

**SCHOOL OF PUBLIC HEALTH  
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**FACTORS INFLUENCING THE USE OF TRADITIONAL BIRTH  
ATTENDANTS IN AMASSOMA COMMUNITY, BAYELSA STATE,  
NIGERIA**

**BY**

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**DECLARATION**

I, Ebiede Timi Marclint, author of this thesis, declare that aside references to other articles which are acknowledged, this research in its entirety is the independent work of Ebiede, Timi Marclint undertaken under the supervision of Dr Phyllis Dako-Gyeke. Also, no part of this thesis or in whole has been presented elsewhere for the award of another degree.

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## **DEDICATION**

I dedicate this thesis to my elder brother, teacher and friend Dr. Tarila Marclint Ebiede, thank you for all the sacrifices you have made for me your little sister. Also, to my mother Mrs. Akpodibalukumo Ebiede, for setting the pace for me to follow, and for all your endless sacrifices and commitment you have rendered for over thirty years saving the lives of women and children in rural communities in Bayelsa State.

## ABSTRACT

**Background:** The number of women dying annually from pregnancy and child birth related issues still remains a global health problem. Current statistics in maternal mortality as recorded by World Health Organization shows that there has been a reduction in maternal deaths, however there has not been much progress in Sub-Saharan Africa. Nigeria is the second largest contributor to maternal mortality globally. This has been due to low utilization of maternal health services, including skilled birth attendant. Rather there is a high use of traditional birth attendant.

**Objective:** The purpose of this study was to investigate the factors influencing the use of Traditional Birth Attendant (TBA). Specifically, the study sought to determine the prevalence of traditional birth attendant use among women in Amassoma, characterize maternal health care services available for pregnant in Amassoma, identify socio-economic influencing the use of the services of the traditional birth attendant.

**Methods:** A community based cross sectional study was carried out in Amassoma with a sample size of 401 women in their reproductive age (15-49), who have given birth in the last five years (2014-2019). Structured questionnaires were used in collecting data; the questionnaire was made up of three sections, which are socio demographic and economic data, prevalence of the use of traditional birth attendant, and the kind of health services available for pregnant women in Amassoma community. Stata version 15.0 was used in analyzing data. Bivariate and logistic regression analysis were used to examine factors influencing the use of TBA.

**Results:** Out of the 401 women, 78% to have used the services of a TBA. More than half of the participants knows another woman who has used the services of a TBA. Seventy three percent (73%) of the participant responded that they can easily asses a government health facility, 63% responded that they can easily access the services of a traditional birth

attendant, and 25% have access to private facilities. 143 of the participants responded that they will not use the services of a skilled birth attendant because of poor service, and 127 responded that cost of service is a barrier to the use of skilled birth attendant.

**Conclusion:** From the studies the prevalence of traditional birth attendant use is high. Poor service by health workers, high cost of delivery and absence of health workers are factors influencing the use of traditional birth. It is recommended that training and reorientation of health workers should be done in order for them to offer better health services, the Bayelsa State government should include maternal health services in the state health insurance scheme for all residents, and awareness should be created on the use of skilled birth attendants during deliver

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## **LIST OF ABBREVIATIONS**

NDHS- Nigeria Demographic and Health Survey

SBA- Skilled Birth Attendan

SSA- Sub- Saharan Africa

TBAs- Traditional Birth Attendant

WHO- World Health Organization

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background of Study

Globally, Sub-Saharan Africa has the highest rate of maternal mortality (Moyer & Mustafa, 2013). Poor maternal health service is one of the leading cause of death among women in Sub-Saharan Africa (Anyait, Mukanga, Oundo, & Nuwaha, 2012). Use of unskilled home delivery is a major obstacle in reducing maternal mortality (Oshonwoh, Nwakwuo, & Ekiyor, 2014), and a major barriers to achieving Sustainable Development Goal three, which is good health and wellbeing.

The number of women dying annually from pregnancy and childbirth related issues still remains a global health problem. Current trends in maternal deaths as recorded by World Health Organization shows that there has been a reduction in maternal deaths, however there has not been much progress in Sub-Saharan Africa including Nigeria (WHO,2015). Globally maternal mortality ratio in 2013, was 210 live births per 100,000 live births (WHO, 2014). Out of the 289,000 global maternal deaths recorded in 2013, Sub-Saharan Africa recorded 179,00 (i.e. 62%) (WHO, 2014).

Research shows that utilization of skilled delivery during childbirth is an important factor in reducing maternal mortality (WHO, 2014). Consequently In Nigeria several interventions have been put in place to curtail the use of traditional birth attendant and in turn reduce maternal mortality (Erim, Resch & Goldie, 2012). In developing countries millions of women still use the services of traditional birth attendant during delivery (Envuladu, Agbo, Lassa, Kigbu, & Zoakah, 2013). Several studies have researched into the factors influencing the use of traditional birth attendant in Nigeria, South Asia, Sub-Saharan Africa (Bangladesh, India, Pakistan, Kenya, Nigeria and Tazania), and Northern

Nigeria. (Adewemimo, Msuya, Olaniyan, & Adegoke, 2014; Onasoga, Osaji, Alade, & Egbuniwe, 2014; Tey & Lai, 2013). The factors established from these studies includes socio economic status, maternal and paternal levels of education, and distance from health facility, also several health system factors were found to be associated with the use of traditional birth attendants. Although these studies have given insight into the factors influencing the use of traditional birth attendant, very few of these studies were conducted in rural communities such as Amassoma. One of these few studies found that 30.6 percent of women use unskilled delivery during child birth in Bayelsa State (Onasoga et al., 2014). It was against this note, that this study is aimed at examining the factors influencing the use of traditional birth attendant in Amassoma community.

## **1.2 Problem Statement**

The World Health Organization estimates that globally 830 women die each year due to pregnancy complications. In developing countries 239 per 100,000 live births versus 12 per 100,000 live births in developed countries (<https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>). According to NDHS on percentage of birth type of birth attendant, 65.6 percent of child birth in Bayelsa state is delivered by a TBA (National Population Commission, 2013).

Unskilled home delivery is one of the major threats to maternal and child health in Africa. Especially the use of traditional birth attendants (Abubakar, Adamu, Hamza, & B. Galadima, 2017). In communities where there are no health facilities these traditional birth attendants play a major role in saving the lives of women by assisting during delivery. Where there is no doctor, nurse or a community health worker a traditional birth attendant becomes the only option before, during and even after delivery (Onikpe *et al.*, 2014). The TBAs offers ANC and PNC services, which is of great help to the women who live in communities where there is no access to skilled health care, this is a common situation in most rural communities in Sub-Saharan Africa (Wilunda et al., 2014)

Access to skilled health care and during pregnancy and child birth is necessary for both mother and child, and it is an indicator of the maternal and child health in that environment (Okafor, Sekoni, Ezeiru, Ugboaja, & Inem, 2014).

Nigeria is the second largest contributor to maternal mortality occur, where about 19% of maternal mortality occur (Fapohunda & Orobato, 2013). In Nigeria about 800 women die in 100,000 live birth (Tukur, Cheekhoon, Tinsu, Muhammed-Baba, & Aderemi Ijaiya, 2016). WHO, UNICEF, World Bank and the United Nations Population Fund, estimates that about 58,000 maternal deaths occur in Nigeria every year (World Health Organization, Nigeria, 2018). Despite the high rate of maternal mortality, the use of skilled and professional health services remain very low and patronage of unskilled birth attendants is widespread (Envuladu *et al.*, 2013).

Studies have shown that in Bayelsa State, attitude and knowledge of women of child bearing age toward the health consequences of delivery handled by an unskilled birth attendant is very poor (Oshonwoh *et al.*, 2014). A study conducted in Amassoma shows that despite the numerous disadvantages that comes with the use of traditional birth attendant, women still seek their services during child birth (Onasoga, Osaji, Alade, & Egbuniwe, 2014).

### **1.3 Research Questions**

1. What is the prevalence of traditional birth attendant use?
2. What are the maternal health care services available?
3. What are the barriers to the use of skilled birth attendant?

### **1.4 Objectives of the Study**

#### **1.4.1 General Objective**

To determine the factors influencing the use of traditional birth attendant, among women in Amassoma community, in Southern Ijaw Local Government Area of Bayelsa State, Nigeria.

### 1.4.2 Specific Objectives

1. To determine the prevalence of traditional birth attendants among women in Amassoma.
2. To characterize maternal health care services available for pregnant women in Amassoma.
3. To identify socio- economic factors influencing the use of the services of traditional birth attendants.

### 1.5 Significance of the Study

Preference for the use of TBA is associated with the high level of maternal mortality in Nigeria. This study accentuates the factors responsible for the preference of the use of TBA in Bayelsa State. This will also inform government of better strategies and ways in improve, and increase the percentage of skilled birth delivery, it will be useful for public office holders while formulating health policies, there approach to maternal and child health programs, and also educate women on the importance of institutional delivery.

