed that formal training is not a requirement for this function
77 (Chowdohury R, Goodburn E and Arleta, 2008).

78 **Statement of the Problem:**

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

85 In sub-Saharan Africa, a woman faces a 1 in 39 lifetime risk of dying due to pregnancy or childbirth-related
86 complications. Ten countries have 60 per cent of the global maternal deaths: India (56,000), Nigeria (40,000),
87 Democratic Republic of the Congo (15,000), Pakistan (12,000), Sudan (10,000), Indonesia (9,600), Ethiopia (9,000),
88 United Republic of Tanzania (8,500), Bangladesh (7,200) and Afghanistan (6,400) (WHO, UNICEF, UNFPA and the World
89 Bank, 2012). This makes Nigeria the second largest contributor to child and maternal rate in the world. New data from
90 Partnership for Maternal and Child Health (PMCH) shows that as the death toll in Nigeria is falling, the percentage of

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91 deaths that happen in the first month of life is increasing. Newborn deaths now make up 28% of all deaths under five
92 years compared to 24% two years ago. 6 out of 10 mothers give birth at home without access to skilled care during
93 childbirth and it is in the first few days of life when both women and newborns are most at risk (PMCH, 2012). Women
94 in Sub-Saharan Africa mainly rely on traditional birth attendants (TBAs), who have little or no formal health care training.
95 In recognition of their role, some countries and non-governmental organizations are making efforts to train TBAs in
96 order to improve the chances for better health outcomes among mothers and babies (Mathur and Sharma, 2009).
97 Basically, one of the millennium development goals is to improve maternal health care. Despite much progress,
98 achieving the Millennium Development Goals (MDGs) related to maternal and child health is considered unlikely, given
99 that the majority of high-burden, priority countries in which Nigeria is not left out, are not on track to reach MDGs 4 and
100 5 (Ogunbode, 2010).

101 Therefore, against this background, this study, having perceived this silent maternal and child health crisis
102 attempts to uncover the Impact of Traditional Birth Attendants on Maternal and Child in Ikole LGA of Ekiti State, Nigeria.

103 **Objectives of the Study**

104 1. Investigate the role of Traditional Birth Attendants in the provision of maternal and child health services.
105 2. Assessing the health care factors associated with access to traditional birth attendant care services and
106 maternal and child health in Ikole LGA
107 3. Evaluate the working relationship between Traditional Birth Attendants and the formal health system: By
108 exploring the referral linkage between Traditional Birth Attendants and the formal health system.

109 **Global Overview of Maternal and Child Mortality**

110 Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth. 99% of
111 all maternal deaths occur in developing countries. Maternal mortality is higher in women living in rural areas and among
112 poorer communities. Young adolescents face a higher risk of complications and death as a result of pregnancy than older
113 women (Matic, S., Lazaarus, J. F., & Donoghoe, M. C, 2010). Between 1990 and 2010, maternal mortality worldwide
114 dropped by almost 50% maternal mortality is unacceptably high. In 2010, 287 000 women died during and following
115 pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been
116 prevented (WHO,2012).

117 Improving maternal health is one of the eight Millennium Development Goals (MDGs) adopted by the
118 international community in 2000. Under MDG5, countries committed to reducing maternal mortality by three quarters
119 between 1990 and 2015. Since 1990, maternal deaths worldwide have dropped by 47% (Wilkinson, D. & Wilkinson, N.
120 2008). In sub-Saharan Africa, a number of countries have halved their levels of maternal mortality since 1990. In other
121 regions, including Asia and North Africa, even greater headway has been made. However, between 1990 and 2010, the
122 global maternal mortality ratio (i.e. the number of maternal deaths per 100 000 live births) declined by only 3.1% per
123 year. This is far from the annual decline of 5.5% required to achieve MDG5 (Wilkinson, D. & Wilkinson, N. 2008).

124 **Maternal deaths in Nigeria**

125 An estimated 500,000 women die each year throughout the world from complications of pregnancy and
126 childbirth. About 55,000 of these deaths occur in Nigeria. Nigeria, with only 2% of the world's population therefore
127 accounts for over 10% of the world's maternal deaths.

128 In (2003), the World Health Organization and the Federal Ministry of Health of Nigeria reported that about 145 women
129 die everyday in Nigeria as a result of causes related to childbirth. In terms of absolute numbers, Nigeria ranks second
130 globally to India in number of maternal deaths. The risk of a woman dying from child birth is 1 in 18 in Nigeria, compared

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131 to 1 in 61 for all developing countries, and 1 in 29,800 for Sweden. The next session deals with the importance of
132 traditional medicine to mothers and children especially in developing countries.

133 **Traditional Medicine**

134 Traditional medicine (also known as indigenous or folk medicine) comprises knowledge systems that developed
135 over generations within various societies before the era of modern medicine. According to WHO (2004), traditional
136 medicine is the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based
137 medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose
138 and prevent illnesses or maintain well-being (MacArthur, 2009). In some Asian and African countries, up to 80% of the
139 population relies on traditional medicine for their primary health care needs. When adopted outside of its traditional
140 culture, traditional medicine is often called complementary and alternative medicine (MacArthur, 2009). Traditional
141 medicine may include formalized aspects of folk medicine, i.e. longstanding remedies passed on and practiced by lay
142 people. Practices known as traditional medicines include Ayurveda, Siddha medicine, Unani, ancient Iranian medicine,
143 Irani, Islamic medicine, traditional Vietnamese medicine, traditional Chinese medicine, traditional Korean medicine,
144 acupuncture, Muti, Ifá, traditional African medicine, and many other forms of healing practices (Prata, N; Sreenivas A,
145 Vahidnia F, Potts M. 2009).

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

155 Globally, traditional healers have been reported to offer treatments for hypertension, cancer, AIDS, tuberculosis,
156 malaria, sexually transmitted infections, epilepsy and infertility (Curtis, S. and Taket, A. 2005). However, there is paucity
157 of studies on the role of traditional healers in vaccination. For most communities studied in Kenya, Tanzania, Swaziland
158 and South Africa, as is the case with most of Africa, traditional medicine is the only affordable and accessible health
159 care. African traditional medicine thus plays an almost inestimable role in the health care delivery, and the
160 pharmacopoeia of indigenous prescriptions traditionally used in Africa including the communities studied is colossal
161 (Ensor and San 1996).

