LGJDX ISSN No: 1008-0562 Journal Of Liaoning Technical University Natural Science Edition

MATERNAL AND CHILD HEALTH CARE PROCESSES BETWEEN SKILLED AND TRADITIONAL BIRTH ATTENDANTS IN EKITI STATE

AKUTE, Yewande Ifelola
Ekiti State Ministry of Health and Human Services,
Ado – Ekiti, Ekiti State, Nigeria/
Faculty of Nursing, Lincoln University College, Malaysia

Dr. REGIDOR III Poblete Dioso
Lincoln University College, Malaysia

ELUSOJI, Christiana I. (Ph.D)
Department of Nursing Science,
Faculty of Basic Medical and Health Sciences,
Benson Idahosa University, Benin City,
Edo State, Nigeria

MUNGE, Mary
Department of Nursing Science,
Faculty of Basic Medical and Health Sciences,
Benson Idahosa University, Benin City
Edo State, Nigeria

OGUNFOWOKAN, Gbenga (Ph.D)
University of Jos

Abstract

This study aimed to assess maternal and child healthcare processes involving Skilled Birth Attendants (SBAs) and Traditional Birth Attendants (TBAs) in Ekiti State. Specific objectives included investigating delivery methods, antenatal, delivery, and newborn care procedures, the content of health talks for pregnant women, participants in group discussions, means of instrument sterilization, and the process of referral in cases of emergencies. The study employed a qualitative phenomenological approach and included interviews with SBAs, and TBAs. Findings revealed that both SBAs and TBAs are actively involved in delivering care to pregnant women, offering antenatal education, monitoring, and facilitating childbirth. However, challenges such as financial constraints, limited access to skilled services, transportation issues, and difficulties in referrals and TBA recognition hinder optimal care provision. Recommendations were made to strengthen referral systems, improve access to skilled healthcare, and enhance TBAs' knowledge and skills through training. These recommendations aim to address the identified barriers and improve maternal and child healthcare services, especially in underserved areas.

Keywords: Maternal health care, Child health care, Skilled birth attendant, Traditional birth attendant

Introduction

According to a number of studies, nations that have a high maternal, perinatal, and neonatal mortality rate also have inadequate and low quality health care. This is because there is a scarcity of skilled birth attendants in these nations. Nearly 800 maternal fatalities are recorded every day in the world, with the majority of them occurring in poor and medium income nations. According to Olonade et al. (2019), maternal mortality is a social equality indicator since it measures the increased lifetime risk of dying prematurely as a result of pregnancy, which is one in 41 in impoverished countries and one in 3300 in wealthy ones. According to the World Health Organisation (WHO), 2020, poor countries also have a much greater rate of maternal morbidity as a result of serious damage or impairment brought on by obstetric difficulties. According to the WHO (2013), this is the time when the majority of maternal and baby mortality occur.

Although they are more than skilled birth attendants and attend births more frequently than SBAs, Nigeria, which is a member of the developing countries align with this policy of safe motherhood initiative suspended the training of TBAs officially and did not recognise them as skilled birth attendance. This is despite the fact that TBAs are more than skilled birth attendants. Up until this point in time, around 59% of births have taken place at the patient's house with the assistance of traditional birth attendants (ND**HS, 2018).**Traditional birth attendants, often known as TBAs, are an essential component of the social, cultural, and religious fabric of the majority of Nigeria's rural communities. TBAs are generally accepted and patronised, especially in rural regions (Iwu, et al, 2021), despite the fact that they are not equipped to handle the difficulties that might arise during childbirth. As part of this change, the government discontinued providing "training," and oversight is not carried out in a comprehensive manner. TBA services continue to be treated in a hazy manner as a sort of informal assistance; there is no clear direction on how they should be included into the official health institution, nor is there any information on the legal issues that may arise from them. Schew and Jchew are responsible for getting people to go to the health facility; however, they have not been doing this and have instead remained at the health facility to attend to patients and deliver immunisations. TBAs continue to be widely used and are present at roughly 47–52% of all deliveries in urban and rural regions respectively.

Between nations with high and low incomes, there is a discernible difference in the percentage of births that take place in a health facility and are attended by skilled birth attendants. This disparity may be attributable to the high level of community patronage of TBAs in low-income nations. This may be the case for a variety of reasons, including the fact that TBAs are readily available, affordably priced, easily accessible, and have an attitude of friendliness and caring that is particularly noticeable.

According to the World Health Organisation (WHO, 2015), traditional birth attendants (TBAs) are community-based providers of care throughout pregnancy, delivery, and the postpartum period. TBAs are also considered to be autonomous within the health system and have no official training. According to the Millennium Development Goals end point report for Nigeria, women who reside in rural regions have a likelihood of giving birth at home that is 77% higher than if they gave birth in a health facility. About 80% of Nigeria's population lives in rural areas. This may also explain why the use of TBAs continues to be common across the nation despite the presence of skilled birth attendants who are trained and have reasonably current equipment (Iwu, et al, 2021).

Traditional Birth Attendants (TBAs) in Nigeria have a high potential to improve maternal health outcomes because of their massive utilisation within the country (Amutah-Onuka, et al., 2019). As a result, there is a need for collaboration so that there will be an effective referral system and supervision, which could lead to an increase in the number of deliveries performed by skilled attendants.

According to statistics from around the world, one woman dies every minute as a result of difficulties associated to labour and after childbirth. These issues are, to a greater extent, due to inadequate maternal health services (Nyongesa et al., 2018). Because traditional birth attendants are unable to handle the treatment of obstetrics crises, the worldwide policy has been shifting towards the employment of skilled birth attendants since the middle of the 1990s. According to Sibley et al. (2012), the nations that have the greatest rates of maternal and newborn mortality typically have a shortage of maternal and neonatal health providers, as well as poor performance, unequal distribution, and high expenditures.