### 1.6 Definition of terms

**Traditional Birth Attendant:** WHO defines traditional birth attendant as “a person who assists the mother during child birth and who initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants” (Oshonwoh *et al.*, 2014).

**Antenatal Care:** It is a type of health service given to a pregnant woman to ensure a safe gestation and delivery, in order to prevent complications during pregnancy and child birth (Abubakar *et al.*, 2017).

**Maternal Mortality:** The death of a woman not more than 42 days of termination of pregnancy, within the frame and site of the pregnancy from any cause related to management, but not as a result of coincidence or incidental causes (Blencowe *et al.*, 2016)

**Skilled Birth Attendant:** Skilled birth attendant is a health professional who has been trained and accredited by the government, to manage uncomplicated pregnancies, childbirth and immediate post-natal period and be able to manage and identify cases that needs to be referred (Utz, Siddiqui, Adegoke, & Van Den Broek, 2013).

## **1.7 Conceptual Framework**

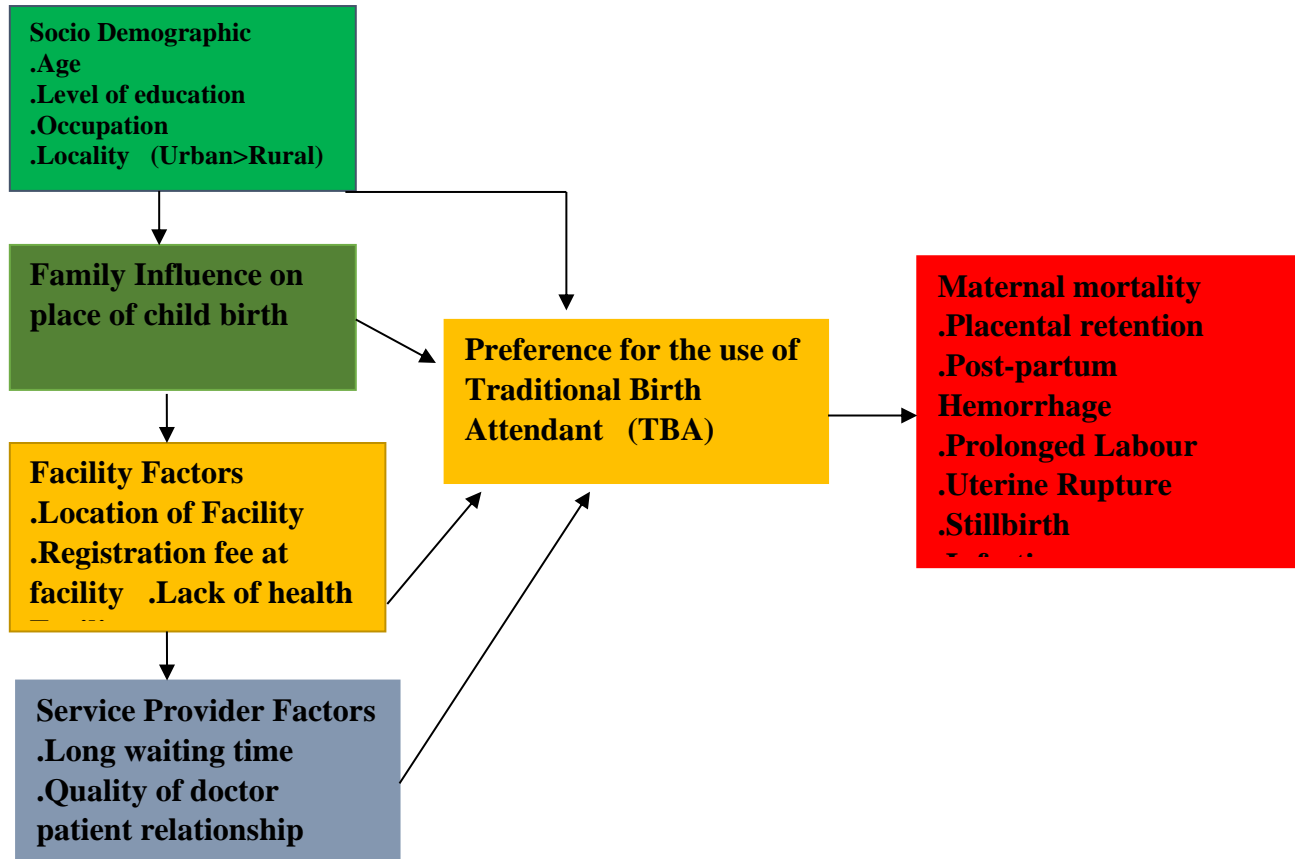
### **1.7.1 Narrative Explaining Conceptual Framework**

The conceptual framework explains the factors that influence the use of traditional birth attendants, among women in Amassoma community. Some studies have shown that doctor patient relationship, walking distance to health facility results in pregnant women going to the Traditional birth attendant during child birth (Kabakyenga, Östergren, Turyakira, & Pettersson, 2012)

Social and cultural beliefs affect the interpretation and meaning of pregnancy , this is a determinant of a woman's choice on where to go during child birth (Anastasi *et al.*, 2015). Level of education, economic status, place of residence if rural or urban area, are factors influencing the use of traditional birth attendant among women (Ugboaja, Oguejiofor, Oranu, & Igwegbe, 2018).

Apart from the factors influencing the use of TBA, there are other risk factors and outcomes associated with the use of traditional birth attendant. Maternal mortality, placental retention, post-partum Hemorrhage, prolonged labor, uterine rupture, still birth and infection, are issues that a TBA cannot handle such challenges or even detect during any of the trimesters in pregnancy (Goldenberg, McClure, & Saleem, 2018).

**Conceptual Framework Showing the Factors Influencing the Use of Traditional Birth Attendants**



**Figure 1: Conceptual Framework Showing the Factors Influencing The Use of Traditional Birth Attendants**

Source: Adapted from Andersen & Newman Health Care Theory (1973).

The conceptual framework was adapted from Andersen & Newman Health Care Theory(1973). The framework illustrates factors influencing the use of traditional birth attendant. Numerous factors influencing the use of traditional birth attendant has been recognized, which informed the development of the framework. Development of the conceptual framework for this study is guided by Andersen and Newman’s healthcare utilization theory. The Andersen and Newman’s healthcare theory was propounded to determine the factors that either promote or prevent health care service utilization. It was

first propounded in 1960, and has gone through four stages of development. The first was in 1970, 1980-1990 and 1995 respectively.

They proposed that the use of health care is dependent on individual characteristics and the immediate environment. The environment consists of the external and all the health care systems. The external is made up of physical structure, economic and political characteristics, and the care includes the policies, resources and organization structure (Andersen & Newman, 1973). When individuals use health care service is said to be an interaction of three components. These three components determine the kind of health services they use, when in need of health care. These are the social structure, demographic and predisposing factors. The demographic factors include age, gender, area of residence, attitudes, occupation, values, ethnicity and knowledge people have towards health (Andersen & Newman, 1973).

The theory was used to determine factors that influence or impede utilization of maternal health care service. A pregnant woman's use of health care services is dependent on her socio demographic and economic characteristics, like age, marital status, ethnicity, education, occupation and income. These characteristics may influence their health behavior either negatively or positively. The knowledge, values, belief and attitudes a pregnant woman has will influence the kind of maternal health care services, that she will use when she is pregnant, during delivery and after delivery.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

Due to the negative implications of the use of traditional birth attendant and its effect on maternal health and maternal mortality, a lot of researches have been conducted on the phenomena. Thus, literature on factors influencing the use of traditional birth attendant among women, maternal health, antenatal delivery and the dangerous health outcomes of the use of TBAs is quite reputable. This chapter reviews some relevant literature on maternal health, specifically on factors influencing the use of traditional birth attendant among women.

Evidence in literature shows that in developing countries, a high proportion of women attend antenatal but yet go to the traditional birth attendant when they eventually fall into labor (Boah, Mahama, & Ayamga, 2016). Although the aim of this study is to determine factors influencing the use of traditional birth attendant, a little attention will be given to the importance of a skilled birth attendant during child birth, and the dangerous health outcomes of the use of traditional birth attendant during and after child birth.

#### **2.2 Traditional Birth Attendants (TBAs)**

Mwangi (2012) defined the traditional birth attendant as a person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or working with other TBAs. The term traditional birth attendant is one around which there is currently a lot of controversy and debate. It is used to define a wide and heterogeneous group of traditional careers most of whom operate in the informal sector, and their individual competencies and skills can vary considerably, as can the names and titles by which they are commonly referred to, depending on the specific country context

(Bernis, 2003). Although in some countries it is clear that women utilize the skills of such careers.