162 Conventional medicine focuses on experiment and disease causing pathogens. Traditional medicine however
163 postulates that the human being is both a somatic and spiritual entity, and that disease can be due to supernatural
164 causes arising from the anger of ancestral or evil spirits, the result of witchcraft or the entry of an object into the body
165 (Pickett, G. & Hanlon, J. J. 2010). It is therefore not only the symptoms of the disease that are taken into account, but
166 also psychological and sociological factors. In developing countries, traditional healers often have the role of being the
167 primary health care providers for their communities (Twumasi, P. A,. 2005). In addition to traditional birth attendants
168 (TBAs), there are distinct groupings of traditional healers that provide primary health care in communities, in different
169 forms based on their skill level, their accessibility, and whether they underwent lengthy apprenticeships or a spiritual
170 "calling" to their role (Digambar A.Chimankar and Harihar Sahoo. 2011).

171 Although many traditional healers are herbalists, this is not the only way traditional health care is practiced.
172 Some call upon the ancestral spirits or perform exorcism to treat an illness, yet the herbalist may also incorporate this

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173 spiritual aspect in diagnosing the patient's illness (Jonathan D. Eldredge, 2003). Faith healers may utilize prayer, touch,
174 and ointments in their healing rituals. There are also healers who combine Islamic medicine, and will invoke verses of
175 the Koran and/or use astrology in the healing process (Digambar A.Chimankar and Harihar Sahoo. 2011).
176
177 **Categories of Traditional Healers**

178 Though, the focus of this study is to unravel the impact of traditional birth attendants, but it is imperative to
179 bring into limelight the categories of traditional healers. For most countries of the world, just as we have in Nigeria, a
180 traditional healer may be able to per form many functions thereby becoming more versa tile as a healer. The various
181 categories of tradition al healers, perhaps specialists known in traditional medicine today include (Titiyal JS, Pal N,
182 Murthy GV, Gupta SK, Tandon R, Vajpayee RB, Gilbert CE, 2011: Causes and trends of blindness and severe visual
183 impairment on children in schools for the blind in North India). The traditional healers can be categorized into;
184 Herbalists, Traditional Surgeon: The various forms of surgery recognised in traditional medical care include: (i) The
185 cutting of tribal marks, (ii) Male and female circumcision (Clitoridectomy), (iii) Removal of whitlow, (iv) Cutting of the
186 uvula (uvulectomy); Bone Setters; Traditional Medicinal Ingredient Dealers**;**
187 These dealers, more often women, are involved in buying and selling of plants, animals and insects, and minerals used in
188 making herbal preparations. Some of them who indulge in preparing herbal concoctions or decoctions for the
189 management or cure of febrile conditions in children or some other diseases of women and children, may qualify to be
190 referred to as traditional healers; Traditional Psychiatrists; Practitioners of Therapeutic Occultism and Traditional
191 Birth Attendants (TBAs). Since this study dealt with the impact of traditional birth attendants on maternal and child
192 health, it is imperative to unearth the diction of traditional birth attendants.
193
194 **Traditional Birth Attendants (TBAs):**

195 The World Health Organisation opines that a traditional birth attendant (TBA) is a person who assists the mother
196 at childbirth and who initially acquired her skills delivering babies by herself or by working with other birth attendants.
197 In the northern parts of the country, TBAs are of the female sex only, whereas in some other parts both males and
198 females are involved (WHO, 2004).

199 TBAs occupy a prominent position in Nigeria today as between 60-85 per cent of births delivered in the country
200 and especially in the rural communities are by the TBAs. They know how to diagnose pregnancy, confirm it and
201 determine the position of the growing foetus. They have been seen to pro vide pre-natal and post-natal care and so
202 combine successfully the duties of the modern-day mid-wife. Highly experienced TBAs have been recognised to assist in
203 obstetric and paediatric care, as they man age simple maternal and babyhood illnesses (Peltzer, K. & Mngqundaniso, N.,
204 2008).

205 Because of their exposure and experience, and more particularly the TBA's concept of human reproduction, as
206 exemplified by pregnancy and childbirth being normal biological functions of human life linked holistically to
207 cultural/social practices, TBAs have been trained to assist in orthodox medicine practices at the primary health care level
208 (Pickett, G. & Hanlon, J. J., 2010). With their extra hands, a greater coverage of primary health care leading to improved
209 material or child health and the lowering of maternal and child mortality and morbidity, have been achieved (Pickett, G.
210 & Hanlon, J. J. (2010).

211 **Historical Background of Traditional Birth Attendants**

212 Historically, Traditional Birth Attendants have been in existence since the 1800s in the U.K. and from 1952
213 onwards, UNICEF has been providing delivery kits to Traditional Birth Attendants. From 1978 with the Alma Ata
214 Declaration, the WHO has also approved of training Traditional Birth Attendants to be integrated into primary health
215 care services (Sibley and Sipe, 2006). Sibley and Sipe (2006) even approximate that nearly 85% of developing countries
216 engage in utilization of Traditional Birth Attendants. This is a large number, even though their role has shifted from

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217 integration with the modern sector as promoted by the WHO in 1992, to the present, where they are seen to be a link to
218 skilled birth attendance.

219 In developing countries, two main tenets of decreasing maternal and child health problems exist. The first was
220 developed by the WHO in the 1950s and the 1960s, emphasizing the need for mothers' education, ANCs, and family
221 planning. The second main tenet was formed in the 1970s with the training of Traditional Birth Attendants (Anderson,
222 2009). But, at the core of these important elements was also the availability and access to emergency obstetric care.
223 From this, the push to patronize Traditional Birth Attendants was based on the fact that there were not enough health
224 care professionals to handle maternity cases, neither at the present nor in the future, and there were not enough
225 facilities to handle all cases that could potentially present to the hospital (Simpson, 2004). This process was formalized
226 by the WHO, including Antenatal Care (ANC) and risk approaches, and Traditional Birth Attendants were trained until the
227 middle of the 1980s. Eventually, the effectiveness of Traditional Birth Attendants was questioned in terms of neonatal
228 morbidities and other areas. It was concluded that ultimately, it was essential to have access to EmOC with or without
229 Traditional Birth Attendants (De Brouwere et al., 2008).