In these nations with high rates of maternal and newborn mortality, traditional birth attendants (TBAs), relatives, and other people are frequently called upon to assist with childbirth. According to Ayede (2012), the usage of untrained birth attendants such as Traditional Birth Attendants and Voluntary Health Workers is one of the primary contributors to the high rates of maternal and newborn mortality in Nigeria and other developing countries. Other contributors include poverty and a lack of access to modern medical care. The importance of skilled birth attendants providing high-quality care cannot be overstated as a means of lowering the cost of maternal and newborn care. Because traditional birth attendants (TBAs) rely on their profession as a source of income, policymakers and planners ought to make sure that there are other employment opportunities available for TBAs and other health workers with fewer qualifications throughout the transition period to skilled birth attendants. Due to the significant role that professional care plays during birth, skilled attendance was chosen as an indicator for tracking progress towards attaining maternal health MDG-5, which aims to reduce the maternal mortality ratio by three quarters between the years 1990 and 2015. This maternal mortality ratio is much lower than the aim of less than 70 deaths per 100,000 live births established by the Sustainable Development Goal (SDG), which must be reduced by 75% in order to meet one of the five Millennium Development Goal (MDG) targets. According to Byrne and Morgan (2011), the majority of maternal and newborn deaths can be prevented with the use of several simple procedures. In order to achieve the Sustainable Development Goals (SDGs), maternal and newborn mortality must be prevented (Sulayman & Adaji, 2019).

In addition, pregnancy and childbirth-related problems claim the lives of nearly a half a million women annually in the United States alone. The overwhelming majority of these fatalities might have been avoided. During the Millennium Summit in the year 2000, state governments made the commitment to lower the rate of maternal mortality by 75 percent by the year 2015. According to Okonofua et al. (2013), the promise to reduce maternal and newborn mortality is reflected in the Millennium Development Goals. These goals, which arise from the pledge made at the Millennium summit, have come to play a defining role in the activities of international development organisations.It is not a new commitment on the part of states to lower the rate of maternal mortality, but the lack of major results from this effort has been disheartening.

It is depressing to learn that the maternal and newborn mortality rate in Nigeria is still high despite the efforts of the government. The present condition of around 40,000 maternal fatalities,

with one in every 22 women dying in pregnancy and child birth (FMOH, 2019), and infant mortality rates of approximately 89 deaths per 1000 deaths per 1000 live births (USAID, 2018) are both undesirable and are mostly connected to a lack of skilled birth attendants. One in every 22 women dies during pregnancy and child birth (FMOH, 2019). According to Ibrahim (2016), in the year 2010, roughly 287 thousand women passed away while pregnant or during giving birth, and 3.1 million babies perished in the neonatal period. TBAs continue to play an essential role as providers of maternity care in nations with lower-income populations. Up to sixty percent of births in some areas are still attended by these TBAs, despite several campaigns stressing the need of giving birth in a medical setting with the assistance of skilled birth attendants.

The effects of the pregnancy are seen more in the morbidities and mortalities that are particularly associated with post-partum haemorrhage, prolonged obstructed labour, infection, eclampsia, prematurity, perinatal asphyxia, and neonatal sepsis, which are the leading causes of maternal and neonatal deaths in Nigeria (Ayede, 2012). Prematurity is one of the leading causes of preterm birth. Ten percent of all deaths that occur worldwide among pregnant women, labouring women, and mothers having their babies occur in Nigeria. The use of skilled maternal healthcare services (during pregnancy, delivery, and the postpartum period) is one of the primary treatments that is being undertaken all over the world in an effort to lower the mortality rates of mothers and newborns. Although there has been a 44% decrease in the global maternal death ratio since 1990, there are still 800 women who die every day from avoidable causes connected to pregnancy and delivery. The majority of these fatalities occur in underdeveloped nations of the world among women of reproductive age.

According to previous research, the lifetime risk of a woman dying during pregnancy or childbirth in developed countries is 1 in 3700, whereas the risk of dying in sub-Saharan Africa is 1 in 38, which equates to approximately 1 (one) woman dying every two minutes (WHO, 2020). Furthermore, for every woman who passes away during pregnancy or childbirth, 20 or 30 other women experience complications that have serious or long-lasting consequences. These fatalities and injuries are totally preventable with higher utilisation of skilled maternal healthcare services. They are partially caused by inadequate utilisation and low quality of maternal health care during prenatal care, skilled attendance at birth, and postnatal care. In addition, these deaths and injuries are entirely preventable. It is essential to reduce the risk of maternal mortality to get at least four antenatal care (ANC) visits and to have a delivery assisted by a skilled birth attendant (SBA). It is essential, while formulating solutions to a problem, to have a solid understanding of the factors that contribute to a low rate of utilisation of the available services (Weitzman, 2017).

Traditional birth attendants (TBAs) are known to have a long history as childbirth attendants in many communities in developing countries, including Nigeria. Studies show that in rural and deprived communities in sub-Saharan Africa, TBAs make up the majority of childbirth care providers due to the lack of skilled birth attendants such as midwives, nurses, and doctors. Many individuals have argued in favour of skillfully training TBA, something that the WHO has attempted in the past but failed to accomplish since the majority of them are illiterate and some of them are full of superstitious beliefs and relate everything that happens to religion and culture. According to Turinawe et al.'s 2016 research, the rate of maternal mortality in Nigeria is on the rise, which is quite depressing despite the fact that both the government and non-governmental organisations have been working to reduce it.

Additionally, this maternal mortality has been linked to factors such as maternal education, maternal age, and autonomy of the mother, all of which have been shown to minimise the likelihood of undesired pregnancies and short intervals between births (Weitzman 2017). Numerous studies have shown that skilled birth attendants may significantly reduce the frequency of maternal and newborn fatalities by providing prompt obstetric and newborn care throughout labour, delivery, and the early postpartum period. Skilled attendance at birth was chosen as an indicator for tracking progress towards the maternal health MDG-5 goal of lowering the maternal mortality ratio by three quarters between the years 1990 and 2015. This goal was not reached, which led to the inclusion of this in the SDG. Due to the vital role that professional care plays during birth, skilled attendance was chosen as an indicator. In Africa, the proportion of births that are attended by skilled workers is less than fifty percent, which is far lower than what is recommended by the WHO.

