Article

Factors Influencing Utilization of Traditional Birth Attendants' Services by Pregnant Women and Nursing Mothers in Kaduna State, Nigeria: A Qualitative study

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Abstract
Studies have shown that unskilled birth attendants during pregnancy and childbirth are one of the major causes of maternal death especially in developing countries. This study aims to examine the reasons for the patronage of traditional birth attendants' services among pregnant women and nursing mothers in Kaduna State, Nigeria. A descriptive exploratory study design was used and Qualitative data was collected through the use of a pre-tested interview guide. Ten healthcare providers participated in the study in urban and rural communities of Kaduna State, Nigeria. They included seven officers in charge of primary health centers, one Chief Nursing Officer of a tertiary health institution and one Medical Officer-in-charge of a General hospital. QDA Miner Lite v2.0.6 was used in the analysis of the data.

Keywords
Unskilled birth attendants, maternal death, Kaduna State, pregnancy and childbirth, utilisation of traditional birth attendants

Introduction

Majority of women who utilise maternal health care services are not ill, and as pregnancy is a frequently and uneventful physiological process, it is logical to imagine that, given the slightest constraints, maternal health services would be

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underused (Abdulkareem, 2018). The main objective of maternal health care is to ensure that expectant and nursing mothers have normal delivery, bear healthy children and maintain good health. The death of a woman while pregnant or during puerperium has been regarded as a public health problem for over a century (Eke & Ossai, 2021).

Unfortunately, the use of antenatal and skilled birth attendants is low in most developing countries, and this includes Nigeria. The Nigerian Demographic and Health Survey, for instance, shows that 57% of pregnant women in Nigeria made four or more antenatal care visits while 43% of births were attended to by skilled birth attendants (Abdulkareem, 2018). It is very important to note that all international efforts aimed at reducing maternal morbidity and mortality including Safe Motherhood Initiative, Millennium Development Goals and presently the Sustainable Development Goals (SDG) amongst others have all emphasize the need for good utilization of antenatal and delivery services.

With the introduction of Sustainable Development Goals (SGDs) for 2016-2030, there remains unfinished business of maternal and child health in Sub-Saharan-Africa (Global Development, 2014). The statistics with reference to Sub-Saharan Africa are startling. Recent statistics according to the United Nations Inter-Agency Estimates indicate that from 1990 to 2015, the global maternal mortality ratio declined by 44% from 385 deaths to 216 deaths per 100,000 live births (UNICEF, 2016). Although this is commendable, it is less than half the 5.5% annual rate needed to achieve the three-quarters reduction in maternal mortality that was targeted for 2015 in Millennium Development Goal 5 (UNICEF, 2016). Levels of maternal mortality between 1999 and 2015 in sub-Saharan Africa remain unacceptably high while every region in the world experienced a decline. The World Health Organization (2013) reveals that there were an estimated 289,000 maternal deaths globally, of which 62% occurred in Sub-Saharan Africa (WHO, UNICEF, UNFPA, World Bank and UN Population Division, 2014). The region also has the highest maternal mortality ratio of 510 deaths per 100,000 births (WHO et al., 2014). It has been noted that a 15-year-old girl living in Sub-Saharan Africa faces about a 1 in 40 risk of dying during pregnancy and childbirth during her lifetime while a girl of the same age living in Europe has a lifetime risk of 1 in 3,300 (WHO et al., 2014).

In England, research shows that having a baby is the most common reason for admission to the hospital. In 2012, there were 694,241 live births. Maternal health care is a unique area of the National Health Service as the services support predominantly healthy people through a natural, but very important, life event that does not always require doctor-led intervention (National Audit Office, 2013). Pregnant women receive care from a range of health professionals. All are cared for by midwives, who act as the coordinating professionals for every birth. For women at higher risk or undergoing medical procedures, care is also

provided by doctors led by consultant obstetricians (National Audit Office, 2013).