230 Traditional Birth Attendants are a resource that has intermittently been seen as bad or good. But, the core of
231 the issue is that, by failing to train them in prevention skills, early recognition, and management of complications, there
232 could be more harm than good done in the interim. Walraven and Weeks (2009) argue that identifying and training
233 these birth attendants with some midwifery skills should be a priority until the longer solution of training more midwives
234 can be achieved (Peltzer, K., Preez, N. F., Ramlagan, S., & Fomundam, H. 2008).

235 In this context, the actual role of the Traditional Birth Attendants juxtaposed to the modern conception of a
236 skilled attendant in functional terms should be considered. Although it is commonly accepted that Traditional Birth
237 Attendants cannot provide the same services as nurse-midwives, based on their lack of resources and access to health
238 facilities, it is often still necessary to work with them in a meaningful way. Sibley and Sipe (2006) address this issue,
239 commenting that, in places where a large proportion of births take place at the Traditional Birth Attendants, it is
240 possible and effective to engage Traditional Birth Attendants in key evidence-based interventions and first-aid for
241 complications as an immediate strategy.

242 **Types of Traditional Birth Attendants**

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

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

253 In others, she may be a woman's elderly relative or neighbour who does not make a living from her work and
254 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
255 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
256 appreciation. A third type of Traditional Birth Attendants is the family birth attendant who only delivers babies of her
257 close relatives (Bolatito, 2008).
258

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The Position of TBAs in the Primary Healthcare System

Ailments have over the years been a scourge and a threat to mankind. People from different cultural backgrounds have used different herbal plants, plant extracts, animal products and mineral substances (Addae-Mensah, 2002) as the means to care, cure and treat ill-health, with disease prevention, and with health promotion (Curtis and Taket, 1996) since pre-historic times. Traditional Birth Attendants embraces the ways of protecting and restoring health that existed before the arrival of orthodox medicine (OM) (World Health Organisation [WHO], 2001). Traditional Birth Attendant is assuming greater importance in the primary health care of individuals and communities in many developing countries (Peltzer and Mngqundaniso, 2008; WHO, 2002; 1978). These approaches to health care belong to the traditions of each culture, and have been handed down from generation to generation (WHO, 1996). China and India, for example, have developed very sophisticated contemporary and alternative medicine systems such as acupuncture and ayurvedic for decades (Addae-Mensah, 2002; Agyare et al, 2006).

In fact, Traditional Birth Attendants reflect the socio-religious structure of indigenous societies from which it developed, together with the values, behaviours and practices within their communities. Traditional Birth Attendants ultimately aim at restoring the physical, mental and social wellbeing of the patient, through alternative health care delivery to the orthodox medical system. Tribes, cultures and indigenous people of nations throughout the world have evolved system of Traditional Birth Attendants service for generations, and communities have found most of these medical practices valuable and affordable and still depend on them for their health care needs. The WHO estimates that about 60% of the world's people uses herbal medicine for treating their sicknesses and up to 80% of the population living in the African Region depends on Traditional Birth Attendants for some aspects of primary health care (WHO, 2000).

Indeed, in rural communities in Ghana, like other developing countries and elsewhere, Traditional Birth Attendants will continue to remain a vital and permanent part of the people's own health care system. The efficacy and potency of Traditional Birth Attendants are indeed attracting global attention (Peltzer and Mngqundaniso, 2008; Mwangi, 2004; Buor, 2003) and that traditional, complementary and alternative medicine is globally increasing in popularity (Kaboru et al, 2006). The global trend indicates that even in the advanced countries, more people with the most advanced and sophisticated medical service system are making headway in Traditional Birth Attendants facility use to cater for their health care requirements (WHO, 2001). Studies have shown that, almost 70% of the population in Australia used Traditional Birth Attendants. Also, the annual 'out of pocket' expenditure on Traditional Birth Attendants, nationally, was estimated at US$ 3.12 billion (Xue et al, 2010). In the Netherlands, 60%, while in the United Kingdom, 74% of the people are advocating for the inclusion of Traditional Birth Attendants into the National Health Service. The percentage of the population which has used Traditional Birth Attendants at least once in Canada, France, USA and Belgium stands at 70% , 75%, 42% and 38% respectively (WHO, 2002). A survey conducted in the member states of the European Union in 1991 revealed that 1,400 herbal drugs were used in the European Economic Community by patients (WHO, 1996). One-third of American adults have also used alternative treatment and there is a fast growing interest in Cotemporary Alternative Medical system (CAM) in the developed world (WHO, 2001; 1996).

The traditional healers are recognized, acknowledged and trusted in their communities; they could therefore be used as counsellors and health educators to cure the spread of STIs, HIV and AIDS in Africa. Furtherance, 60% of the children with high fever due to malaria was successfully treated with herbal medicines in Ghana, Mali, Nigeria and Zambia in 1998 (WHO, 2001). Indeed, the use of Traditional Birth Attendants and the services of traditional healers by millions of Africans have been recognized by the WHO and in 1977, the World Health Assembly (WHA) drew attention to the potentials and the efficacy of herbal medicine in the national health care systems. The WHA urged member countries to utilise those medicines (Akerele, 2007; Nakajima Nandini, 2010.) to broaden the coverage of health care in

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301 their respective countries. The malaria endemic countries in Africa have herbs for treating the fever. According to Buor
302 (2002) and Awadh, et al (2004) the malaria parasite, especially the plasmodium falciparum has developed resistance to
303 almost all the anti-malaria drugs and there is the need to develop herbal substitutes not only for the chemical side
304 effects of orthodox medicine but also for the expensiveness of the orthodox health care.

305 In Nigeria, up to the middle of the 19th century, most indigenous people had no access to Orthodox Medicine
306 and relied entirely on herbal and Traditional Birth Attendants services for their primary health care needs (Ogundari,
307 2008). With the scarcity of orthodox doctors, nurses and paucity of modern hospitals and clinics, the large majorities of
308 people have to rely on sources other than modern health facilities. For example, in Ghana there is one traditional
309 practitioner to approximately 386 people, whilst the ratio of orthodox doctors to population stands at 1:10 700; nurses
310 to population ratio is 1:1 578 (MOH, 2008). People's own perception of the role of Traditional Birth Attendants is not
311 explicitly studied in Ghana.