In 2004, the World Health Organisation (WHO), the International Confederation of Midwives (ICM), and the International Federation of Gynaecology and Obstetrics (FIGO) released a joint statement defining "Skilled Birth Attendants" as a responsible and accountable professional who works in partnership with women to provide the necessary support, care, and advice during pregnancy, labour, and postpartum period, to conduct births on the midwife's own responsibility, and to care for the newborn and the Lynn Freedman (2021) highlighted the fact that not all solutions are created equal based on the findings of health research and experience. If the human right that is being questioned is the right to avoid dying an unnecessary death during pregnancy and delivery, then the first line of acceptable steps that will advance gradually towards the realisation of the correct objectives is what has to be taken.

According to Jacqui Wise, maternal mortality is a violation of human rights and the current rate is far higher than the aim set by the Sustainable Development Goal (SDG) of less than 70 deaths per 100,000 live births. According to Okpoko (2018), the vast majority of the factors that contribute to maternal and newborn mortality and morbidity are recognised to be avoidable via the use of fundamental treatments. It is essential to meeting the Sustainable Development Goals (SDGs) (WHO, 2020) to make headway in reducing avoidable maternal and newborn mortality.

In many communities in underdeveloped nations, including Nigeria, traditional birth attendants have a long history of serving as delivery attendants. Many individuals have argued in favour of skillfully training TBA, something that the WHO has attempted in the past but failed to accomplish since the majority of them are illiterate and some of them are full of superstitious beliefs and relate everything that happens to religion and culture. It is extremely discouraging that the rate of maternal mortality in Nigeria is climbing steadily higher, despite the efforts of both the government and non-governmental organisations to reduce the problem.

The health care delivery system in the country is structured to provide primary, secondary, and tertiary levels of treatment, and these three levels of care are linked to one another through a referral system. The primary level is made up of primary health care units such as primary health care centres, which are further subdivided into comprehensive health centres, basic health centres, and health posts. Health posts also fall under this category. In addition to professional midwives, nurses, and public health nurses, community health extension workers, junior community health extension workers, and other health professionals who have received training at a school or college of health sciences, the health centres are staffed with community health extension workers. Community Health Extension Workers (CHEWs) are in charge of running

health posts in Nigeria, which are the lowest level of government structures in the country's health care system.

The maternal mortality ratio takes into account deaths that occur during pregnancy, delivery, or within 42 days after a successful pregnancy termination, regardless of the length of the pregnancy or the location of the pregnancy. The maternal mortality ratio is the yearly number of female deaths per 100,000 live births from any cause connected or exacerbated by pregnancy or its treatment (excluding accidental or incidental causes). This statistic is referred to as the maternal death rate. The rate of maternal mortality in Nigeria, also known as the maternal mortality ratio (MMR), was calculated to be 512 deaths for every 100,000 live births in the seven years before to the study. Nigeria Demographic Health Survey (NDHS, 2018) found that an average of seven years had passed since the last survey.

But, more importantly, quality maternity care requires the service of skilled birth attendants such as a midwife, doctor, or nurse who have been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, as well as in the identification, management, and referral of complications in women and newborns (WHO, 2020). These birth attendants can be found at hospitals, clinics, or private practises. Women continue to give birth at home with the aid of traditional birth attendants (TBAs) because they are available and accessible than skilled birth attendants (Gurara et al, 2020). Despite the fact that skilled birth care has been designated as the ultimate approach for saving the lives of pregnant women, women continue to give birth at home with the assistance of TBAs.

The broad objective of the study was to assess maternal and child health care processes between skilled and traditional birth attendants in Ekiti State. The specific objectives were to:

1. examine the methods people used to deliver in the selected community;
2. explore the methods of antenatal care, delivery and newborn care in SBA's and TBA's facilities in Ekiti State;
3. explore the contents of the health talk given to pregnant women at TBA and SBA;
4. find out who participated in group discussion in the SBA's and TBA's;
5. explore the means of sterilization of delivery instruments among TBA's and SBA's; and
6. find out the process of referral TBA's utilize in case of emergency.

Research Method

This study adopted a qualitative design which is a phenomenological approach. The study population comprised of all skilled birth attendants from Ekiti State University Teaching Hospital, Ado – Ekiti, and traditional birth attendants in Ekiti State. Sample size for the study was determined by data saturation while paying attention to the scope of the study, quality of data gotten, nature of the research topic, the study design and the presence of shadow data. In-depth interview was used to elicit information from the skilled birth attendants while all the skilled birth attendants who consented to participate in the study were recruited from Ekiti State University Teaching Hospital.

Sample size of the selected traditional birth attendants was determined by data saturation while paying attention to the scope of the study, quality of data gotten, nature of the research topic, the study design and the presence of shadow data. This was done to ensure that there are no new or lost information. At least One (1) traditional birth attendant who registered with the Ministry of Health was recruited per town for in-depth interview. Convenience sampling technique and Criterion based purposive sampling technique were used to select available skilled birth attendants, traditional birth attendants and officials of Ministry of Health.

In-depth interview guide (IDIG) developed by the researcher was used to collect relevant information from the respondents, through verbal interaction between the respondents and the researcher; this allowed the researcher to get in-depth information on maternal and child health care processes between skilled and traditional birth attendants in Ekiti State. Participants were involved in a one-on-one interview (individual interview). Recordings from participants' discussion were saved on recording devices which was later be transfer to a computer drive and saved in distinct separate folders. Information retrieved were transcribed word for word on paper and typed into a Microsoft Word document. Transcriptions from the recordings formed the data that were used for the qualitative analysis of the study.

In-depth interview was conducted among skilled birth attendants and this involved one on one discussion with them. The interview was conducted in preferred place by the interviewee with adequate privacy maintained. Informed consent was taken from participants. The study lasted for a period of one month and in-depth interview was conducted until data saturation is attained. The data were recorded using audio tape/recorder and field notes.