TBAs have existed since time immemorial, and fall into the category of informal health care providers who work locally in the rural areas of low- and middle-income countries. Women in rural areas usually use their services more than they use formal health care providers (Sudhinaraset *et al.*, 2013). TBAs still exist despite the formal health care system because rural areas are characterized by poor infrastructure, including impassable roads and less equipped facilities, among other things. TBAs fall under the informal health system, which, according to Sudhinaraset *et al.*, (2013), is defined by four categories: training, payment, registration, and profession. The authors described TBAs as having received no formal training, although they may have gone through some level of formal training such as apprenticeships, seminars, and workshops funded by NGOs.

Sudhinaraset *et al.*, (2013) stated that TBAs receive payments directly from the clients they serve. The payments are undocumented, and may come in forms other than money, such as food-stuffs. TBAs are not registered with any organization, nor do they have any professional affiliation. Furthermore, Kamal (1998) noted four categories of TBAs: urban TBAs, who practice for a living but are not trained in the formal way; rural TBAs, often an elderly relative or neighbor who assists during child delivery but makes no living from it; family TBAs, who only tend to close family members; and finally, trained TBAs, who have received some type of formal training but are not fully skilled.

According to Ferdinand *et al.* (2014), the existence of TBAs in most Low- and Middle-income countries is due to limited availability of professional health care providers in rural areas, leaving TBAs to fill the gap. There is a wide gap between formal and informal health care providers in LMIC due to literacy levels (Kamal, 1998). The TBAs are here to

stay. They are part of the community; socially and culturally accepted; and available whenever needed (Turinawe *et al.*, 2016). This explains how important TBAs are in their communities. The TBAs enjoy an important status in the community, which likely explains why policy makers should consult with TBAs to improve the health of the mothers in the rural areas. The following section looks into the role of TBAs, benefits of training TBAs, and factors that lead pregnant women to use their services

### **2.3 Role of TBAs**

TBAs have existed for as long as women have given birth. The work they do has been tremendous, and people in the rural areas value their services. Originally, TBAs had no form of training, but they still performed midwifery duties. Training began in the 1970s by the WHO and other funding organizations (Kruske & Barclay, 2004; Saravanan, Turrell, Johnson, Fraser, & Patterson, 2011). Nelms and Gorski (2006) asserted that TBAs are a link between the rural people of Africa and health care delivery. They further stated that TBAs have a unique talent in that they use inherited knowledge of methods and practices that have evolved from the social, cultural, and spiritual wealth of the communities they serve. Despite TBAs being linked to high maternal mortality, they may also play a significant role in mitigating maternal mortality because they are first and often the only health care provider who can be easily accessed in rural areas; therefore, there is a need to involve them.

Among professionals, opinions differ about the role of TBAs in maternity care while some insists that in the interest of maternal health, empowering TBAs through training and retraining is the best option because community members will continue to patronize them, others express that TBAs have little role in obstetric care. The debate of who is qualified to take delivery of a pregnant woman in labour has been renewed as the Lagos state government released its 2010 maternal mortality health survey conducted by IPAs, sexual

reproductive health organization. According to Adebayo (2012), stake holders in the medical profession, obstetricians who were present at the presentation called on the state government to reverse its policy that allows (TBAs) trained by the state to take delivery of pregnant women. According to them, the move is practically endorsing unskilled personnel to attend to pregnant women. This they warned could increase maternal and infant mortality rate in the country.

Abioye-Kuteyi, Elias, Familusi, Fakunle, and Akinfolayan (2001) found that more than two thirds of TBAs are older women who practice singlehandedly. About half of the TBAs in their study had no designated delivery rooms. They also did not consider any pregnant woman to be in danger; therefore, they saw no need to refer them to the hospital for further check-up. The authors also stated that few of the TBAs examined women during their pregnancies. Despite this, mothers still used their services; of the 109 clients interviewed, half used TBAs for all their deliveries. TBAs met with an average of five clients per month, which demonstrates their value in the community. The 109 clients interviewed were aware that the TBAs were ill-equipped, but they felt satisfied using their services and recommending them to other women (Abioye-Kuteyi *et al.*, 2001).

The authors highlighted the unique roles played by TBAs and how greatly their clients valued them although the WHO recommends people be within an hour of the nearest healthcare facility, this was not possible in the Manxili region of South Africa where Selepe and Thomas (2000) conducted their research. The authors described the region as unstable, with a geographical terrain that does not favour pregnant mothers. Here, TBAs offer their services to pregnant mothers due to the inaccessibility of health facilities. Similarly, in Bangladesh, Sarker *et al.*, (2016), found that poor roads and weather do not favour the women; during the rainy seasons the only accessible means of transport is by boat, leaving women to turn to TBAs. Selepe and Thomas (2000) described the distinct

roles TBAs play in the region during each stage of pregnancy. At the prenatal stage, TBAs serve as health educators, giving dietary advice to the mothers, such as avoiding alcohol and smoking. They also estimate date of delivery by examining physical changes. During the labor and delivery period, TBAs usually encourage the mothers to have someone present, especially a mother in-law or grandmother. During postpartum, TBAs visit mothers to check breast milk flow and vaginal blood loss, and also advise them to maintain hygiene. The TBAs described by Selepe and Thomas seemed to be better educated and able to provide more comprehensive care as compared to TBAs described by Abioye-Kuteyi *et al.*, (2001).

In climes where the government supports TBAs, the TBA promotes health, provides prenatal and neonatal health counselling, and initiates timely referrals (Pfeiffer & Mwaipopo, 2013). There are disparities between women in urban and rural areas in terms of maternal health care utilization. For example, women in urban Tanzania use modern health facilities, while rural women use TBAs when delivering (Pfeiffer & Mwaipopo, 2013). The authors stated that rural women prefer to deliver with assistance from TBAs because of the TBAs' motherly nature. In addition, some rural women in Tanzania prefer to deliver in a private and confidential environment with the assistance of someone from the same community.

However, another study found that as much as the government supports TBAs, there is still a problem (Vyagusa *et al.*, 2013). The authors showed that TBAs lack knowledge for handling pregnancy complications. TBAs also shared gloves and used unsafe delivery materials. Despite the challenges TBAs encounter in their work, women still turn to them for services. This is due to various factors that hinder women from delivering in a formal health care setting. These factors include poor roads, distance from the clinic, and lack of electricity and water (Essendi *et al.*, 2015). Kaingu *et al.* (2011) conducted a study with

200 TBAs and 20 clients. The authors used unstructured questionnaires, interviews, and focus groups, and found that although TBAs are female dominated, there are also males who practice. Further, the authors asserted that TBAs are culturally accepted in their communities and are considered a valuable resource. TBAs are consulted routinely by pregnant mothers. Mothers value them because they are easily accessible as compared to the inaccessible health facilities.

Kaingu *et al.*, (2011) also mentioned that more than half of the TBAs were untrained and yet had attended to over 200 pregnant women. Their skills were earned through inheritance. Similar to the findings of Selepe and Thomas (2000), Kaingu *et al.*, (2011) mentioned that TBAs observe hygiene and tend to pregnant women during and after delivery. In addition to the roles mentioned above, Kaingu *et al.*, (2011) stated that TBAs provide social support during labor and postpartum periods, something which is not available in health care centers. However, in another study conducted in Kenya, Wanyua *et al.* (2014) found that the majority of TBAs do not offer after-delivery services.

#### **2.4 The importance of skilled delivery**

In order to reduce maternal mortality, the most crucial intervention to employ is skilled delivery (WHO 2014). The connection between early and regular attendance of antenatal care and skilled health delivery and reduced better maternal health outcomes has been recorded for a long period of time (Doctor, Nkhana-Salimu, & Abdulsalam-Anibilowo, 2018) This is because 75% percent of all maternal deaths occur within 24 hours of child birth, due to complications associated with labor and child birth (Khans *et al.*, 2016). Skilled delivery is when a woman receives appropriate care during and immediately after delivery (Graham *et al.*, 2001).

The requisite is that labor and child birth takes place in an environment where there is appropriate infrastructure, equipment and supplies in addition to effective referral and

communication systems (Graham *et al.*, 2001). Although complications during child birth are highly unpredictable, they can be managed properly and maternal death prevented if they are detected and treated early. It is therefore highly recommended by the World Health Organization (WHO) that all deliveries must be done by a skilled birth attendant, a professional who can identify and manage normal delivery complications and refer appropriately (Graham *et al.*, 2001, Khans *et al.*, 2006). Although despite the recommendations, prevalence of unskilled birth delivery is very in high Sub Saharan Africa, only 50% percent of deliveries are carried out by skilled birth attendants (Moyer and Mustafa, 2013).