Maternal care in Australia and New Zeeland is among the safest in the world with 1 in 7800 lifetime risk of maternal death, compared with other nations in the Organisation for Economic Co-operation and Development (OECD) (Australian Health Ministers Advisory Council, 2014-2015). There is increase in access to local maternity care by expanding the range of models of care available to Australian women and their families (Australian Health Ministers Advisory Council, 2014-2015). This includes increasing access to midwifery care and continuity of career programs. It also involves investigating options for providing publicly funded homebirth and considering the implementation of publicly funded homebirth models.

The Conference of African Union (AU) Ministers of Health launched CARMMA (Campaign on Accelerated Reduction of Maternal, New Born and Child Mortality in Africa) in May 2009, under the theme of "Universal Access to Quality Services: Improve Maternal, Neonatal and Child Health." The continental launch of CARMMA has up to date been followed by national and subnational launches and follow-up implementation of maternal health actions. Thirty-seven (37) Member States have domesticated CARMMA up to date. These campaigns have given more visibility to maternal, newborn and child health issues in Africa, increased high level political commitment, country ownership and social mobilization, (Ezekiel, Iwelumor, Grigsby, 2017). Despite that, in 2017 the sub-Saharan African region accounted for about 66% of all maternal deaths in the world (WHO, 2019). At the country level, Nigeria records the highest number of maternal deaths globally (WHO, 2019). There is evidence that the country also has one of the largest burdens of obstetric fistula in the world and this is a complication of pregnancy (Eke et al., 2021). The current maternal mortality ratio for Nigeria has estimated at 512 maternal deaths per 100,000 live births and the burden is higher in rural areas when compared to urban (Abdulkareem, 2018).

Kaduna State with a population of 8,216,037 (National Population Commission, 2016) can boast of functional primary health facilities in every political ward of the state. In Kaduna State, maternal and child health is of paramount importance. A recent survey shows that Immunization coverage is 25% and antenatal visit attendance has improved from 30% in 2008 to 43% in 2017. Also, contraceptive prevalence rate is 24.10% while the unmet need for family planning is 22% (Maternal and Child Health Monthly Flasher, 2017). Despite all these Kaduna State maternal mortality rate stands at 576 per 100,000 live births (Kaduna State Government, 2016-2020).

According to the National Population Commission Report (2013), the Northwest has the highest proportion of deliveries at home (88%), followed by the North East (79%). In Kaduna State, 29.1% of deliveries were done in the public sector, while 3.3% were done in private sector. The percentage of home deliveries was high (67.5%) and delivery in health facilities was 32.4%.

This calls for concern and the need for improvement. This study is therefore designed to examine the factors influencing utilization of traditional birth attendants by pregnant women and nursing mothers in Kaduna State, Nigeria.

Methods

Study Setting

The study was carried out in Kaduna State which is located in the North-West geopolitical zone of Nigeria. The State has a population of 8,216,037 inhabitants, consisting of 4,153,290 males and 4,062,747 females distributed across the 23 Local Government Areas (LGAs) and 225 political wards (NPC, 2016 projected population). The State has three Senatorial districts, they are: the Northern Zone, Southern Zone and Central Zone.

The State has five tertiary health facilities belonging to the federal government, four of which provide specialized care, while the Ahmadu Bello University Teaching Hospital serves as the apex reference tertiary health care facility. In addition, there are two hospitals belonging to the armed forces. The general hospitals belonging to the state have been categorized as either rural hospitals, general hospitals, or specialist hospitals, a range of services and skills available for service delivery improving along as one moves from the rural hospitals to the specialist hospitals.

The primary health care facilities owned by the LGAs are expected to provide a full complement of PHC services to the communities. The state is comparatively well endowed with private health facilities, majority providing primary care (Kaduna State Ministry of Health, 2015).

Study Design

This is a qualitative descriptive study. Information was obtained using a pre-tested interview guide for providers of antenatal and delivery services in urban and rural communities of Kaduna State, Nigeria. Ten providers of antenatal and delivery services participated in the key informant interview (KII). Majority of the providers serve in urban area. Five were Officers in Charge of primary health centers while three were Chief Nursing Officers of a tertiary health institution. Two participants were Medical Officer in charge of a General hospital. They were selected based on their official positions and the roles they play in policy formulation and in the delivery of maternal health services in the health facilities.