312 There are numerous expressions associated with the potentials of Traditional Birth Attendants. Exploring these
313 concerns will inform decision towards its improvement and sustainability.
314

315 **Effectiveness of Traditional Birth Attendants Training Programs**

316 The role of the Traditional Birth Attendants started to be taken seriously in the early 1950s when high maternal
317 mortality rates became a concern in many developing countries. In the past, Traditional Birth Attendants were
318 considered to be a cause of high maternal mortality and as a consequence were trained on the assumption that
319 mortality would reduced with changed in their practices. In 1978, during an international conference on primary health
320 care held at Alma Ata, Traditional Birth Attendants were recognised as an important part in community health care and
321 it was proposed to engage them in primary health care and to train them in biomedical knowledge as a vital intervention
322 to address maternal mortality (Krasovec, K, and Barclay 2004, WHO 2007). Throughout the 1970s and 1980s, WHO
323 promoted the training of Traditional Birth Attendants in Africa, Asia and Latin America with biomedical knowledge to
324 reduce the maternal mortality rate (Krasovec and Barclay 2004, WHO 2005).

325 World Health Organisation (WHO) advocated for safe and clean delivery through the "three cleans" programme
326 (hand washing with soap, clean cord care and clean surface), promoted awareness of the importance of breastfeeding
327 and weighing babies and addressed some of the unhygienic and harmful practices (WHO, 2007). Over a period of time
328 the training content changed and included various other aspects of reproductive health including family planning,
329 HIV/AIDS, oral rehydration, identification of risk, legal issues of female infanticide and referral.

330 Studies of the effectiveness of these training programs, however, showed that reductions in maternal and infant
331 mortality occurred only in areas where the Traditional Birth Attendants had skilled backup support. The studies found
332 that the majority of the programs were ineffective because Traditional Birth Attendants did not have sufficient literacy
333 or general knowledge when they started their training (Jeremy, 2006). Without supervision and backup support, they
334 ended to slide back into old ways and were not able to prevent death when life-threatening complications arose during
335 childbirth. Although training programs for Traditional Birth Attendants have not contributed directly to reductions in
336 maternal mortality, they do appear to improve Traditional Birth Attendants' effectiveness in other areas. Traditional
337 Birth Attendants training programs have contributed to Traditional birth attendants ' effectiveness in reducing neonatal
338 tetanus, increasing the use and provision of antenatal care, and increasing timely referrals for complications (Jeremy,
339 2006).

340 **Recognizing the Traditional Birth Attendants' Key Contributions**

341 Recognizing that Traditional Birth Attendants are the most affordable and accessible system of health care for
342 the majority of the African rural population, the Organization for African Unity (now the African Union) declared 2001-
343 2010 to be the Decade for African Traditional Medicine. The goal was to bring together all the stakeholders in an effort

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to make safe, efficacious, quality, and affordable traditional medicines available to the vast majority of our people. This goal was supported by the World Health Organization and IDRC, among others. IDRC played a major role in the process that led to the declaration of the Decade. A decision that was vital for the health of African populations who depend largely on traditional medicines and medicinal plants." That view is supported by Dr Philippe Rasoanaivo, who wass responsible for traditional medicine in the Ministry of Health in Madagascar (Brouwer JA, Boeree MJ, Kager P, Varkevisser CM, Harries AD, 2007).

It is being increasingly recognized that TBAs have a role to play in improving health outcomes in developing countries because of their access to communities and the relationships they share with women in local communities, especially if women are unable to access skilled care (Makundi EA, Malebo HM, Mhame P, Warsame , 2006). Some countries, training institutes and non-governmental agencies are initiating efforts to train TBAs in basic and emergency obstetric care, family planning, and other maternal health topics, in order to enhance the links between modern health care services and the community, and to improve the chances for better health outcomes among mothers and babies (Byrne, and Morgan, 2011). Historically, Traditional Birth Attendants (TBAs) have operated outside of the formal healthcare delivery structure (WHO, 2011). TBA training has been used as a means of extending health services to underserved communities in developing nations in hopes of decreasing mortality and morbidity (Koblinsky, M, 2003). While the focus in the past two decades has been on training TBAs, studies on training impact has shown conflicting results in maternal outcomes with many studies showing little to no impact on high maternal mortality outcomes (Koblinsky, M 2003). As a result, there has been a shift toward skilled birth attendants, capable of averting and managing complications

While the WHO initially encouraged the training of these TBAs through the mid-1980s (WHO, 1986), many authors argued about their effectiveness (Okafor and Rizzuto, 1994). Nevertheless, studies from Guatemala and Nigeria have shown that the training of TBAs can indeed increase the number of referrals of women with obstetric complications to hospitals, which supports the extension of such programmes until the presence of skilled birth attendants is a reality in developing countries (Reichler MR, Darwish A, Stroh G, Stevensen J, Al Nasar MA, Oun SA, Wahdan MH, 1998). Namboze (1985), while recommending their training, expresses doubts as to whether such women in a traditional setting would change their usual way of conducting delivery, or whether it would mean encouraging a substandard cadre of professionals within the communities. Other authors have argued that over the years the training of TBAs in developing countries has had little impact on maternal mortality and that the most effective measures are those which make it possible to reach a well-equipped hospital (Turmen, 1993).

In addition to providing emotional and household support to the woman and her family, the Traditional Birth Attendants may provide health education in nutrition, prevention of sexually transmitted infections (including HIV), breastfeeding and family planning. In some maternal health programs Traditional Birth Attendants distribute iron and folate supplements or vitamin A supplements to pregnant women or supply oral contraceptives to the community. In others, they team up with a midwife to provide neonatal care during the postpartum period. The Traditional Birth Attendants can also be a valuable resource for dispelling false information and harmful practices such as the interruption of unwanted pregnancies and rituals of female genital cutting (World Bank, 2006).

The Role of Traditional Birth Attendants in Managing Complications

A complication during childbirth is one of the main causes of death and disability among women of reproductive age ain developing countries. Some of the main maternal complications during delivery include excessive post partum bleeding, retained placenta and abnormal presentation. Haemorrhage due to serve bleeding is a major cause of maternal death worldwide (Khan, et al, 2006; Costello, et al 2006). Studies have found that postpartum haemorrhage

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can kill within an average of two to six hours and therefore effective community awareness of treatment and first aid could prevent many of the maternal deaths (Kvale, et al, 2005).