Also, in-depth interview was conducted among traditional birth attendants and this involved one on one discussion with them. The interview was conducted in preferred place by the interviewee with adequate privacy maintained. Informed consent was taken from participants. The study lasted for a period of two month and in-depth interview was conducted until data saturation is attained. The data was recorded using audio tape/recorder and field notes. Informed consent was taken from participants.

The data obtained were analyzed by transcribing the tape/voice recording using NVivo. Code was developed whereby data were grouped into meaningful categories to make analysis easier. The developed categories were reviewed closely, the data were coded (dividing the information gathered into different groups, each group was labelled with codes and same were collapse into themes thereafter). The researcher found themes, patterns and relationships. The data were summarized by streamlining and making it brief in readiness for analysis.

Results

The qualitative data analysis took different stages. First the recorded interview was transcribed according to participants' responses. The themes and sub-themes were identified while the main ideas were assigned codes. Table 1 shows the themes and sub-themes for the qualitative data.

Table 1 Theme and Sub-themes for the Qualitative Data

S/N	THEMES	SUB-THEMES
1	Facility Choice	SBA

		TBA
2	**Process of care**	**Antenatal** **Delivery** **Newborn**
3	**Health talk**	**Contents** **Discussants**
4	**Referral Process**	**Individual** **Family** **Standby car** **Ambulance**

Table 2 shows the main ideas identified from the themes for qualitative data collection with their assigned codes which are as follows; F (Type of facility), P for process of care, C for contents of health talk, and R for process of referral.

Table 2: The main ideas of Qualitative Data

S/N	CODES	MAIN IDEAS
1	F1.1 F1.2	SBA in a facility TBA in a facility
2	P.1 P1.1 P1.2 P1.3 P1.4	Process of care Antenatal Delivery Newborn Delivery instruments
3	C.1 C1.1 C1.2	Health talk Contents Discussants
4	R.1 R.1.1 R.1.2 R.1.3 R.1.4	Process of referral Individual Family Standby car Ambulance

Table 3: The Interview Questions and Main Ideas

INTERVIEW QUESTIONS	MAIN IDEAS	SUB-THEMES	THEMES	CODE
Can you describe how delivery takes place in this community? How many	People deliver in a facility with SBA People deliver in a facility with TBA	Facility where delivery takes place	Facility choice	F1.1 F1.2

persons attend to the delivery?			With assistant Without assistant	F.1.3 F.1.4
What are your tasks for pregnancy and delivery care? How do you care for the newly born baby(care of cord ,time of breastfeeding, bonding, warmth) How do you care for your delivery instruments?	**Antenatal** Booking Inspection Palpation Auscultation Head to toe assessment Delivery kit immunization **Delivery** cutting of cord drug to control bleeding **Newborn care** warmth initiation of bonding breastfeeding **Care of Instrument** Green liquid soap then rinsing Washing with soap and water Soak in Jik solution Sterilizing Autoclaving	Process of maternal and newborn care	Process of care	**P.1** **P.1.2** **P.1.3** **P.1.4**
Do you arrange 'group discussions' with pregnant mothers? What type of	Antenatal talk contents Diet	Contents of health	Health-talk	C.1 C.1.2

health talk do you give your client? Who are the discussants?	Dressing Hygiene Immunization Routine ANC check Blood tests in pregnancy Discussants with pregnant women Nurse/midwife Doctor Medical lab. Scientist	talk shared with pregnant women and who are the discussants		 C.1.3
What would you do in case of problems? How would you try to reach the nearest SBA?	Process of referral Individual Family Standby car Ambulance	TBA referral process	Referral Process	R.1 R.1.1 R.1.2 R.1.3 R.1.4

Analysis of Research Objectives

Objective 1: What are the methods people used to deliver in the selected community?

In table 3 above, people deliver in facility with Skilled Birth Attendants (SBA) and also facilities with Traditional Birth Attendants TBA (agbebi). 7 participants mentioned SBA according to code F1.1, while 20 mentioned TBA. On the number of persons who attend to delivery, 12 participants mentioned the presence of an assistant (F1.3) while 15 mentioned without assistant (F1.4).

Objective 2: What are the methods of antenatal care, delivery and newborn care in SBA's and TBA's facilities in Ekiti State?

In table 3 above shows the example of tasks for pregnancy and delivery care which are booking, immunization, inspection, palpation, auscultation, head to toe assessment, delivery kit distribution and immunization according to all the 27 participants. However, the TBA's mentioned their clients were encouraged to get immunization from the clinic while one had liaised with the nearby PHC for weekly visit of the T.T immunization team.

At delivery, all the 27 participants (P.1.2) mentioned cutting of cord and drug administration to control bleeding. The SBA's used oxytocin before but now misoprostol (participant 6), the TBA's still uses oxytocin (Participant 4). For newborn care in P.1.3, warmth, initiation of bonding and breastfeeding was rampant however only one of the TBA (participant 4) delayed bathing till 7days according to how she was trained but later got enlightened. Breast feeding was initiated after the newly delivered woman had rested enough, nipple cleaned with cotton wool swab wet with methylated spirit. There were little discrepancies in the time initiation of bonding was done.

Objective 3: What are the contents of the health talk given to pregnant women at TBA and SBA?

The TBA's and SBA's (C.1) arrange group discussions with the pregnant women in their respective facilities, the TBA's are weekly irrespective of gestational age because their antenatal care is weekly but the SBA's are on appointment days depending on gestational age and women with risky pregnancies.

The health talk contents ranges from diet, dressing, hygiene to immunization, routine ANC check and laboratory tests in pregnancy. The SBA's has laboratory facilities and the tests run on the pregnant women are HIV test, Hepatitis test, packed cell volume, and full blood count. The ultrasound scan is done by all the facilities, the TBA enjoins their client to go for the scan in the nearest scan center whether private or public (Participant 15). The TBA's does not give Tetanus Toxoid immunization but only few has liased with the CHEW who brings it to their clients in the facility but for others he TBA enjoin them to go to the government hospital for it (Participant 3).

Objective 4: Who participate in group discussion in the SBA's and TBA's?