## **2.5 Factors Associated with the Use of Traditional Birth Attendant**

Several factors have been found to influence the use of traditional birth attendant during delivery. These factors could be as a result of the poorly managed health system or individual, they can be categorized into socio-demographic, facility and service provider factors.

### **2.5.1 Socio demographic characteristics**

#### **2.5.1.1 Mothers age**

Age of a mother have been reported to affect the health seeking behavior, a teenager who gets pregnant is completely at the disposal of the older members of the family on where to go and where not to go to when she falls into labor (Owili *et al.*, 2016). A study conducted in Nigeria shows the relationship between maternal age and seeking skilled care during delivery (Onasoga *et al.*, 2014). As a result of poor knowledge on the dangerous outcomes of unskilled care during delivery, many young girls are indecisive as to where to have their baby and seek advice from older and experienced women in the community.

In a study conducted by Chibuikwe and Constance (2013) data collected found that women below 19 years are the least users of skilled delivery, during child birth. In Senegal, a

woman's age at first marriage highly determines the use of skilled birth attendant (Kyoko, 2015). It is therefore very important to note that maternal age at birth is an important factor for uptake of institutional delivery.

### **2.5.1.2 Rural/ Urban**

A study conducted by the Nigeria midwives service scheme shows that women living in rural communities are most likely to seek the services of a traditional birth attendant (Exley *et al.*, 2016). In southern Nigeria women in rural communities contribute 70% of unskilled delivery, when compared to women in urban areas, who contribute only 30% of unskilled deliveries (Innocent Mbachu *et al.*, 2014). In Nigeria there is a huge disparity between women who live in rural communities and their counterparts in urban areas as regards place of child birth (Solanke & Rahman, 2018). Women in rural communities more often seek the services of a traditional birth attendant than women in the urban areas (National Population Commission, 2013). However the use of traditional birth attendant is a major maternal health challenge and a contributing factor to the high maternal mortality rate in Nigeria (Solanke & Rahman, 2018). This situation is not only peculiar to Nigeria but also exists in other sub-Saharan African countries.

### **2.5.1.3 Occupation**

Most often, poor health is attributed to poverty. People with higher socio-economic status have better health-seeking behavior, therefore the occupation of a woman's household plays a significant role as to where she goes when she falls into labor (Ganle, Parker, Fitzpatrick, & Otupiri, 2014). Low financial status is a barrier in accessing skilled health care during child birth (Sialubanje *et al.*, 2015).

In a study conducted in Sub-Saharan Africa, using 58 demographic health surveys, results show that women with higher source of income were 68% more likely to deliver in health facilities than women with lower income (Doctor *et al.*, 2018).

#### **2.5.1.4 Level of education**

The level of education a woman has determines the use of health care facilities (*Owili et al.*, 2016), because the higher the level of education the better she is more informed about the disadvantages of seeking the services of traditional birth attendant during child birth. In Senegal and Tanzania maternal Education is positively related to the use of skilled birth attendant during delivery (Shimamoto & Gipson, 2017a). In line with the above statement the National Population Commission, (2013), reported that a mother's level of education determines the likelihood of her seeking the services of a skilled birth attendant during delivery.

#### **2.5.2 Health System Factors**

Several factors in the health system has been found to influence the use of traditional birth attendant by women during delivery, especially in sub Saharan Africa. Some of which includes, poor quality in health service, inadequate health staff, poor attitude of health workers, cost of delivery in health facilities and long waiting time before care is received (Ganle, Fitzpatrick, Otupiri, & Parker, 2016). Providing mothers with mother pack at health facilities will improve the use of skilled birth attendant during delivery (Enameh *et al.*, 2016). This basic provision should be made to encourage mothers to seek the services of a skilled birth attendant, because financial limitations is a major constrain in preventing women from using the services of a skilled birth attendant (Titaley, Hunter, Dibley, & Heywood, 2010).

In rural Zambia, requirements to bring food and baby clothes while at the clinic, prevented pregnant women from coming to the health facility. Continuity of care is a challenge in Africa, because lack of money has been found to be predictor to drop out at ante natal care and delivery. July 31<sup>st</sup> 2018, the Bayelsa state government launched a safe motherhood project, free maternal health care services and monthly stipends for women who attend

antenatal and also deliver at the health facility, in order to reduce the use of traditional birth attendant (anecdotal evidence).

Babalola & Fatus (2009) stated that utilization of maternal health services is associated with improved maternal and neonatal health outcomes, effective intervention should be done in order to improve health services. Primary health care (PHC) was designed to provide universal access to skilled pregnancy care for the prevention of maternal deaths, however a study conducted in southern Nigeria concluded that reasons for none use of PHC is poor quality of PHC service delivery (Okonofua *et al.*, 2018)

The health systems needs to be functional , the attitude of health workers has been found to be one of the major determinants why women prefer the use of traditional birth attendants(Karanja *et al.*, 2018). Ill treatment of pregnant women during delivery is a major determinant of maternal health service uptake, poor quality of relationship between health workers and pregnant women makes them use the traditional birth attendant (Chi, Bulage, Urdal, & Sundby, 2015). Therefore the care a pregnant woman receives from a skilled birth attendant , will determine her subsequent use of the health facility (Karanja *et al.*, 2018).

The care a pregnant woman is given in a health facility will determine her subsequent use of the health facility, poor attitude of health workers has been identified as a barrier to the effective and constant use of health facility during delivery, in developing countries (Boah *et al.*, 2018). This may impede the progress in the campaign to reduce, maternal mortality, especially in sub Saharan Africa(Sam-Agudu *et al.*, 2017).

## **CHAPTER THREE**

### **METHODS**

#### **3.1 Introduction**

In this chapter we looked at the methodology to for this study. Including the study area, variables, population, sampling technique, sample size, areas of data collection, data analysis ethical consideration, quality control and pre-test.

#### **3.2 Research Design:**

The study design was a community based cross-sectional, using quantitative methods to collect data. Using a structured questionnaire to identify the factors that influences the use of traditional Birth attendant in Amassoma community. The study design gathered information from women in their reproductive age (15-49years) on factors influencing the use of traditional birth attendant.

The choice a cross sectional study design, and use of questionnaires, is because it is economical, with reference to data collection and data analysis(Bhattacharyya, Srivastava, Roy, & Avan, 2016).

#### **3.3 Study Area:**

The study was done in Amassoma community. Amassoma is one of the biggest community in Southern Ijaw Local Government Area, Bayelsa State(Lawani, Alade, & Oyelaran, 2015). It is the headquarters of Ogboin Clan and Ogboin North rural development Authority in Southern Ijaw Local Government Area, Amassoma is known to be host community of the Bayelsa State government owned university (Niger Delta University) (Olayinka, Achi, Amos, & Chiedu, 2014). In as much as Amassoma is home to Niger Delta University, it is also a host community to other educational institutions, like Community secondary school Amassoma, and St Stephens Primary school.

Two government health facilities, private clinics and drug stores are located in the community (Olayinka *et al.*, 2014). The services rendered in the health facilities are; immunization, antenatal care, delivery, treatment of minor ailments, referral services, laboratory services such as screen of HIV test, widal and mp test, collection of sputum for TB test, and urinalysis for pregnant women. The government general hospital Amassoma and Tantua private hospital, have the human resource and facilities for surgeries like appendectomy and Caesarean section.

According to the 2006 census report, Amassoma had an estimated population of 28,717 people, it is made up of 22 compounds also known as Ama, majority of the residents are petty traders with farmers, civil servants and students (Articles *et al.*, 2014). Most of the residents in Amassoma community are predominantly farmers and small and medium scale business men and women, civil servants and students. Residents are mainly Izons and other ethnic groups which includes the Igbos, Hausas, Yorubas, Urhobos, Isokos and a few non-Nigerians. Christianity is the most commonly practiced religion(Onasoga *et al.*, 2014).



**Figure 2: Map of Amassoma Community**

Source: Map data@2019 google

### **3.4 Study Variables:**

Dependent variable: Use of traditional birth attendant

Independent variables: Age, level of education, culture, distance of health facility, attitude of health workers.

### **3.5 Study population:**

The target population for the study was women living in Amassoma between 15-49years, who has delivered children in the past five years. These should be women who delivered in the hospital or with a traditional birth attendant.

#### **3.5.1 Inclusion Criteria**

Women in their reproductive age (15-49 years) who must have given birth five years.

### 3.5.2 Exclusion Criteria

Women who have given birth for more than five years before the data collection period. The study also excluded women who are not mentally stable, and also women who have never given birth.