A two-stage sampling method was used for the study. In the first stage, a simple random sampling technique of balloting was used to select two local government areas each in the three senatorial zones of the state. In the second stage, a list of all health facilities in the selected local government areas was

made and ranked based on the number of women that utilized the health facilities for antenatal and delivery services in the last five months using hospital records. Nine health facilities, three each in every senatorial zone were selected based on this criterion. The key providers of antenatal and delivery services in each of the facilities were purposively selected for interview.

Instrument for Data collection

A pre-tested key informant interview guide was used to obtain information from the healthcare providers. Four KII guides were pretested among providers of Antenatal Care and delivery services in another local government area not selected for the study. The aim of the pretesting was to detect deficiencies or ambiguities of the study instrument and necessary corrections were made when they were detected. The key informant interviews were conducted using the English language and the discussions took place in the offices of the providers. All the interviews were recorded manually and with a digital recorder. Personal contacts were made with all the participants after which a date for the interview was fixed.

All the ten selected participants took part in the study. The interviews except for two, were conducted after working hours with the assistance of a note taker who helped in summarizing the responses of the providers in detailed notes. Probing questions were asked during the interviews so as to have a deeper understanding of any issue in case the explanation was unclear. The average duration of the interviews was 35minutes.

Data Management

Following each session, the key informant interviews and recorded discussions were transcribed verbatim. The scripts, for quality assurance purposes, were compared with the written notes for completeness and accuracy. An independent reviewer then checked each script against the audiotape. Tapes were doubly transcribed as a way of verifying the quality of translations, after which both scripts were checked for similarity and where differences existed, the transcribers reconciled them. As they emerged during the coding process, coding of transcripts was done based on themes. The researcher reviewed and grouped the themes from each interview under wider themes. The researcher used QDA Miner Lite v2.0.6 in analysing the data.

There are five themes from the KII, which include utilization of antenatal and delivery services in health facilities and reasons for high and low utilizations, reasons why women prefer to deliver at home and by traditional birth attendants and the constraints to use of health facilities for antenatal and delivery services. Also, the interview probes included how to improve utilization of antenatal and delivery services and the involvement of husbands in antenatal and delivery services.

Results

Participants' Profile

The participants' age range was between 32 and 56 years with a median age of 45 years. The discussants' years of experience ranged from 6 to 20 years. Five of the discussants are officers-in-charge of primary health centers, three were chief nursing officers of a tertiary health institution and two are Medical Officer in-charge of a General hospital. Seven of the discussants have been in their current positions for 2 years and more. Six of the discussants are females and more than half of the discussants serve in the urban area.

Many care providers in both urban and rural communities agreed that good utilization of maternal health care services enhances the quality of delivery care. Poor health seeking behaviour by women in many rural communities is a result of poor utilization of maternal health care services. The result also revealed that poor attitudinal behaviour of health care providers in rural areas of the state leads to poor utilization of maternal health care services in rural communities. Some of the participants (female) opined that the neglect of primary health care centers in rural communities leads to poor utilization. The major barrier to the utilization of health care services such as Antenatal Care and Delivery care in both rural and urban communities was ignorance. Another barrier recorded was cost of health care services. On way forward to improve the utilization of health care services such as Antenatal Care and Delivery care, most of the participants agreed that good health providers attitude and public enlightenment will improve utilization of health care services for Antenatal Care and Delivery care. All the participants agreed that to record high success in utilization of Antenatal Care and Delivery care, men need to be involved in matters related to maternal health care.

Utilization of Antenatal care and delivery services in health care centers

All the participants both in urban and rural areas opined that antenatal care is more used compared to delivery services in health facilities. One of the participants said that only few percentages of women who come for antenatal care use delivery services. The participant who is a female ranked utilization of antenatal care as very good while according to her, the use of health care center for delivery services was fair.