Therefore, TBAs and other family members present during delivery can prevent these deaths by identifying the complication and taking appropriate action. Studies have shown an increase in knowledge of risk factors and signs of danger in pregnancy and childbirth with TBA training (Jahn, 2001; Rodgers, 2004, UNFPA, 1996). Studies in developing countries have also demonstrated increase in referral for immunization and complication with TBA training (Goldman and Glei, 2000; Smith, 2002, Rogers, K.A., Malaika, L. And Nelson, S., 2004; UNFPA, 2004)

Integrating Traditional Birth Attendants' Services within Primary Health Care

In recent years, the treatments and remedies used in traditional African medicine have gained more appreciation from researchers in Western science. Developing countries have begun to realize the high costs of modern health care systems and the technologies that are required, thus proving Africa's dependence to it (Cayamettes M, Placide MF, Barrere B, Soumaila M, 2000). Due to this, interest has recently been expressed in integrating traditional birth attendants into the continent's national health care systems (Cayamettes M, Placide MF, Barrere B, Soumaila M, 2000). An African healer embraced this concept by making a 48-bed hospital, the first of its kind, in Kwa-Mhlanga, South Africa, which combines traditional methods with homeopathy, iridology, and other Western healing methods, even including some traditional Asian medicine (Titiyal JS, Pal N, Murthy GV, Gupta SK, Tandon R, Vajpayee R. B and Gilbert C.E, 2011) However, the highly sophisticated technology involved in modern medicine, which is beginning to integrate into Africa's health care system, could possibly destroy Africa's deep-seated cultural values (Olusoga, 2011).

The diagnoses and chosen methods of treatment by traditional birth attendants rely heavily on spiritual aspects, oftentimes based on the belief that psycho-spiritual aspects should be addressed before medical aspects. In African culture, it is believed that "nobody becomes sick without sufficient reason" (Abel C, and Busic K:, 2008). Traditional birth attendants look at the ultimate "who" rather than the "what" when locating the cause and cure of an illness, and the answers given come from the cosmological beliefs of the people (Abel C, Busic K:, 2008). Rather than looking to the medical or physical reasons behind an illness, traditional birth attendants attempt to determine the root cause underlying it, which is believed to stem from a lack of balance between the patient and his or her social environment or the spiritual world, not by natural causes (Abel C, Busic K:, 2008). Natural causes are, in fact, not seen as natural at all, but manipulations of spirits or the gods. For example, sickness is sometimes said to be attributed to guilt by the person, family, or village for a sin or moral infringement. The illness, therefore, would stem from the displeasure of the gods or God, due to an infraction of universal moral law (Titiyal JS, Pal N, Murthy GV, Gupta SK, Tandon R, Vajpayee R. B and Gilbert C.E, 2011).

Just as the Traditional Birth Attendant needs to work with a skilled provider in order to have an impact on maternal mortality, the skilled provider needs the Traditional Birth Attendants to help build a relationship with the community.

Theoretical Framework

For the purpose of this research work, there is theoretical triangulation of Structural Functionalism. 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

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429 takes account of the behaviour of others and is thereby oriented in its course". It is important in any study of disease
430 management among the Yoruba to investigate the persistence of their belief and also to examine the effect of such
431 beliefs on curative measures likely to be adopted. It is further averred that action is influenced not only by the situation
432 but by the actor's knowledge of it. It is for this reason that knowledge of available means and perceived efficacy of
433 action play important role in determining what course of action to take in improving or maintaining maternal and child
434 health.

435 **METHODOLOGY**

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

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

445 **Findings and Discussion**

446 **SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE**
447 **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**

448 **Source: Fieldwork: (2012)**

449 Table 4.1.1 above shows the socio-economic and demographic characteristics of respondents, who are currently
450 attending antenatal and/or postnatal care with TBAs in the study, Nigeria. For the age distribution, the data shows that

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451 the respondents age range between 14-50 years which is in line with reproductive age for women. While the majority of
452 pregnant women and mothers between ages 31-40 years and 41-50 years 32.4% and 30.8% constitute the highest,
453 meaning that in the rural area, older women are indifferent to family planning. Those below 20 years constitute 6.8%.
454 Data on educational attainment of the respondents revealed that the population consists mostly of mothers
455 with little education. Respondents with no education constitute 10.4% while 21.6% and 44.8% had primary and
456 secondary education respectively. Respondents with tertiary education 23.2% are slightly higher than primary
457 education. This shows that many TBAs clients in Ikole LGA did acquire formal education.
458 The majority of the respondents 84.4% were Yoruba, followed by Igbo 8.0%, Hausa 4.0% and 3.6% were from
459 other ethnic groups in Nigeria. This finding was expected because the study was conducted in the Yoruba speaking
460 community. The proportion of the Yoruba women attending antenatal and postnatal was higher compared to other
461 ethnic groups. The religion affiliation of the respondents' shows that majority of them are Christians 89.6% followed by
462 Muslim 6.8% and 3.6% of the respondents claimed to be Traditional worshipers.
463 An examination of the monthly income reveals that the population consists of low income earners. The figure
464 shows that majority of the respondents earned between the average income of ₦11,000 – ₦20,000 28.4%, those with
465 income below ₦10,000 were 22.4%. pregnant women and mothers with income between ₦21,000 - ₦30,000 and
466 ₦31,000 – ₦40,000 constitute 19.6% and 8.4% respectively while income earner between ₦61,000 and above were
467 2.8%. This shows that the pregnant women and nursing mother may not have enough financial capability to attend
468 modern health centre. The pregnant women and nursing mothers with low income, that had little or no support from
469 their husbands would surely prefer TBAs facilities to health centres due to the low cost.