### 3.6 Sample Size Determination

The sample size for this study was determined using the Cochran formula which is;

$$n = \frac{2^2 \times pq}{e^2}$$

According to (NPC, 2006), the total female population in Southern Ijaw Local Government was 70,766 and total population is 155,000 representing both male and female. Hence the sample size is estimated:

When n= sample size, z is = to confidence of 95% (standard value of 1.96), e = margin of error=0.05, p = q = 1-p.

$$n = \frac{2^2 \times pq}{e^2}$$

$$n = \frac{1.96^2 \times 0.4566 (1-0.4566)}{0.05^2} = 382$$

To make up for non-response 19 participants (5% Of 382) would be added. This would come to total of 401 respondents.

### 3.7 Sampling Technique /Procedure

Simple random sampling technique was used to select a representative sample, consisting of 14 compounds out of the 22 compounds in Amassoma. Selecting 14 compounds out of the 22 compounds in Amassoma. A simple random sample is a subset of individual's chosen from a larger set. In order to do the selection effectively and without bias, balloting was done in order to select the 14 compounds. The names of all the 22 compounds was

written in separate sheets of paper folded and put in a hat, and 14 compounds were selected.

### **3.8 Data collection methods and instruments**

Data was collected using a structured questionnaire, seeking consent from the participants. Research assistants were recruited and trained, they were sensitized about the purpose and focus of the research, the handling of unresponsive interviewees during the field work administration and completion of questionnaires. The research assistants administered the questionnaires to willing participants, in Ijaw, the predominant language spoken in Amassoma, and for the non-Ijaw speaking tribes, in Pidgin. Administering the questionnaires took averagely 20 minutes per participant. The questionnaire is made up three domains, they are socio and economic data of participants, maternal health services available for pregnant women and the prevalence of traditional birth attendant.

### **3.9 Data Analysis**

The data was analyzed using Stata version 15, it was entered and cleaned in MS excel and exported to Stata 15 to generate tables.

### **3.10 Ethical consideration**

Ethical consideration was gotten from the Bayelsa State Ministry of Health, through the department of Research planning and Statistics. Ethical approval was also sought from Ghana Health Service. The king of the community and his council of chiefs was informed of the research. The head of primary health care in Southern Ijaw Local Government Area was also put in the known.

The objective and procedure of this study was explained to all participants. Participation was voluntary, and participants was allowed to discontinue at any stage of the study,

privacy and confidentiality of every participant was ensured. Participants was informed of the benefits of the study, which can be used to influence maternal health policies.

The participants were briefed on the research and given an informed consent form to fill if they are willing to participate in the study. No participant was coerced or convinced to participate in the study to avoid conflict of interest. The interview was done one after the other with the pregnant women to ensure privacy and the filled questionnaire will be placed in a bag without the researcher or the research assistants looking at the responses of the participants. Pregnant women, women not in their reproductive age and mentally ill women, was exempted from the study to avoid any potential risks and the participants will be given a small package after participating in the study as a form of appreciation. Participants who wish to withdraw from the study will also be allowed to do so and also take a package for volunteering to be a part of the study. Data will be stored under lock and key and used only for the purpose of the study. The Principal Investigator will solely fund the study.

### **3.11 Data Security**

All study materials were stored in a locked file in the office of the Principal Investigator, on a hard drive and in google drive to ensure safety. Data entry was done and analyzed by the principal investigator. Study materials (questionnaires, informed consent) was well labeled and code numbers given to each participant.

## CHAPTER FOUR

### RESULTS

#### 4.1 Introduction

This chapter presents the findings from the analysis of data collected. Data for this study was collected using questionnaires, guided by the operational definition of variables in chapter three to meet the objectives of the study. The study had 401 participants with a 100% response rate.

#### 4.2 Socio-Demographic and Characteristics

The mean age of respondents was 30.82 (SD = 10.15) years with majority (29.18%) of them being between the age 21-30 years. Almost half (48.38%) of the respondents were married whilst only (5.49%) of the respondents were cohabiting. Respondents with secondary education constituted the majority (40.15%), whilst those with vocational education constituted 16.46% of the sampled population. More than half (75.31%) of the respondents were Christians. Majority of the participants (38.15%) are of the Ijaw ethnic group. Thirty four percent (34.4%) of the respondents were petty traders whilst 26.68% were housewives. More than half of the respondents (55.36%) had more than six individuals living in their household. About 21.69% of the sampled population family income is below ₦20,000. Details of the demographic and socio-economic characteristics of the participants are presented in the table 4.1.

**Table 4. 1: Sociodemographic characteristics of study population (n=401)**

<b>Characteristics of study population</b>	<b>Frequency (%)</b>
<b>Age</b>	
15- 20	91 (22.69)
21- 30	117 (29.18)
31- 40	95 (23.69)
41- 49	98 (24.00)
<b>Marital Status</b>	
Single	124 (30.92)
Married	194 (48.38)
Divorced	31 (7.73)
Widowed	30 (7.48)
Cohabiting	22 (5.49)
<b>Level of education</b>	
Primary	29.68 (29.68)
Secondary	161 (40.15)
Tertiary	66 (16.46)
Vocational	19 (4.7)
No Education	36 (8.98)
<b>Religious Affiliation</b>	
Christianity	302 (75.31)
Islam	42 (10.47)
Traditionalist	57 (14.21)
<b>Ethnic Group</b>	
Ijaw	153 (38.15)
Yoruba	50 (12.47)
Urhobo	62 (15.46)
Igbo	46 (11.47)
Isoko	52 (12.97)
Hausa	35 (8.73)
Others	3 (0.75)
<b>Occupation</b>	
Housewife	107 (26.68)
Civil Servant	51 (12.72)
Farmer	55 (13.72)
Petty Trader	138 (34.41)
<b>Monthly Income (₦)</b>	
less than 20,000	87 (21.69)
20,000 - 30,000	149 (37.15)
31,000 - 41,000	49 (12.46)
More than 41,000	29 (7.23)
<b>Household Size</b>	
2-3	34 (8.48)
4-5	145 (36.16)
6+	222 (55.36)

### 4.3 Sources of maternal health services and barriers to its use

Table 4.2 below shows the places where maternal health services can be accessed by the study population and the reasons given for not accessing facility-based services. Seventy two percent (72.32%) of the respondents on a multiple-choice question, indicated that they could easily access government access health, while 25.19% indicated that they could easily access a private health facility. On barriers to the use of skilled birth attendant 35.66% indicated that poor service will make them not to use the services of a trained and qualified health professional and 31.7% will not use the services of a skilled birth attendant as a result of delivery cost.

**Table 4. 2: Sources of maternal health services and barriers to its use**

<b>Variable</b>	<b>Frequency</b>	<b>Percentages (%)</b>
<b>Source of maternal health service</b>		
Government Facility	290	72.32
Private Facility	101	25.19
Traditional Birth Attendant	247	61.6
<b>Barriers to Use of facility-based Services</b>		
poor service	143	35.66
long waiting	59	14.71
Absence of health workers	107	27.00
long distance from home	29	7.00
cost of delivery	127	31.67

### 4.4 Socio-Demographic Characteristics and use of Traditional Birth Attendants

To determine the socio-demographic characteristics associated with the use of traditional birth attendant, a binary logistic regression was conducted to examine the relationship between the selected socio-demographic factors and the use of TBA. The results are shown in table 4.3a&b. Level of education was significantly associated with the use of traditional birth attendant ( $<0.01$ ), ethnic group ( $<0.01$ ), Occupation ( $<0.01$ ), and family

monthly income (0.04), were also found to be significantly associated with the use of traditional birth attendant. However, no association was found between age, religious affiliation, and household size.