Reasons for good use of antenatal and delivery services

The majority of the health care providers in urban and rural areas who attested to good utilization of antenatal and delivery services in their respective facilities

said it is because of the quality of healthcare services being provided in medical facilities. This concept of quality of care was expressed by the health workers in several ways. A participant in the urban area had this to say:

> "Apart from offering our patients good and quality healthcare, we make sure they are satisfied with the services they receive from us and we also ensured that the attitude of health workers to the women is good." (*A female nurse participant in urban area*)

Another nurse participant from the urban has her view thus:

> "The main practice here is respectful maternity care. Our patients are allowed to maintain any position that suit them during labour unlike before when health workers shunned such practices. The Health workers in this facility now respect the dignity of the women and this make them feel free to come for delivery here." (*Female participant, urban*)

From the rural area a participant perceived rendering of good services to women as the main reason for the almost 100% utilization of antenatal and delivery services. She expressed her assertion thus:

> "Good market always sells itself. When the women come, we attend to them in a very cordial manner and they inform others of our good services. women cannot attend health facilities where they will always be harassed and treated badly." (*Female participant, rural*)

A participant from rural area attributed the successful health care services in her facility to the fact that they operate a 24 hours service delivery. Another participant from the urban setting acclaimed that a particular programme in her facility encourages women to always want to come for both antenatal and delivery services. she submitted thus:

> In our facility we run a programme for women which we call "Beautiful women" what we do in this programme is to send messages and calls to the expectant mothers and their husbands. Whenever they come, we do give them some incentives and we teach them what they need to know about taking care of themselves and the unborn babies. This attracted other women and some of their husbands too. (*Female participant, urban*)

Reasons for poor utilization of health services for antenatal and delivery services

In both urban and rural areas, the participants gave different opinions on poor utilization of healthcare services for antenatal and delivery services. In the urban area, the participants maintained that poor utilization of health facilities for antenatal and delivery services is due to poor health-seeking behaviour of the women while in the rural, it was a result of the poor attitude of health workers. One of the participants in urban area expressed her thoughts thus:

> "People of this community have poor health seeking behavior as they prefer going to traditional birth attendants and patent medicine stores for antenatal and delivery care and only go to the hospitals when there are complications." (*Female participant, urban*)

A rural participant said poor utilization is a result of the poor attitude of health workers. He said:

> "The attitude of the health care workers discouraged women from coming to the facility as they are rarely seen on duty and when they come, they are too harsh on the women. This makes the women patronise the traditional birth place. (*Male participant, rural*)

Why women prefer to deliver at home and/or at traditional birth attendants place

While majority of the participants in urban and rural areas believe that it is a result of ignorance, some were of the opinion that it is due to lack of finance.

The participants opined thus:

> Many women feel there is no need going to hospital for delivery except when there are complications." *(Female participant, urban)*

> "Most women believe that what they do in a big hospital is just caesarian section (operation) and they are afraid of being operated upon, so they don't go." (*Female participant, urban*)

> "Some women don't come for facility delivery because they believe we charge high but we don't use to charge high is just that they have made up their mind not to use facility delivery services." (*Female participant, rural*)

Some of the participants said most of the women that use traditional birth attendants are influenced by other women in their community especially those that have delivered before. The elderly women in the community always tell the younger ones that the best place to have their babies is with the traditional birth attendants.

The participants expressed their thoughts thus:

> "The elderly women in the community or some mother-in-laws always insist that traditional birth attendants are the main place for delivery and that it is easier there (with TBA) than in hospitals where the health workers give unnecessary instructions." (*Female participant, rural*)

Culture also plays a significant role as the women perceive delivery at home to be more natural than doing same in a hospital.

However, a participant in the urban area had a different opinion about using traditional birth attendants place for delivery. She said the use of traditional birth attendants is obsolete

She expressed herself thus:

> "No woman will come for Antenatal in this health care center and deliver at home or in the traditional birth attendant place. Even if they do not come to deliver, I am very sure they will go to maybe a private hospital or another health care center that is close to them because of the health education they received here during antenatal care." (*Female participant, urban*)

Constraints women face using healthcare centers for antenatal and delivery services

Majority of the participants both in urban and rural areas believed that ignorance and cost are the main barrier to the use of health facilities for antenatal and delivery services. One of the participants in the rural area said:

> "There is no awareness of the importance of using antenatal care and delivery services in health facilities. As it is now, even if you tell the women that antenatal and delivery in health facility is free of charge they will still

> prefer to deliver at home or with the traditional birth attendant." (*Female participant, rural*)

Some of the participants opined that lack of finance is another major barrier to using health facilities for antenatal and delivery services in urban and rural areas. A participant in a rural area expressed herself thus:

> "If you don't have money there is factually nothing you can do. Lack of finance is a very serious problem because despite the fact that we charge only a very little amount, some of the women cannot afford it. This is where the traditional birth attendants appeal to them as they charge them almost nothing, some they will give maybe soap or anything they have at home in form of appreciation. (*Female participant, rural*)

Some of the participants (health workers) in rural area said that women patronize traditional birth attendants or deliver at home because of the wrong impression they have of the attitude of health workers.