The discussants (C.1.3) are Nurse/Midwife, Doctor, and Medical Laboratory Scientist in the SBA facilities according to ten participants while TBA and her assistant is the lead discussants in the TBA homes.

Objective 5: What are the means of sterilization of delivery instruments among TBA's and SBA's?

The care of delivery instruments in P.1.4 ranged from use of green liquid soap and rinsing (participant 1) to washing with soap and water then soak in Jik solution (participant 23) to sterilizing and autoclaving (participant 2). Majority of the TBA's used liquid soap to wash before rinsing; only few soaked in Jik solution. Participant 21 did not even mix the Jik solution in any ratio but only used her discretion to mix Jik in water then soaked thereafter. The SBAs used sterilizing or autoclaving respectively.

Objective 6: What process of referral do TBA's utilize in case of emergency?

The process of referral (R.1) highlighted were individual, family, standby car and ambulance. Majority followed their patient to the referral centre except participant 3. The kinds of patient referred are breech, transverse presentation and ectopic gestation, small sized shoe women. The relative do follow them in ambulance as mentioned by the SBAs while the TBA's do charter cab or bike during emergency, or use the neighbor's car

Discussion of Findings

Based on the findings, a greater number of participants mentioned utilizing the services of Traditional Birth Attendants (TBA) compared to Skilled Birth Attendants (SBA) during childbirth. Specifically, 20 participants mentioned using the services of TBAs, while only 7 participants mentioned utilizing the services of SBAs. Regarding the number of persons attending to the delivery, the findings indicate that 12 participants mentioned the presence of an assistant during childbirth, while 15 participants mentioned having no assistant present. These findings suggest that a significant portion of the participants in the study opted for the services of TBAs during childbirth and that there is variation in the presence of an assistant during delivery. To corroborate this finding, Awotunde et al., (2017) showed that 55.4% of people have ever used the TBAs, and the key reasons for use of TBAs were due to the fact that the TBAs were more user friendly ($p = 0.012$), were widely available ($p = 0.000$), and their believe in them ($p = 0.000$).

Based on the findings, it seems that the tasks involved in pregnancy and delivery care were consistent among all 27 participants. The identified tasks include booking, immunization, inspection, palpation, auscultation, head to toe assessment, delivery kit distribution, and immunization. It is noteworthy that all participants mentioned these tasks, suggesting a general agreement on the essential components of pregnancy and delivery care. These tasks encompass both prenatal and intrapartum care, ranging from initial booking and assessments to the distribution of delivery kits. Ahmed et al., (2015) found out that over three quarters of users, or 74.8 percent, were pleased with the services provided by TBA. According to the findings of the survey, some of the tasks of TBAs are as follows: taking normal birth, giving prenatal care, conducting caesarean section, offering family planning services, and doing gynaecological procedures. Health care providers and policy makers should make an effort to ensure that contemporary health care services for mothers are more easily available, user pleasant, and deliver care that is culturally appropriate

Regarding immunization, the findings indicate that TBAs mentioned encouraging their clients to seek immunization from a clinic, indicating recognition of the importance of immunization during pregnancy. Additionally, one TBA mentioned collaborating with a nearby Primary Health Center (PHC) to facilitate the weekly visit of the T.T immunization team. This collaboration demonstrates an effort to ensure that clients receive necessary immunizations even in the context of traditional birth attendance. These findings highlight the importance of comprehensive care during pregnancy and delivery, including tasks such as immunization that contribute to the health and well-being of both the mother and the baby. The inclusion of immunization-related tasks indicates an understanding of the significance of preventive healthcare measures and aligns with the broader goal of promoting maternal and child health.

Rodriguez, et al. (2017) indicated that the TBA was responsible for providing care during the prenatal, intrapartum, and postpartum periods. The majority of the TBAs' treatment was non-interventionist; however, this did not always mean that it was in line with best practise. Ofili and Okojie (2015) came to the conclusion that the practise of Traditional Birth Attendants (TBAs) in the promotion of women's health (Maternal and child health) in rural Nigeria cannot be disregarded, despite the fact that there is a negative view about the practises of TBAs.

Based on the findings, it appears that during delivery, all 27 participants mentioned the practice of cutting the umbilical cord and administering drugs to control bleeding. This suggests that these practices are consistently performed across both Skilled Birth Attendants (SBAs) and Traditional Birth Attendants (TBAs) in the studied context. According to the findings of Aziato and Omenyo (2018), traditional birth attendants (TBAs) like maternal health professionals work to improve the quality of maternal health care.

However, a notable difference emerged between the two groups in terms of the specific drug used. The SBAs mentioned a shift from using oxytocin to using misoprostol for controlling bleeding during delivery, while the TBAs continued to use oxytocin for this purpose. The use of oxytocin and misoprostol in managing postpartum bleeding is in line with established medical practices. Oxytocin is a uterotonic drug commonly used to prevent or treat postpartum hemorrhage, as it helps in contracting the uterus and reducing bleeding. Misoprostol, another uterotonic drug, is an alternative option that can also effectively prevent and manage postpartum bleeding. The observed shift from oxytocin to misoprostol among SBAs may be due to factors such as cost, availability, or guidelines and recommendations from healthcare authorities. The decision to use a specific drug may vary based on local protocols and resources. It is important to note that the findings indicate the current practices mentioned by the participants and do not provide an evaluation of the effectiveness or safety of these practices. The use of medications during delivery should be based on evidence-based guidelines, local healthcare policies, and the expertise of healthcare professionals.

Based on the findings, several aspects of newborn care were identified, including warmth, initiation of bonding, and breastfeeding. These practices were reported to be prevalent among the participants, indicating recognition of their importance in promoting the health and well-being of newborns. The findings suggest that most of the participants engaged in practices such as ensuring the newborn's warmth, initiating bonding between the newborn and the mother, and initiating breastfeeding. These practices align with established guidelines for newborn care, emphasizing the importance of providing a warm and nurturing environment, promoting early bonding between the mother and baby, and initiating breastfeeding soon after birth.