**Table 4. 3: Socio-Demographic Characteristics and use of Traditional Birth Attendants**

Variable	TBA Use		P-value
	Yes	No	
<b>Age</b>			0.97
15-20	70 (76.92)	21 (23.08)	
21-30	93 (79.49)	24 (20.51)	
31-40	75 (78.95)	20 (21.05)	
41-49	76 (77.55)	22 (22.45)	
<b>Marital Status</b>			0.51
Single	101 (81.45)	23 (18.55)	
Married	153 (78.87)	41 (21.13)	
Divorced	24 (77.42)	7 (22.58)	
Widowed	21 (70.00)	9 (30.00)	
Cohabiting	15 (68.18)	7 (31.82)	
<b>Educational Level</b>			<0.01*
Primary	104 (87.39)	15 (12.61)	
Secondary	142 (88.20)	19 (11.80)	
Vocational	27 (40.91)	39 (59.09)	
Tertiary	14 (73.68)	5 (26.32)	
No Education	27 (75.00)	9 (25.00)	
<b>Religious Affiliation</b>			0.76
Christian	238 (78.81)	64 (21.19)	
Islam	31 (73.81)	11 (26.19)	
Traditional	45 (78.95)	12 (21.05)	
<b>Ethnic Group</b>			<0.01*
Ijaw	127 (83.01)	26 (16.99)	
Yoruba	39 (78.00)	11 (22.00)	
Urohobo	54 (87.10)	8 (12.90)	
Igbo	23 (50.00)	23 (50.00)	
Isoko	43 (82.69)	9 (17.31)	
Hausa	25 (71.43)	10 (28.57)	
Others	3 (100.00)	0 (0.00)	

\* denotes significance at  $p < 0.05$

**Table 4.3cont.: Socio-Demographic Characteristics and use of Traditional Birth Attendants**

Variable	TBA Use		P-value
	Yes	No	
<b>Occupation</b>			<0.01*
house wife	94 (87.85)	13 (12.15)	
civil servant	28 (54.90)	23 (45.10)	
Farmers	50 (90.91)	5 (9.09)	
Traders	103 (74.64)	35 (25.36)	
fish mongers	29 (85.29)	5 (14.71)	
Others	10 (62.50)	6 (37.50)	
<b>Family monthly income (₦)</b>			0.04*
less than 20,000	87 (76.99)	26 (23.01)	
20,000- 30,000	149 (83.71)	29 (16.29)	
31,000- 41,000	49 (75.38)	16 (24.62)	
more than 41,000	29 (64.44)	16 (35.56)	
<b>Household Size</b>			0.94
2-3	26 (76.47)	8 (23.53)	
4-5	113 (77.93)	32 (22.07)	
6+	175 (78.83)	47 (21.70)	

\* denotes significance at  $p < 0.05$

#### 4.4 Results of the multiple logistic regression analysis

Table 4.4 below shows result for a multiple logistic regression analysis for all variables that were found to be statistically significant for the bivariate analysis. Women who had their last delivery with a traditional birth attendant had an increased odds of having their next delivery with a TBA 30 times higher, compared to those who had their last delivery in a government health facility ( a OR =50.95, 95% CI =12.30, 211.07. Also comparing women whose family influence their choice of place of delivery have an four times increased odds of using a traditional birth attendant compared to those who can

independently decide their place of delivery without being influenced by their family (aOR =3.12, CI= (1.32,7.38)). Also there was a 76% decreased odds for use of a TBA for women with tertiary education as compared to those with primary education (aOR=0.24, CI= (0.01, 0.07)).

For occupation, women that were in civil service were found to have a 92% decreased odds of using TBA as compared to those that were unemployed (aOR=0.08, CI= (0.02, 4.78)). The odds for using a TBA during delivery, was 9 times higher for women whose family earnings were within ₦20,000- ₦30,000 as compared to those whose earnings were much less than ₦ 20,000

**Table 4.4: Results of multiple logistic regression on factors influencing use of traditional birth attendants**

Variables	Unadjusted		Adjusted		
	OR	(95% CI)	P-value	AOR (95% CI)	P-value
<b>Educational Level</b>					
Primary	Ref			Ref	
Secondary	1.07	(2.71, 7.50)	0.839	1.78 (0.66, 4.80)	0.25
Tertiary	0.99	(0.04, 0.20)	<0.001	0.24 (0.009, 0.070)	0.009
Vocational	0.40	(0.12, 1.28)	0.124	0.87 (0.15, 4.81)	0.877
None	0.43	(0.17, 1.09)	0.077	0.61 (0.15, 2.53)	0.505
<b>Occupation</b>					
Unemployed	Ref			Ref	
Civil servant	0.16	(0.07, 0.37)	<0.001	0.08 (0.02, 4.73)	<0.001
Farmer	1.38	(0.46, 4.10)	0.559	1.01 (0.21, 4.73)	0.982
Trader	0.40	(0.20, 0.81)	0.011	0.24 (0.08, 0.69)	0.008
Fish monger	0.80	(0.26, 2.43)	0.698	0.34 (0.71, 1.67)	0.187
Others	0.23	(0.71, 0.74)	0.014	0.18 (0.33, 1.02)	0.053
<b>Place of last delivery</b>					
Government Health Facility	Ref			Ref	
Traditional birth attendant	30.06	(9.25, 97.71)	<0.001	46.09 (11.79, 180.20)	<0.001
Private health facility	0.27	(0.11, 0.64)	0.003	0.11 (0.03, 0.37)	<0.001
<b>Monthly Income (₦)</b>					
less than 20,000	Ref			Ref	
20,000 - 30,000	1.53	(0.84, 2.77)	0.155	9.33 (3.30, 26.38)	<0.001
31,000 - 41,000	0.91	(0.44, 1.86)	0.808	6.43 (1.92, 21.49)	0.002
More than 41,000	0.54	(0.25, 1.14)	0.11	12.82 (3.47, 47.38)	<0.001
<b>Ethnic Group</b>					
Ijaw	Ref			Ref	
Yoruba	0.72	(0.32, 1.60)		0.32 (0.09, 1.13)	0.077
Urohobo	1.38	(0.58, 3.24)		1.10 (0.32, 3.73)	0.869
Igbo	0.20	(0.10, 0.41)		0.27 (0.08, 0.087)	0.029
Isoko	0.97	(0.42, 2.25)		0.26 (0.07, 0.94)	0.041
Hausa	0.51	(0.21, 1.19)		0.20 (0.53, 0.81)	0.024
Others	1				
<b>Family Influence</b>					
Yes	Ref			Ref	
No	4.51	(2.71, 7.50)	<0.001	3.49 (1.65, 7.38)	0.001

\* denotes significance at p<0.05

## **CHAPTER FIVE**

### **DISCUSSION**

#### **5.1 Introduction**

This chapter gives a summary of the results and discusses findings of the study. The aim of this study was to examine the factors influencing the use of traditional birth Attendant among women in their reproductive age in Amassoma community.

#### **5.2 Prevalence of the use of traditional birth attendant**

Use of traditional birth attendant at last delivery was significant at the bivariate and multivariate level. In rural communities in Nigeria several studies has found that women in rural communities are most likely to use the services of a traditional birth attendant. Exley et al. (2016) found that women living in rural communities are most likely to seek the services of a traditional birth attendant. A study by Innocent Mbachu et al (2014), found that in Southern Nigeria women in rural communities contributes 70% of unskilled delivery, when compared to women in urban areas, who contributes only 30% of unskilled delivery. Solanke & Rahaman (2018) also found out in their study, that there is a significant difference among women who live in rural communities and their counterparts in urban areas as regards place of child birth. Nigeria National Population Commission (2013), in line with other findings also found that women in rural communities more often seek the services of a traditional birth attendant than women in urban areas.

#### **5.3 Maternal Health Care Services Available and Barriers to its use**

One of the specific objective of this study was to characterize the maternal health care services available for pregnant women in Amassoma Community. Findings from this study shows that 290 participants (72.32%) can easily access government owned health

facility, while 247 (61.6%) can easily access traditional birth attendant and a small percentage of the study participants can easily access a private health facility.

Two hundred and forty-seven participants being able to easily access the services of a traditional birth attendant, this can be attributed to the fact that traditional births attendant can be easily accessed in mostly rural communities. Amassoma which is also a rural community, is not exempted in the dilemma of absence of health workers in health facilities, which is a common feature in most rural communities. As a result of this, women seek the services of a traditional birth attendant when they fall into labor. According to Ferdinard et al (2014), the existence of Traditional birth attendants is due to limited availability of professional health care providers in rural areas, leaving TBAs to fill the gap. Turinawe et al (2016), noted that traditional birth attendants are part of the community, socially and culturally accepted and available whenever they are needed.

This study also found that the study population will not use the services of the traditional birth attendants because of cost of delivery, poor service, absence of health workers, and long waiting time.

#### **5.4 Socio-demographic factors influencing the use of traditional birth attendants**

In this study, highest level of education, occupation, family monthly income and family influence was statically significant at bivariate and multivariate analysis. Age was not significant at both levels, however other studies have shown age to be statically significant (Onasoga *et al.*, 2014; Owili *et al.*, 2016; Shimamoto & Gipson, 2017) However in this study age was not found to be a barrier to the use of skilled birth attendants. Owili *et al.*, (2016), in their found age to be an influence as an influence in the use of skilled birth delivery. A Demographic and Health Survey data from 12 sub-Saharan African countries was used, and was restricted to women who gave birth in the last five years before the

study. Onasoga *et al.*, (2014), used a descriptive research design in their study. Study location was Amassoma and age were significant socio-demographic characteristics influencing the non-use of skilled birth delivery. This study was limited to women who had delivered within the last two years, using a purposive sampling to select study participants. Shimamoto & Gipson (2017), also used Demographic and Health Survey data. Their study was to determine the relationship of women's status and empowerment with skilled birth attendant use, in this study age was found to be a factor influencing the use of traditional birth attendants. It is important to note that the reason why age was not significant in this study, could be as a result of the different sampling method and study population. This study used a community based simple random sampling method. The other study which was done in same study population had a smaller sample size and was focused on women who had given birth in the last two years, and they used a health facility-based study. Therefore, data collection method and sample size could be the reason why age was not statically significant as compared to the above-mentioned studies

Educational level was significantly associated with the use of traditional birth attendant. The study showed decreased odds of using a traditional birth attendant among women with tertiary education, as compared to women with primary education. In a study by Owili *et al.*, (2016) found that the level of education a woman has determines the use of health care facilities, the higher the level of education the better a woman is more informed about the disadvantages of seeking the services of a traditional birth attendant during child birth. Shimamoto & Gipson (2017), in their studies found that in Senegal and Tanzania maternal Education is positively related to the use of skilled birth attendant during delivery. In another study conducted in Amassoma community seeking to find out the barriers to the utilization of maternal health care services among women in their

reproductive age, found that level of education is a significant determinant to the utilization of maternal health services in both government and private facilities.