470 **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

471 **Source: Fieldwork, (2012)**

472 The table above shows the frequencies and percentages of respondents that had exclusively used the services of
473 Traditional Birth Attendants in their communities. 90.4% of the respondents agreed that they had exclusively utilized the
474 TBAs' services while 9.6% of the respondents had never had exclusively utilization of TBA in their locality. This
475 percentage shows that they also make use of other health facilities with TBAs' health services.
476 The highest percentage of the respondents that had used TBA services patronized Healing Church (84.0%) while
477 2.4% of the respondents visited herbalist home, those that patronized Alfa home were 6.8% and 6.8% of them visited
478 others, which could be homebirth or other places. Despite the high level of awareness about maternal and child high
479 mortality rate, the number of the respondents that made use of TBAs' facilities was still high. The reason for this is not
480 far fetched; public health care facilities that are supposed to provide basic prevention and health promotion services
481 that include immunization, health education, promotion of adequate nutrition and management of malaria, diarrhea,
482 acute respiratory infection and other common illness are not available, which makes the rural dwellers make use of the
483 available health facilities such as TBAs (Simpson 2004). This is corroborated by the interview of a TBA;

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484 In relation to above, one of the pregnant women attending antenatal care at TBA said that as long as they know
485 that the health centre is not accessible, they are comfortable with conducting deliveries at home or TBAs and with
486 confidence.

487 *It is very expensive to deliver at the hospital. At the same time, the health centre is very far from my place.*
488 *I have been attending TBA for long time and it is good for me. The TBAs are really taking care of us.*
489 ***(IDI/Female/Iyemero/April 19 2012)***

490 To ascertain reasons for patronizing TBAs facilities, a woman interviewed was of the opinion that:

491 *It is better to deliver at home or Ile-Agbebi than anywhere else. In the Health Centres, there are men*
492 *around, which I don't like. So, the only thing that can make me go to the health centres is when my people*
493 *TBA and family members are not able to take care of my delivery of which it has never happened. I also go*
494 *to health centre for my child immunization but for delivery, I prefer TBAs than hospitals. In fact, all my four*
495 *children were delivered at TBAs and home.**(IDI/Female/Ijesa-Isu/April 21 2012.)***
496

497 **THE SERVICES RENDERED BY TBAs**

Nature of Services Rendered by TBA	**Frequency**	**Percentage %**
Prenatal Care/Labour/Delivery	48	19.2
Postnatal Care	54	21.6
Spiritual Support (Prayers)	79	31.6
All of the above	64	25.6
I don't know	5	2.0
Total	**250**	**100**

498 **Source: fieldwork, 2012**

499 Table 4.2.3 indicates the services rendered to mothers and children by the TBAs. 19.2% of the respondents
500 believed that the TBAs help mothers before and during delivery, 21.6% of them were of the opinion that the TBAs take
501 care of both mothers and children after delivery postnatal care and 31.6%, which is the highest percentage of the
502 respondents saw that the TBAs assist them in prayers. Moreover, 25.6% of the respondents believed that the TBAs
503 rendered all the services mentioned above while only 2% of the respondents did not know the services.

504 In support of the above, (Joesoef, Baughman and Utomo, 1988) observed that the role of TBAs on maternal and
505 child health care cannot be undermined. Exiting literatures have shown that when the TBAs are cooperative and
506 supportive in child health care, it has good impact on the mother and child health of the rural dwellers.

507 **RESPONDENTS' HEALTH PROBLEMS SOLVED BY TBAS**

TBAs give post delivery treatment to mother and/or child?	**Frequency**	**Percentage %**
Yes	185	74.0
No	65	26.0
Total	**250**	**100**.0
Major mother's health problem solved by TBA		
Stomach-ache	32	12.8
Barrenness	28	11.2
Fibroid	12	4.8
Miscarriage	38	15.2
Long Labour	12	4.8
Spiritual Attack	99	39.6
Others	17	6.8
No Problem	6	2.4
No Comment	6	2.4
Total	**250**	**100.0**
Childhood diseases ever treated by TBAs		

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Malaria	3	1.2
Measles	38	15.2
Smallpox.	32	12.8
Convulsion	75	30.0
Makije not reaching seven days	58	23.2
Fontanelle *Oka-Ori*	12	4.8
Uvulectomy *Belubelu*	3	1.2
Others	29	11.6
Total	**250**	**100**

Source: fieldwork (2012)

Table 4.2.4 depicts whether the TBAs give post delivery treatment to mother and children. Data shows that 74.0% of the respondents indicated that TBAs give postnatal care to mothers and children whereas 26.0% of the respondents indicated that TBAs do not give post delivery care for mothers and children.

Furthermore, to determine the kind of diseases that has been cured by TBAs for mothers, the table above shows that 13.1% of the respondents had suffered from stomach pain, which healed by TBAs; 11.5% was Barrenness; 4.9% of them had suffered from fibroid and were taken care by the TBAs; 15.6% of the respondents suffered from miscarriage; 4.9% mothers among the respondents had experienced long labour, which was taken care of by TBAs in their communities; those who had suffered from spiritual attack were amounted to 39.6%, which is the highest percentage in which the solution was gotten from the TBAs. Moreover, 7.0% of the respondents had been assisted by the TBAs on other occasions whereas, 2.5%, had never experienced any problem that was healed by the TBAs but they patronize the TBAs for delivery and any other issue.

Furthermore, the above table also depicts the findings on the kind of child diseases that were treated by TBA. From the data, 1.25% of the respondents had had their children malaria being treated by TBAs; 15.2% of them indicated that their children measles was healed by TBAs. Moreover, 12.8% of them had their children smallpox treated by TBAs; 30.0% of the respondents' children had suffered from convulsion, which is the most common child disease in Yoruba communities and they were treated by the TBAs. 23.2% of the respondents' children had Makije, a disease that kills baby within seven days of delivery. According to Yoruba belief, Makije has been the major reason for celebrating naming ceremony the 8th day of delivery when the baby has crossed over the deadly disease called Makije; 4.8% of the respondents' children had Fontanelle Oka Ori which was treated by TBAs and 1.2% of the respondents' children had suffered from Uvulectomy Bellubelu whereas, 11.6% of the respondents' children suffered others diseases.