Sulayman and Adaji (2019) noted that favourable outcomes were observed in regard to the relationships that traditional birth attendants had with their local health institutions. These findings provide cause for optimism. 69% of respondents rated the friendliness of local health facilities as excellent, 68% of respondents rated the ability of local health facilities to communicate as good, and 68% of respondents rated the ability of local health facilities to connect with families as good.

It is noteworthy that one of the Traditional Birth Attendants (TBA) mentioned initially delaying the bathing of newborns until 7 days, as per her training. However, she later gained new knowledge and changed her practice. Delaying bathing for a certain period is sometimes advocated to allow the baby to benefit from the protective vernix coating on their skin. However, the optimal timing for newborn bathing may vary based on cultural practices and individual circumstances.

Regarding breastfeeding, the findings indicate that breastfeeding initiation was done after the newly delivered woman had rested enough, and the nipple was cleaned with a cotton wool swab wet with methylated spirit. It is worth noting that the use of methylated spirit for nipple cleaning

is not recommended in current breastfeeding guidelines. The current recommendation is to clean the nipple and breast with plain water before breastfeeding to maintain proper hygiene without potentially harmful substances.

The findings suggest a general adherence to important aspects of newborn care, such as warmth, initiation of bonding, and breastfeeding. However, it is crucial to continuously update and align practices with evidence-based guidelines to ensure the provision of optimal care for newborns and support the well-being of both the mother and the baby

Based on the findings, both Traditional Birth Attendants (TBAs) and Skilled Birth Attendants (SBAs) organize group discussions with pregnant women in their respective facilities. However, there are differences in the frequency of these group discussions based on the antenatal care schedules followed by the TBAs and SBAs. The findings suggest that TBAs hold weekly group discussions with pregnant women, regardless of their gestational age. This indicates that TBAs prioritize regular interaction and communication with pregnant women throughout their pregnancy, providing opportunities for education, support, and sharing of information.

On the other hand, SBAs schedule group discussions on appointment days that depend on gestational age and the presence of any identified pregnancy risks. This approach suggests that SBAs may tailor the timing of group discussions to address specific needs and concerns based on the stage of pregnancy and potential risk factors. The utilization of group discussions in antenatal care is valuable as it provides a platform for pregnant women to learn, ask questions, share experiences, and receive support. Group discussions offer opportunities for women to access important information on various aspects of pregnancy, childbirth, and postpartum care. They can also foster a sense of community and mutual support among the participants.

It is important to note that while group discussions can be beneficial, individualized care and attention are also crucial, particularly for women with higher-risk pregnancies. In such cases, personalized appointments and additional medical monitoring may be necessary to address specific needs and ensure optimal care. The differences in the frequency and approach to group discussions between TBAs and SBAs may be influenced by various factors, including available resources, organizational policies, and the level of risk associated with the pregnancies they attend to.

The findings indicate that both TBAs and SBAs recognize the importance of group discussions in antenatal care, although their scheduling and frequency may vary based on their respective practices and the characteristics of the women they serve. The provision of regular group discussions can enhance communication, education, and support for pregnant women, contributing to improved maternal and child health outcomes.

Based on the findings, the health talk contents during antenatal care cover a wide range of topics, including diet, dressing, hygiene, immunization, routine antenatal check-ups, and laboratory tests. The Skilled Birth Attendants (SBAs) have access to laboratory facilities and perform tests such as HIV testing, Hepatitis testing, packed cell volume, and full blood count on pregnant women. All facilities, including Traditional Birth Attendants (TBAs), conduct ultrasound scans, but TBAs encourage their clients to go to the nearest scan center, whether private or public. The inclusion of various health topics in the health talks during antenatal care reflects a comprehensive approach to addressing the physical and preventive aspects of pregnancy.

Discussions on diet, dressing, and hygiene highlight the importance of maintaining a healthy lifestyle during pregnancy.

The availability of laboratory facilities with SBAs allows for essential tests to be conducted, such as HIV and Hepatitis screening, as well as blood-related tests like packed cell volume and full blood count. These tests are essential for monitoring the health status of pregnant women and identifying any potential complications that may require medical attention. The utilization of ultrasound scans by all facilities indicates the recognition of the value of this diagnostic tool in assessing fetal development and identifying any potential issues. Encouraging clients to visit nearby scan centers, whether public or private, is a practical approach to ensure access to ultrasound services.

Regarding Tetanus Toxoid immunization, the findings suggest that TBAs do not administer this vaccine themselves. Instead, they either liaise with Community Health Extension Workers (CHEWs) who bring the vaccine to their clients in the facility, or they advise clients to go to government hospitals to receive it. This approach reflects an understanding of the importance of Tetanus Toxoid immunization and the need for qualified healthcare providers to administer it. These findings highlight the importance of comprehensive antenatal care that covers a wide range of health topics, utilizes appropriate diagnostic tools, and ensures access to necessary laboratory tests and immunizations. The collaborative approach of TBAs in coordinating with CHEWs or referring clients to government hospitals for certain services reflects an awareness of the need for specialized care and adherence to established protocols.

Based on the findings, the discussion during antenatal care involves different healthcare professionals depending on the type of facility. In the facilities led by Skilled Birth Attendants (SBAs), the discussants include Nurse/Midwives, Doctors, and Medical Laboratory Scientists, as reported by ten participants. On the other hand, in the homes of Traditional Birth Attendants (TBAs), the TBA and her assistant are the primary discussants. The presence of various healthcare professionals in SBA-led facilities reflects a multidisciplinary approach to antenatal care. Nurse/Midwives, Doctors, and Medical Laboratory Scientists each contribute their specialized knowledge and expertise to ensure comprehensive care for pregnant women. This diverse team can address various aspects of pregnancy, including medical assessments, laboratory tests, and the provision of healthcare services.

In TBA-led settings, the TBA and her assistant take on the responsibility of leading the discussions. This aligns with the role of TBAs as traditional birth attendants who provide care and support during childbirth. While TBAs may not have the same level of formal medical training as healthcare professionals in SBA facilities, they play a significant role in providing community-based care and promoting safe delivery practices. It is important to note that the findings reflect the specific context of the participants involved in the study and may not be representative of all healthcare practices. The composition of the discussion team may vary based on factors such as the healthcare system, the level of training of healthcare providers, and the specific protocols followed by different facilities.