Occupation of the women was significant at both the bivariate and multivariate level, with women that are civil servants having decreased odds in the use of traditional birth attendant as compared to those that are unemployed. These findings are in line with other studies. According to Ganle, Parker Fitzpame & Otupiri (2014) in their studies found that most often people with higher socio-economic status and white-collar jobs have better health care seeking behavior, and therefore the occupation of a woman play a significant role as to where she goes when in labor. Recent study conducted in Sub-Saharan Africa found that, women with a highly placed socio economic status were 68% more likely to deliver in health facilities than their counterparts (Doctor *et al.*, 2018).

This study also looked at health system factors influencing the use of traditional birth attendant. Health sytem factors that have been identified as barriers to the use of skilled birth attendant are poor service and absence of health workers. Over 35% of the study participants affirmed that poor service by health workers will make them not use the services of a traditional birth attendant. Also, about 27% of respondents acknowledged that absence of health workers in the health facility is a barrier to use of skilled delivery during child birth.

Studies have found health system factors as a barrier to the use of skilled delivery. In sub-Saharan Africa poor quality in health service, inadequate health staff, poor attitude of health workers are barriers to the use of skilled delivery (Ganle *et al.*, 2016). Karanja *et al.*, (2018), found that health systems need to be functional, as attitude of health workers which is a determinant of how well they offer their services, has been found to be one of the determinants and barriers why women will not use the services of a skilled birth

attendant. Also in line with other studies (Wilunda *et al.*, 2014), found that ill treatment of pregnant women during delivery is a barrier of maternal health service uptake. Poor quality of relationship between health workers and pregnant women makes them use the services of a traditional birth attendant.

### **5.5 Conceptual Framework and Findings of the study**

The conceptual framework for this study was adapted from Anderson and Newman's theory as a guide to back up the framework. The conceptual framework shows that there is a relationship between socio- demographic characteristics, like age, level of education, occupation and locality (rural & urban) with the use of traditional birth attendant. Also, other factors such as cost of delivery, quality of doctor patient relationship (poor service), long waiting time, and family influence, were all described on the framework as factors influencing the use of traditional birth attendants. Anderson and Newman's health care utilization theory, propounded that the use of health care services is dependent on the individual characteristics and the immediate environment. That individual use of health care services is an interaction of three components, they are; social structure, demographic and predisposing factors. The demographic factors are age, area of residence, gender, occupation, values, ethnicity and knowledge of the people towards health.

This study focused on women; therefore gender was not a factor. Although the framework suggested age as a factor to the use of traditional birth attendants, however age was not statically significant. Family influence was statically significant, this could also be related to the environment as in most rural communities where communal living is still practiced, extended and nuclear family members have an influence on the kind of health services its residents use. Educational level was also not significant, which may mean that knowledge about the benefits of using a skilled birth attendant might not influence their decision on where to go to during child birth. Occupation and income were also statically significant.

From the findings of this study, civil servants have a reduced odds of using a traditional birth attendant as compared to those who are unemployed.

### **5.6 Limitations of the study**

- The study was limited to the use of close ended questionnaires. A mixed method would have most likely given more information, as qualitative and quantitative have inherent strengths, combining both methods can integrate the strengths of both approaches.
- The time frame for this study was a limitation to the study
- Amassoma is a rural community, there for it will be difficult to generalize the findings of this study to that of the urban areas.

## CHAPTER SIX

### CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 Introduction

This chapter presents the summary of the key findings of the study and suggests recommendations for specific institutions, in order to increase skilled birth attendant in Amassoma.

#### 6.2 Conclusion

This study looked at factors influencing the use of traditional birth attendant among women in Amassoma community, Bayelsa State, Nigeria. A high prevalence of the use of traditional birth attendant was reported. Most of the respondents were between the ages of were between age 15-49years. We also discovered that high cost of delivery, poor service are major factors influencing the use of traditional birth attendant.

Other factors such as level of education and occupation of the sampled population, independently affected the use of traditional birth attendant.

#### 6.3 Recommendations

From the findings of this study, recommendations below has been made to improve the patronage of skilled birth delivery.

- Health workers must be trained and equipped to offer services to pregnant women.
- Special incentives should be given to health workers who work in rural communities.
- The Bayelsa State should include maternal health services not only for the civil servants but also other individuals who are resident in Bayelsa State.

- Community awareness campaign should be done, for both men and women on the importance of using a skilled birth attendant during delivery.

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## APPENDICES

### APPENDIX 1 - INFORMATION SHEET

**STUDY TITLE: FACTORS INFLUENCING THE USE OF TRADITIONAL BIRTH ATTENDANT: A STUDY AMONG WOMEN IN AMASSOMA COMMUNITY, BAYELSA STATE, NIGERIA.**

**INTRODUCITON:** I am Ebiede, Timi Marclint, a student at the University of Ghana School of Public Health, studying for a masters in Public Health. I am conducting a research on the topic “Factors influencing the use of Traditional birth Attendant: A study among women in Amassoma, Bayelsa State, Nigeria” in partial fulfillment of the award of a Masters Degree in public health. My contact details are as follows;

Address: P.O.BOX 430, THE WORLD INTERNATIONAL SACRED PEACE MOVEMENT, AMARATA, YENAGOA, BAYELSA STATE, NIGERIA.

Mobile: +2347063811166, +233203620773

E-mail: tmebiede001@st.ug.edu.gh

Location: Amassoma community

**BACKGROUND AND PURPOSE OF RESEARCH:** This research seeks to identify the factors influencing the use of traditional birth attendant, in Amassoma community. This is to help identify some of the reasons why women in Amasoma patronize the TBAs.

**NATURE OF RESEARCH:** This study is to identify factors that influence the use of Traditional Birth Attendant. This study will take place in Amassoma community (401) women in their reproductive age (15-49) will be interviewed.

**PARTICIPANTS INVOLVEMENT:** Participants will be required to fill a short questionnaire, which will not take more than ten (10) minutes of their time. Participants

who cannot read or write will be given the necessary aid where the questions will be interpreted in a local language they understand and their responses written for them. The questionnaire is designed in a friendly form though some of the questions may seem a bit unfriendly. Participants are reassured that their responses will not be used against them and it will be used solely for the purposes of the research.

**BENEFITS:** The study will help put measures in place to combat the issue of low skilled birth and help reduce maternal mortality in Amassoma community, Bayelsa State. This will in turn influence better policies in maternal and child health programs.

**COST:** In this study, no cost will be incurred since the study will be done when the pregnant women come for Antenatal Care.

**COMPENSATION:** Participants who partake in the study will be given a small token after the interview is completed as a form of appreciation.

**CONFIDENTIALITY:** Code numbers will be used for the participants and not their personal names and the data collected will be kept under lock and key and used solely for the purpose of research.

**VOLUNTARY PARTICIPATION/WITHDRAWAL:** Participation is voluntary and participants have the right to decline to participate and also withdraw from the study at any time without penalty and without having to give any reasons.

**OUTCOME AND FEEDBACK:** The data collected will be analyzed and interpreted for the purpose of the research. After which the data collected will be discarded a few months after the study is entirely completed. The results of the study will be published in journals and social media platforms to allow everyone the opportunity to know the finding and to be used as existing literature for future research.

**FUNDING INFORMATION:** The Principal Investigator solely funds this study.

**SHARING OF PARTICIPANTS INFORMATION/DATA:** Participants are reassured that the data collected will not be shared with any individual or organization and will be used solely for research purposes by the Principal Investigator.

**PROVISION OF INFORMATION & CONSENT FOR PARTICIPANTS:** A copy of the Information sheet and consent form will be given to you after it has been signed or thumb-printed to keep.