Some deficiencies of the health system which could have been regarded as barriers to utilization of services were viewed differently by the health workers as they have done their best to mitigate such circumstances. These were how the participants made known their views:

> "I am the only health worker in this health center and I do all the work. Even though I am overworked it does not affect round the clock service delivery in the health center as I reside in the health facility." (*Female participant, rural*)

> "There is no enough equipment in this health center, as a matter of fact I am using my money to buy the equipment that I need here. We do not allow lack of equipment to affect the delivery of services to our clients as we do the best with what we have." (*Female participant, rural*)

Ways to improve utilization of antenatal and delivery services

Although the attitude of the health workers is not recognised as major barrier to utilisation of health facilities, but if the health workers create good rapport with the few women that come to their facilities will help to enhance utilisation. The

participants in both urban and rural areas have the same story. These quotes summed up the participants views:

> "We (health workers) as the image makers of the health system, we should treat the few women that come to health facilities with dignity and respect so that they go back happy and speak 'good' about the health workers. If we fail to treat these women nicely, they will go to quacks which is not good." (*Female participant, urban)*

> "Let there be change in attitudinal character on the part of healthcare providers. Some providers may be tired and they will transfer their aggression on the women and the women go back with that bad impression and spread the information that health workers are rude. This will help other women form their opinion about health workers." (*Female participant, urban*)

Some participants from the rural area suggest that house-to-house visit by health workers and public enlightenment will go a long way in encouraging the women to know the importance of utilizing health facilities for antenatal and delivery services. One of the participants expressed her view this way:

> "If government embark on public enlightenment and house-house visits by health workers, it will help in accentuating the relevance of antenatal care and delivery in health facilities to the women. The impact will be great if members of the community are included in the enlightenment programme." (*Female participant, rural*)

A participant also from the rural area stressed on the empowerment of women is very important as it will help women to make decisions such as to go to the health center when the husband does not appreciate it because he cannot afford it. She expressed her views thus:

> "Once a woman is educated and has something doing that is bringing in cash she might not need to wait for her husband or anybody to come and give her money to visit the health facility for antenatal and delivery services." (*Female participant, rural*)

Involving men (husbands) in antenatal and delivery services

In both urban and rural study groups, all the participants agreed on the importance of involving men in matters related to maternal healthcare. In the

urban area, a participant pointed out roles men play in family matters and the importance of such when applied to antenatal and delivery care. She put her view this way:

> "A husband being the head of the home, will never instruct his wife to go for antenatal care having provided money and other supports for that purpose and the woman refuses." *(Female participant urban)*

A few participants in the urban area traced the practical way they have involved men in matters related to antenatal care. One of the participants had this to say:

> "Here in our facility, we attend to women that come for antenatal care with their husbands first. By doing this, we make the husbands feel the importance of supporting their wives from the first day of pregnancy to delivery and this encourages the husbands to be part of antenatal care." *(Female participant, urban*)

A participant in the urban area explained that men are more involved during delivery than in antenatal care. She gave her assertion thus:

> "In our facility about 65-70% men come with their wives for delivery while less than 10% follow their wives for antenatal. We do give gifts to couples that attend antenatal together." (*Female participant, urban*)

Discussion

All the participants were of the opinion that use of health facilities for antenatal care is higher than that for delivery services in the study area. This is similar to findings by Adegboyega and Abioye (2017) in which it was found that percentages of women utilising antenatal care are higher than those deliver in health care centers. It was also observed that the use of health facilities for delivery services is poor. The majority of the health care providers both in urban and rural areas attributed the good utilisation of health facilities for maternal health services to the delivery of quality healthcare in the various health facilities. The concept of quality was described by the participants in various forms. This is commendable as women have been known to avoid using health facilities for maternal health services when they are not treated well.