Collaboration and coordination among healthcare professionals, regardless of the setting, are crucial for ensuring comprehensive antenatal care. When healthcare providers work together, they can contribute their expertise and provide holistic support to pregnant women, resulting in improved maternal and child health outcomes.

Based on the findings, the care of delivery instruments varied among the participants, with different approaches and practices observed. The findings indicate that the majority of Traditional Birth Attendants (TBAs) used liquid soap to wash the delivery instruments before rinsing them. This suggests that TBAs recognize the importance of cleaning the instruments to maintain hygiene and reduce the risk of infection during childbirth. However, it is important to note that the specific details of the washing process, such as the duration and technique used, were not mentioned in the findings.

In contrast, only a few TBAs reported soaking the delivery instruments in a Jik solution. Jik is a commonly used household bleach that contains sodium hypochlorite and is known for its disinfectant properties. Soaking instruments in a Jik solution can be an additional measure to further sanitize and disinfect them. However, the findings suggest that this practice was not widespread among the TBAs. Interestingly, one respondent mentioned using Jik solution without specifying any specific ratio or guideline for mixing it with water. This indicates that the decision-making process regarding the concentration of the Jik solution was left to the discretion of the TBA. It is important to note that using disinfectants such as Jik should follow recommended guidelines to ensure appropriate concentration levels for effective disinfection and to prevent any harm to the instruments or individuals involved.

In contrast, the Skilled Birth Attendants (SBAs) reported using sterilizing or autoclaving methods for the care of delivery instruments. Sterilization and autoclaving are more rigorous methods of instrument disinfection that involve subjecting the instruments to high heat or steam to kill potential microorganisms.

The findings highlight the different practices employed by TBAs and SBAs in the care of delivery instruments. While TBAs generally focused on cleaning the instruments with liquid soap and rinsing, SBAs utilized more stringent methods such as sterilization or autoclaving. It is important to consider that the effectiveness of instrument cleaning and disinfection practices is crucial for preventing infections and promoting safe childbirth practices. Standard infection prevention and control guidelines recommend the use of appropriate cleaning, disinfection, and sterilization techniques for medical instruments to ensure patient safety.

Based on the findings, the process of referral for patients experiencing certain complications during pregnancy or childbirth involved various means of transportation and different approaches to accompanying the patient. The identified methods of referral included individual means, such as patients arranging their own transportation, family members providing transport, standby cars, and ambulances. These methods reflect the different resources available and the urgency of the situation. The findings indicate that the majority of participants, including Skilled Birth Attendants (SBAs), followed their patients to the referral center. This practice ensures continuity of care and support during the transfer, which can be crucial for patient well-being and effective communication between healthcare providers. Titaley et al. (2019) stated that there were high rates of referral to health facilities for many frequent obstetric crises, and that comparable rates were recorded for the reporting of pregnancy outcomes to village elders and chiefs.

However, it is worth noting that one participant did not mention following their patient to the referral center. The reasons behind this decision were not specified in the findings. It is important to consider factors such as the severity of the condition, availability of resources, and individual

circumstances that may influence the decision to accompany the patient during referral. The types of patients mentioned as being referred included those with breech or transverse presentation, ectopic gestation (a pregnancy outside the uterus), and small-sized shoe women (which may suggest women with specific risk factors or complications). These specific cases highlight the need for specialized care and intervention, which may not be available at the facility where the delivery initially took place.

The mode of transportation mentioned varied between SBAs and Traditional Birth Attendants (TBAs). SBAs mentioned that relatives would accompany patients in ambulances, suggesting the availability of ambulance services for emergency transfers. On the other hand, TBAs reported using alternative transportation methods such as chartering cabs or bikes during emergencies or relying on neighbors' cars. These methods may reflect the available resources in their respective settings. It is important to ensure that referrals are conducted in a timely and appropriate manner to ensure the best possible care for patients with complications. Access to reliable transportation and coordination between healthcare facilities and providers are essential components of an effective referral system.

Conclusion

The findings highlight that both SBAs and TBAs play significant roles in delivering care to pregnant women and facilitating childbirth in their respective contexts. They contribute to important aspects of antenatal care, such as health education, monitoring, and referral processes. The involvement of both SBAs and TBAs reflects the reality that healthcare systems in certain areas rely on TBAs due to limited access to skilled providers or cultural preferences.

However, the findings also indicate areas that require attention and improvement. Barriers such as financial concerns, limited access to skilled services, transportation issues, and challenges related to referrals and recognition of TBAs hinder the provision of optimal care. These barriers need to be addressed through collaborative efforts, policy interventions, and capacity-building initiatives.

The importance of ongoing training and education for TBAs is evident from the recommendations provided. Enhancing their knowledge, skills, and understanding of emerging health issues and evidence-based practices can help improve the quality and safety of the care they provide. Incentives for appropriate referrals and strengthening referral systems can promote timely access to specialized care when needed.

Recommendations

Based on the findings discussed, several recommendations can be made to improve the provision of maternal and newborn healthcare services:

1. Enhance Referral Systems: Develop and implement efficient referral systems between TBAs and SBAs or higher-level healthcare facilities. This should include clear protocols, guidelines, and mechanisms for timely and appropriate referrals. Emphasize the importance of prompt referrals for high-risk pregnancies or complications to ensure that women receive specialized care when needed.

2. Improve Access to Skilled Healthcare: Address barriers such as financial concerns, limited access to skilled providers, and transportation issues. Develop strategies to increase access to skilled maternal and newborn healthcare services, especially in underserved areas. This can involve measures such as expanding healthcare facilities, improving transportation networks, and implementing financial support mechanisms to alleviate the financial burden on women seeking care.

3. Recognize and Support TBAs: Advocate for the formal recognition of TBAs within the healthcare system, ensuring they receive the necessary training, resources, and support. This recognition can facilitate their integration into formal healthcare networks, allowing for better coordination, supervision, and monitoring of their activities. Provide incentives for TBAs who adhere to established guidelines and make appropriate referrals.