TYPES OF MEDICINE GIVEN AT THE TBA CENTRE

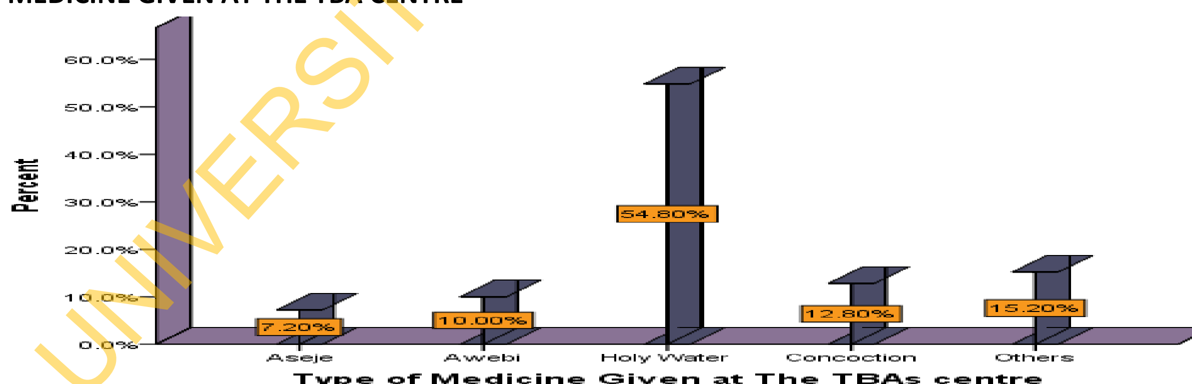

Fig. 4.1 bar chart above shows that 7.25% of the respondents were given Aseje by the TBAs; 10.0% of them received Awebi while 12.8% received concoction and 15.2% received other medicines not mentioned. More than half 58.8% of the pregnant women and nursing mothers patronizing TBAs for antenatal and postnatal respectively were given Holy Water, this is as indication that the TBAs have strong belief in the efficacy of holy water;

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The above finding was supported by the interview of a TBA at Orin – Odo:

> *Since I have been practicing for 32 years as TBA, I never use any medicine for my clients both mother and child other than holy water. Ask anybody, they will tell you that it is only water that I apply and has not failed me. That is why many people do call me '**Iya olomi**' that is, a woman found of water. As you can see, all these three pots have different water serving different purposes. The water in the first pot is used to bath the woman before delivery in order to avert any complication during and after delivery. The second water pot is to bath the new baby to avert any child disease especially a disease called **makije** don't reach 7 days this disease kills baby before seventh day. If I may tell you that it is because of the disease they celebrate naming ceremony on the eightieth day when the new baby escapes the deadly disease while the third pot is also for the mother after delivery to bring her back to this world because delivery period is close death*
>
> ***(IDI/TBA 1/Orin-Odo/May 3, 2012).***

BELIEF IN THE 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**

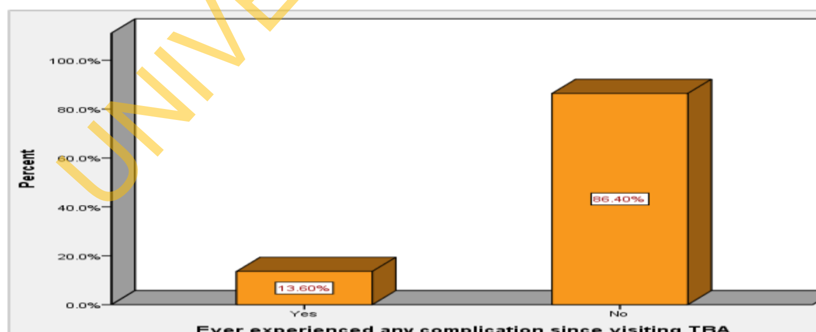
The table above depicts that 79.2% of the respondents believed in the efficacy of the medicine given by the TBA while 18.8% of them did not believe in the efficacy of the medicine. Only 2.0% of them did not have any comment. The result signifies that majority of the respondents believed in the efficacy 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)***

EXPERIENCE OF COMPLICATION AT TBAs CENTRES



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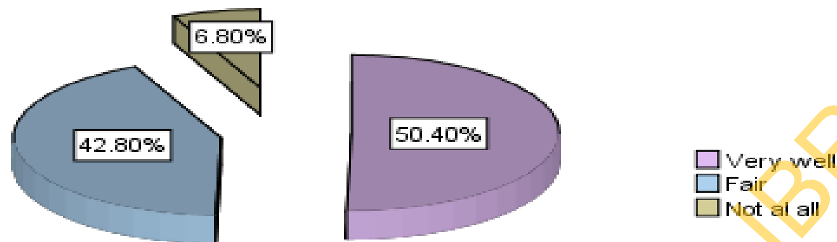
568 In the above, it is illustrated that 13.6% of the respondents said that they had experienced complication since
569 they had been visiting TBAs while 86.4% of the respondents had never experienced complications. From this finding, it
570 could be affirmed that the TBAs' services have been so perfect to record 86.4% of no complication.
571 This was supported by the interview of a 46 years old mother, who utilized the health facility of TBAs;
572 *I gave birth to all my children at TBA centre. I have been using it for over 20 years. Though, I firstly preferred*
573 *going to government hospital antenatal because I was not used to TBA. But my mother-in-law took me to a*
574 *woman, who was the only TBA then and since that time, I have been patronizing TBA without experiencing*
575 *any complication whatsoever. I have not heard any complication of any kind.* (**IDI/Female/Ijesa-Isu)**
576
577 **MANAGEMENT OF COMPLICATION BY TBA**



578 **How well does the TBA deal with complication**
579 From the above, it is illustrated that 50.4% of the respondents confirmed that the TBAs deal with complication
580 very well; 42.8% indicated that they fairly deal with complication while 6.8% of them were of the view that the TBAs do
581 not deal with complication at all. As noted during the interviews with different mothers and TBAs, dealing with
582 complications by the TBAs is as result of their long experience in the service.
583 The above statement was supported by a TBA confessed that:
584
585 *Anytime I perceived any difficulty in the delivery, I quickly referred the patient to hospital in Ikole; because*
586 *that was what we were told in training that if we experience any complication, the patient must be quickly*
587 *referred without delay to avoid death.*
588 ***(IDI/TBA/Ara/April 22, 2012)***
589
590 Another IDI with one the respondents indicated that;
591
592 *Tackling complication is the major challenge facing the TBAs. Many at times, they don't know what to do*
593 *when the delivery situation changes. I remember when one of my co-tenants died at the TBA centre*
594 *during delivery. When there was over bleeding, the TBA did not know what to do so the woman died in a*
595 *pool of blood without holding or feeding her twin babies. There was no clinic around to rush her to. Even*
596 *if the was one, the husband had no money to pay a doctor or a clinic. If he had money, he would have*
597 *taken her to a clinic in Ikole town*
598 ***(IDI/Mother/Iyemero/April 12, 2012).***
599
600 In another view, a TBA was of the point that complications some times occur. She reiterated that;
601 *When I realized that the situation of the woman is getting to a point that I cannot handle, I quickly call*
602 *upon a nurse in our church that stays around the vicinity to render assistance. If there is no improvement,*
603 *she (the nurse) helps us carry the woman to general hospital in Ikole, where she works. Though, this is a*
604 *very rare occasion because complication does not often occur and nobody prays for such"*

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(IDI/TBA/Iyemero/April 22, 2012).