Reasons for poor utilisation for antenatal and delivery services in health care centers were differently stated among participants in both urban and rural areas. While participants in the urban area attributed it to poor health seeking behaviour among women, in rural, however, it was blamed on the poor attitude of health workers and the neglect of primary health centers which are the main health facilities in the area. Increasing delivery at primary health centers is capable of decreasing maternal mortality in rural areas of Nigeria (Abdulkareem, 2018). Going by this, it has been postulated that to decrease maternal mortality in Nigeria, attention should be concentrated on rural areas and the good utilisation of primary health centers (Abdulkareem, 2018).

Ignorance according to the majority of the participants both in urban and rural areas is the main reason why women still deliver with traditional birth attendants and at home. In a study in northwest Nigeria, illiteracy, ignorance, and abuse were identified by women as barriers to seeking delivery services in health facilities (Yaya, Bishwajit, Uthman & Amouzou, 2018). Meanwhile, the same women acclaimed that they patronize traditional birth attendants because it is inexpensive and accessible (Yaya, Bishwajit, Uthman & Amouzou, 2018). With this, it is possible to conclude that there are different factors that push the women from delivery in health facilities and others that pull them to deliver with traditional birth attendants.

However, this study makes very good observations which can bring a possible end to women going to traditional birth attendants for delivery. A participant in the urban area was very emphatic that no woman that attended antenatal care in her facility will deliver with a traditional birth attendant due to the health education the women receive during antenatal care. This remark is of good account as it has been found that women who make four or more antenatal care visits have increased odds of delivering in a health facility (Kuhnt & Vollmer, 2017). Improving maternal health in Nigeria can be achieved only when women are encouraged to use health facilities. Also, a participant in rural area asserts that in her facility they encourage husbands to accompany their wives for antenatal and they enticed them by giving such couple incentives and gifts. This gives credence to the community ownership and management of primary health centers and should be encouraged. Further exploration should be made towards these two approaches towards increasing health facility delivery by the women especially in rural areas.

Majority of the participants in both rural and urban agreed that to have reasonable use of health facilities by women, there must be a great attitudinal change among the health care providers. Meanwhile, this assertion is contrary to their initial submission that the highest barrier to use of facilities among women was ignorance. This they did maybe because they don't want to lay blame on themselves. The issue of attitudinal behaviour on the part of the health care providers is not a new thing as many studies have shown this to be one of the major reasons for women not going for antenatal and delivery in health facilities. In a study from northwest Nigeria, result shows that attitude of health care

workers prevent women from accessing facility delivery (Abdulkareem, 2018). Another study in Ebonyi State shows that most of the women who are not using facility for delivery complained of the attitude of the health care provider as a major reason for them not using it (Eze, Ossai, Ogbonnaya, 2021). Negative attitude of the health providers of maternal health care services can be very dangerous to the society as it will encourage the expectant mothers to seek alternative in traditional birth attendance place which can lead to mortality of either the mother or the foetus or even both. Realising this, there is need for quality training for the health care providers.

Few of the participants in rural area were of the opinion that public enlightenment is key for utilisation of facility services. This supporting the assertion of the health providers who is said ignorance is the major reason for women not using facility services. This is similar to the findings in Kaduna North where it was recommended that there is need for health promotion intervention to improve utilisation of antenatal and delivery services among women (Abdulkareem, 2018).

All the participants in both rural and urban areas are in support of involving men in issue relating to women's health. This is due to the role men play in the family, involving them will have great influence on the health of the women and their children.

Conclusion

The findings of poor attitude of health workers suggests that health care providers should be trained on quality of care. The government should give public enlightenment on need to utilise health care facilities for Antenatal Care and Delivery care. Communities should be encouraged to owned primary health centers especially in rural areas so as to boost utilization of such facilities for maternal health care services. Involving men in matters related to maternal health care will have great influence in improving maternal healthcare in Nigeria in general and in Kaduna State in particular.

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