4. Engage Community Participation: Involve communities in decision-making processes related to maternal and newborn healthcare. Promote community awareness, engagement, and participation in health promotion activities. Empower community members, including women and families, to be active partners in their own healthcare and the healthcare of their communities.

Implications of the Findings

The findings have several implications for nursing practice in the context of maternal and newborn healthcare.

1. Cultural Sensitivity and Patient-Centered Care: Nursing practice should be culturally sensitive and patient-centered, considering the preferences and beliefs of pregnant women and their families. Recognizing that some women may choose to receive care from TBAs due to cultural or accessibility reasons, nurses should approach these situations with respect and work to educate and inform patients about the benefits of skilled care while understanding their perspectives.

2. Continuity of Care: Nurses play a vital role in ensuring continuity of care for pregnant women. This includes proper documentation and sharing of information between different healthcare providers, particularly during referrals between TBAs and SBAs or higher-level healthcare facilities. Nurses should advocate for seamless care transitions and work to bridge any gaps in communication or information transfer to ensure that women receive consistent and coordinated care throughout their pregnancy and childbirth journey.

3. Quality Improvement: The identified barriers and challenges highlighted in the findings should prompt nurses to engage in quality improvement initiatives. This may involve assessing and improving referral systems, enhancing infection prevention and control practices, advocating for resources and infrastructure to support skilled care, and participating in interprofessional collaborations aimed at improving maternal and newborn healthcare outcomes.

References

Ahmed, O. A., Odunukwe, N. N. & Akinwale, O. P. (2015) Knowledge and practices of traditional birth attendants in prenatal services in Lagos State, Nigeria. *Africa Journal of Medical Science.* 34 (1), 55–58.

Awotunde, O., Awotunde, T., Fehintola, F., Adesina, S., Oladeji, O., Fehintola, A., & Ajala, D. (2017). Determinants of utilisation of traditional birth attendant services by pregnant women in Ogbomoso, Nigeria. *Int J Reprod Contracept Obstet Gynecol, 6*, 2684-2689.

Ayede, A.I. (2012). Persistent mission home delivery in Ibadan: attractive role of traditional birth attendants. *Annals of Ibadan Postgraduate Medicine,* 10(2), 67 - 76

Gurara, M., Kristel M., Yves J., Jean-pierre V., & Veerle D. (2020). Traditional Birth Attendants ' Roles and Homebirth Choices in Ethiopia : A Qualitative Study'. *Women and Birth* 33(5):e464–72. doi: 10.1016/j.wombi.2019.09.004.

Ibrahim, O. (2016). Social-Economic Determinants of Maternal Mortality in Rural Communities of Oyo State, Nigeria. *International Journal of Scientific and Research Publications*, 6(9), 280-285

Iwu, C.A., Uwakwe, K., Oluoha, U., Chukwuma, D. & Nwaigbo, E. (2021). Empowering traditional birth attendants as agents of maternal and neonatal immunization uptake in Nigeria: a repeated measures design. *BMC Public Health,* 21, 287

Nigeria Demographic Survey and Health (2018). Maternal and Child Health Services. Retrieved from www.ok.gov/health/child_and _family_health/maternal child_health_service/

Nyongesa, C, Xu, X, Hall, J. J, Macharia,W.M, Yego, F. & Hall, B. (2018). Factors influencing choice of skilled birth attendance at ANC: evidence from the Kenya demographic health survey. *BMC Pregnancy and Childbirth,* 18(1), 88

Ofili, A. N. & Okojie, O. H. (2015). Assessment of the role of traditional birth attendants in maternal health care in Oredo Local Government Area, Edo State, Nigeria. *Journal of Community Medicine and Primary Health Care, 17*(1), 55–60.

Okonofua, F. E. (2013). Reducing Maternal Mortality in Nigeria: An approach through policy research and capacity building. *African Journal of Reproductive Health, 14(3), 9-13.*

Olonade, O., Olawande, T.I., Alabi, O.J. & Imhonopi, D. (2019). Maternal Mortality and Maternal Health Care in Nigeria: Implications for Socio-Economic Development. *Macedonian Journal of Medical Sciences,* 157 (5), 849–855

Rodriguez, M., Opara, I., Gardner, M., Assan, M.A., Hammond, R, Plata, J., Pierre, K. & Farag, E. (2017). Progresses and challenges of utilizing traditional birth in maternal and child health in Nigeria. *International Journal of Maternal and child Health*, 6(2), 130-138 doi:10.21106/ijma.21.

Sibley, L.M., Sipe, T.A. & Barry, D. (2012). Traditional birth attendant training for improving health behaviours and pregnancy outcomes Europe PMC Funder group in *Cochrane Database Syst Rev* on page CD005460

Sulayman, H.U. & Adaji, S.E (2019). Integration of traditional birth attendants (TBAs) into the health sector for improving maternal health in Nigeria: a systematic review. *Lancet*, 46(2), 55-62.

Titaley C.R., Dibley M.J. & Roberts C.L (2019) Factors associated with underutilization of antenatal care services in Indonesia: results of Indonesia demographic and health survey 2002/2003 and 2007. *BMC Public Health* 10(485), 1–10

Turinawe, E.B., Rwemisisi, J.T. Musinguzi, L. Groot, M., Muhangi, D., Vries, D., Mafigiri, D. Katamba, A., Parker, N. & Pool, R. (2016). Traditional birth attendants (TBAs) as potential agents in promoting male involvement in maternity preparedness: insights from a rural community in Uganda. *Reproductive Health*, 13, 24 DOI 10.1186/s12978-016-0147-7

Weitzman, A. (2017). The effects of women's education on maternal health: Evidence from Peru. *Social Science*, 17 (3), DOI:10.1016/j.socscimed.2017.03.004

WHO (2015). Antenatal Care in Developing Countries: Promises, Achievements and Opportunities: an Analysis of Trends, Levels and Differentials, Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland.

WHO (2020). Maternal Mortality Sexual and Reproductive health