Generally, at the time of the actual delivery, the TBAs use latex surgical gloves, warm water and clean cloths. These items, and the blades to cut the umbilical cord are either supplied by the TBA, or the patient brings them herself. Either way, the patient is financially responsible for them.

WORKING RELATIONSHIP BETWEEN TRADITIONAL BIRTH ATTENDANTS AND THEFORMAL HEALTHCARE SYSTEM

Ever being referred to health centres from the TBA centres?	**Frequency**	**Percentage %**
Yes	83	30.8
No	167	69.2
Total	**250**	**100**
Reasons for referral		
Over Bleeding	19	22.9
Unable to deliver	6	7.2
To treat my child disease	23	27.7
Other Complication	29	34.9
No Complication	6	7.2
No comment	167	66.8
Total	**250**	**100.0**
There is trained health worker (s) in the TBA centre patronized		
Yes	46	18.4
No	124	49.6
I don't know	80	32.0
Total	**250**	**100.0**

Source: Fieldwork (2012)

The above depicts the respondents' view on the working relationship between TBAs and modern health system. On whether the respondents had ever been referred to health centres from the TBAs centres, 30.8% of the respondents said they had been referred to health centres from TBAs centres while 69.2%, which means that higher percentage of them had not been in any means referred to health centres.

Furthermore, if the respondents had been referred, to understand why they were referred, 22.9% were referred due to over bleeding during or after delivery; 7.2% of the referred respondents was due to inability to deliver while 27.7% of them were referred to go and treat their children's diseases. Moreover, 34.9% were referred for other complication while 7.2% were of no complication.

Furthermore, to know whether there was any trained health worker in the TBA centre patronized by the respondents, 18.4% of the respondents indicated 'Yes' while 49.6% of the said 'No' and 32.0% did not know whether there was any health worker in the TBAs centre patronized or not.

RECOMMEDATION AND CONCLUSION

INTRODUCTION

This session presents recommendations and conclusions of the study. The rationale and objectives as well as the inferences drawn from the findings of the study were included.

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.

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634 The TBAs that have not been trained should be urged to participate in training programmes or activities, while they
635 should continue to have government links. Funding the TBAs is important as they should be aware that they are not
636 "illegal," and so that their work does not go underground and becomes dangerous.

637 2. There is need for more training of traditional birth attendants (TBAs) to refer women with complication promptly.
638 Attention must also be paid to the antenatal care services with facilities for early detection of complication.

639 3. It is apparent that TBAs have low level of health officer's supervision at the moment. Government should increase
640 the level of supervision by community nurses, midwives at the health centre, or other additional health staff that
641 might be able to assess the record keeping, practices, and needs of TBAs.

642 4. There should an integration of TBAs and the health centres. The Traditional Birth Attendants should be brought into
643 hospital setting as it is practiced in China. There should be TBA department in the health centres to deal with the
644 spiritual aspect of health care delivery which makes many people patronize TBAs.

645 5. It is an interesting development that some states of the federation have established traditional medicine boards to
646 monitor the activities of its practitioners, This development should be encouraged throughout the country.

647 6. Further research should be undertaken in areas where women commonly deliver at home with a family member
648 attending or no attendant. Some policy makers note that the difference between home delivery and TBA attendance
649 is marginal in terms of the number of maternal deaths. However, more research at the community level using verbal
650 autopsies and other methods of tracking maternal deaths could help elucidate this point. In addition, this research
651 could help assess where potential interventions make the most sense, in communities with TBAs or those without
652 TBAs.

653 **CONCLUSION**

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

663 Since government is now training TBAs, it is important for TBAs to adopt any new strategies to improve on
664 health care delivery as recommended by policy of the government to essentially ensure skilled attendance at birth as a
665 means of decreasing the MMR. Particularly, it is significant to understand the challenges that women face in an area
666 that has no maternity clinic to date. Many women are located in remote areas, such as Iyemero and Ijesa-Isu, over 20
667 km away from Ikole Local Government Headquarters where functioning government hospital is located and over 45 km
668 from State Specialist Hospital. The sheer distance and difficulty of the terrain to cross, particularly in the rainy season,
669 are significant barriers that women face in delivering at government hospital. In addition, in some of the villages, there is

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670 not even a TBA and women are simply delivering at home. Further research is required to compare home births to TBA
671 births and use the data to support new policies.
672 The attitudes of health workers and the poor relationship between TBAs in the cluster and the health facility are
673 alarming. Some investigation is also required in this area to see how to best broker a relationship between TBAs and the
674 health system, as the ultimate goal in the redefinition of TBA roles is to engage them as a key liaison between the two.
675 Assessing appropriate supervision of TBAs is also a critical issue.
676 Finally, the overwhelming need for additional health facilities in remote locations is urgent. But it is not only the
677 facility, rather also the personnel. Given the ravages of HIV in the health care sector, it is important to recruit and train
678 healthy health care staff that are able to handle the anticipated increased demands for pregnancy-related services and
679 deliveries that should come with a shift a way from TBAs. How to create these resources is still a challenge and is a goal
680 for the future. Handling the human resources and facilities crisis in the interim requires community collaboration in
681 transport, creation of a birth plan for women, TBA involvement in health care planning, and male involvement;
682 awareness of national policy and its effect at the zcommunity level; and keeping those TBAs that are still practicing safe
683 and attentive to the needs of the women in the community. However, over time, the role of the TBA should shift to a
684 community educator, focused on reproductive health issues. And eventually, the trainees of TBAs daughters and
685 granddaughters should be encouraged to pursue higher education as enrolled nurses in order to use the local expertise
686 and fuse the positive elements of the community with the modern health care sector. The government, as a pioneer in
687 the achievement of the MDGs in unison, should take the matter of TBA training and integration into account as a
688 strategic intervention in decreasing the maternal mortality ratio by its target deadlines.

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