**For further clarifications or questions, kindly contact the following;**

**Ms. Ebiede, Timi Marclint    Dr.Phyllis Dako-Gyeke    Ms.Hannah Frimpong**

Prin. Investigator                      Supervisor                      GHS-ERC Administrator

0203620773                      UG, Legon                      0243235225

tmebiede001@st.ug.edu.gh    gyekenay@yahoo.com

Hannah.Frimpong@ghsmail.org

## **APPENDIX 2: INFORMED CONSENT**

### **Purpose of the study**

Preference for the use of TBA is associated to the high level of maternal mortality in Nigeria. This study accentuates the factors responsible for the preference of the use of TBA in Bayelsa State. This will also inform government of better strategies and ways in engaging the traditional birth attendants, it will be useful for public office holders while formulating health policies, their approach to maternal and child health programs, and also educate women on the importance of institutional delivery.

### **Confidentiality statement**

The records concerning your participation are only to be used for the purpose of this study. A questionnaire will be administered to elicit relevant information. All information obtained in connection to this survey, will be kept strictly confidential.

### **Voluntary participation**

Your decision to participate and withdraw at any time, from participating in this study is voluntary. You can contact my thesis supervisor, Dr Phyliss Dako-Gyeke (gyekenay@ahoo.com) if you have any question about this study.

### **Discomfort**

Concerning this you will be asked some personal questions.

### **Participant's statement**

I have been informed verbally and in writing, about the study and I understand what is involved and also know who to contact if I need more information. I understand that confidentiality will be maintained and that I am free to withdraw from the study at any time. I agree to participate in this study as a volunteer subject.

.....

.....

Date

signature

**Interviewer’s statement**

I, the undersigned, have define and explained to the research participant in a language he/she understands, the procedures of this study, its aims, benefits and risks associated with his/her participation. I have informed the volunteer about the confidentiality will be preserved, that his/her is free to withdraw from the study at any time. Following my definitions and explanations, the volunteer agrees to participate in this study.

.....

.....

.....

Date

Name of interviewer

Signature

**APPENDIX 3 QUESTIONNAIRE**  
**DATA COLLECTION QUESTIONNAIRE**

I am Ebiede, Timi Marclint, a student from the school of Public Health University of Ghana, Legon. I am conducting a community-based study on factors influencing the use of traditional birth attendant among women in Amassoma. Your participation in this study will help us identify the factors influencing the use of traditional birth attendant. Your participation is completely voluntary, and all information collected in the course of this study is strictly for academic purposes and will remain confidential.

**SECTION A: Socio Demographic and Economic Data**

1. Age (At Last Birthday)

- a. 15 – 20 ( )
- b. 21 – 30 ( )
- c. 31 – 40 ( )
- d. 41 – 49 ( )

2. Marital Status

- a. Single
- b. Married
- c. Divorced
- d. Widowed
- e. Cohabiting
- f. Others (Specify):

3. Highest Level of Education

- a. Primary
- b. Junior Secondary

- c. Tertiary
- d. Vocational
- e. None

4. Religious Affiliation

- a. Christianity
- b. Islam
- c. Traditionalist

5. Ethnic Group

- a. Ijaw
- b. Yoruba
- c. Urhobo
- d. Igbo
- e. Isoko
- f. Hausa
- g. Others (Specify):

6. Employment Status

- a. Employed
- b. Self-Employed
- c. Unemployed

7. Occupation

- a. Housewife
- b. Civil Servant
- c. Farmer
- d. Petty Trader
- e. Fish monger

- f. Others (Specify)
8. What is the size of your Household?
- a. 2-3
  - b. 4-5
  - c. 6+
9. What is your monthly income (if any)?
- a. Less than ₦20, 000 Naira
  - b. ₦20, 000 – ₦30, 000 Naira
  - c. ₦31, 000 – ₦ 41, 000 Naira
  - d. More than ₦41,000

**Prevalence of Traditional Birth Attendants in Amassoma**

10. How many children do you have?
- a. 1
  - b. 2
  - c. 3
  - d. 4
  - e. 5
  - f. 6
  - g. 7 or more
11. Have you ever used the services of a traditional birth attendant?
- a. Yes
  - b. No
12. Where did you have your last delivery?
- a. Government Health Facility
  - b. Traditional Birth Attendant

c. Private Hospital/Clinic

13. Do you know anyone that has used the services of a traditional birth attendant?

a. Yes

b. No

14. What type of services do the traditional birth attendants offer before delivery?

a. Giving Herbs and Traditional Medicine

b. Massage

c. Others (Please specify)

15. What type of services do the traditional birth attendants offer during delivery?

a. Delivery (Midwife services)

b. Surgery

c. Injection

d. Massage

e. Others (specify)

16. Does your culture or family encourage you to use traditional birth attendants during delivery?

a. Yes

b. No

17. In your opinion what is the best kind of health service a pregnant woman should seek for child delivery?

a. Traditional Birth Attendant

b. Skilled Birth Attendant (Hospital)

Maternal Healthcare services available for pregnant women

18. What type of health facility is easily available for pregnant women in your community?

- a. Government Clinic (Primary Health Centre)
- b. Private Clinic
- c. Traditional Birth Attendant

19. What will make you not to use government clinic/primary healthcare centre/hospital when you want to deliver?

- a. Poor service
- b. Long wait
- c. Absence of Doctors/Healthworkers
- d. Long distance from your home
- e. Cost of delivery is expensive

20. What will make you go to traditional birth attendant for delivery?

- a. Cultural Reasons
- b. Lack of Healthcare facilities
- c. Distance to healthcare facilities
- d. Lack of trust for Trained Healthcare providers
- e. High cost of services at government hospitals and private clinics

## APPENDIX 4: ETHICAL CLEARANCE

### GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

*In case of reply the  
number and date of this  
Letter should be quoted.*



Research & Development Division  
Ghana Health Service  
P. O. Box MB 190  
Accra  
Tel: +233-302-681109  
Fax + 233-302-685424  
Email: ghserc@gmail.com  
10<sup>th</sup> May, 2019

MyRef: GHS/RDD/ERC/Admin/App 19/180  
Your Ref. No.

Dorothy Tawiah  
University of Ghana  
School Of Public Health

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	<b>GHS-ERC 058/03/19</b>
Project Title	Assessment of Patient Satisfaction with an E-Folder and Non E-folder Systems in two District Hospitals in the Eastern Region of Ghana
Approval Date	10 <sup>th</sup> May, 2019
Expiry Date	9 <sup>th</sup> May, 2020
GHS-ERC Decision	<b>Approved</b>

#### **This approval requires the following from the Principal Investigator**

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....

DR. CYNTHIA BANNERMAN  
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra



## **BAYELSA STATE GOVERNMENT MINISTRY OF HEALTH**

Fax: 089-490257  
Telephone: 089-490257, 49035

30<sup>th</sup> April, 2019

### **BAYELSA STATE HEALTH RESEARCH ETHICS COMMITTEE (BSHREC)**

#### **"NOTICE OF FULL APPROVAL"**

Re: FACTORS INFLUENCING THE USE OF TRADITIONAL BIRTH ATTENDANT: A STUDY AMONG WOMEN IN AMASSOMA COMMUNITY, BAYELSA STATE, NIGERIA

To: Ebiede Timi Marclint  
School of Public Health  
University of Ghana, Legon

Date of receipt of valid application: 25<sup>th</sup> March, 2019  
Date of final determination of research for approval: 30<sup>th</sup> April, 2019  
Approval number: BSHREC/Vol. 4/19/120

The Bayelsa State Health Research Ethics Committee(BSHREC) has considered your application and the attached research proposal document, and a Full Ethical Approval is hereby granted with request to established bio-medical research ethics standard and guidelines. You can now conduct your research on; **"Factors influencing the use of traditional birth attendant: a study among women in Amassoma community, Bayelsa State, Nigeria"**. The effective date of approval is today, 30<sup>th</sup> April, 2019 and expires in 12 months from this date. You are expected to inform the BSHREC of inevitable delay in starting and/or completing the research project within the timeframe assigned, in order that it may be accommodated. Note also that no participant accrual or activity relating to this research may be conducted outside of the approved date. All informed consent forms used in this study must be within the BSHREC approved duration of the study.

However, in case of Multi-Year Research, effort must be made to submit your annual report to the BSHREC early to obtain renewal of your approval to avoid disruption.

The Bayelsa State Health Research Ethics Committee(BSHREC) wishes to request that you comply with all institutional guidelines, rules, regulations and the tenets of the code of conduct of research ethics. **You are further requested to submit a copy of the final report of your research whenever it is ready to the BSHREC.** No changes are permitted in this research without prior approval by the BSHREC. The BSHREC reserves the right to conduct compliance visits to your research site without prior notification.

Congratulations.

Please accept my best wishes,

**Alaba Ategbanyo**  
Assistant Director, Research  
Secretary, BSHREC