PRECURSOR TO PATRONAGE OF TRADITIONAL MATERNITY HEALTHCARE SERVICES IN SOUTHWESTERN NIGERIA

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Abstract. Maternal mortality remains a critical global health challenge, with developing nations, particularly Nigeria, experiencing disproportionately high rates. This study investigates perceived level of maternal death as a precursor to patronage of traditional maternity healthcare services (TMHCs) and their associated maternal mortality risks in Southwestern Nigeria. Using a descriptive design, the research surveyed 1200 pregnant women and nursing mothers across the study area through a multi-stage sampling procedure. A self-designed validated questionnaire was used for this study. Descriptive carried out using ANOVA and Linear Regression Analysis. The study revealed that educational status and income not primary determinants of TMHC patronage. Also, the study identified key factors driving traditional birth centre (TBC) utilization including perceived self-delivery capabilities, passionate care, spiritual beliefs, service accessibility, and quality of care. While traditional birth attendants' (TBAs) refusal to refer patients to modern healthcare facilities was perceived as a low maternal mortality risk, delays in seeking healthcare and mobilizing funds emerged as significant concerns. The study showed some significant variations in TMHC patronage factors across the selected states result shows that there was a significant variation (0.00) in the factors influencing the patronage of traditional maternal health centres across the selected states. $F_{(2872)}=6.932$, $P<0.05$. Regression analysis indicated composite reasons for patronising traditional maternal health centres which were potent predictors of perceived level of maternal death ($\beta=.252$, $t=7.699$, $p<0.05$). This showed that an increase in composite reasons for patronising traditional maternal health centres increased perceived level of maternal death by 25.2%. Therefore, there should be policy, review of TBA training programmes, and increased collaboration between healthcare facilities be done to encourage community support for TBA practices towards ensuring healthy lives for childbearing women.
Keywords: *maternal mortality, traditional maternal healthcare patronage, Southwestern Nigeria, pregnant women*

Introduction

Women's reproductive years begin at puberty and end with menopause. Several women encounter significant life experiences during this time, such as sexual intimacy and motherhood. Since the advent of modern medicine, there has been much concern about the issue of enhancing maternal healthcare (MHC) in attempt to lessen mortality associated with pregnancy and the birth process. However, little progress has been made to date, highlighting the importance of including maternal mortality reduction in the Sustainable Development Goals (SDGs). The rise in maternal mortality in recent times has put the socio-economic advancement of affected nations at risk. Nigeria's maternal health results are grim, according to recent statistics from a World Health Organization (WHO) factsheet published in March 2023. Nigeria had a maternal mortality rate of 917 deaths for every 100,000 live births in 2017. This rate increased by around 14% in just

three years, to 1047 deaths for every 100,000 live births in 2020. These findings point to a serious and concerning discrepancy between Nigeria's maternal health outcomes and the ambitious SDG targets. Nigeria's maternal mortality rate is around ten times higher than what the SDGs aim to achieve. Nigeria's healthcare system faces significant challenges, and comprehensive maternal health measures are urgently needed, as evidenced by the stark difference between the country's reality and the global goal (Alobo et al., 2021).

Nigeria's maternal mortality rate (MMR) was to be decreased with the introduction of the safe motherhood initiative policy. This policy was implemented in order to address Nigeria's rising MMR rate. Unfortunately, the country's weak health system, a lack of consistent and sustained political will to address the system's numerous issues, an inappropriate use of the available financial and human resources, and poor monitoring and evaluation have all contributed to the programmes' lack of success towards achieving the objectives of the programme in the country. As a result, Nigerian women continue to die during childbirth, mostly as a result of avoidable causes. Even though the safe motherhood project was successful in providing excellent and reasonably priced treatments to address the growing demand for maternal health services, some women still choose to give birth in traditional maternal healthcare/faith homes facilities. These findings point to a serious and concerning discrepancy between Nigeria's maternal health outcomes and the ambitious SDG targets. Nigeria's maternal mortality rate is around ten times higher than what the SDGs aim to achieve. The stark discrepancy between the global goal and the actual situation in Nigeria underscores both the pressing need for comprehensive maternal health measures and significant challenges in the country's healthcare system (Ajegbile, 2023).

Research conducted in the nation has revealed a number of obstacles, including subpar care, accessibility bottlenecks caused by distance, transportation costs, affordability of direct and indirect medical costs, rude medical staff, and lengthy wait times (Adewuyi et al., 2018; Yaya et al., 2018). These women's choice of traditional birth attendant (TBA) centers was largely determined by a number of factors, including the low cost of TBA services, the compassionate nature of TBAs, their desire for privacy, the involvement of their spouses in decision-making, early marriage and childbearing, gender inequality, and poverty, the involvement of family in decision making, their religious and cultural beliefs, the unsavory behavior of healthcare professionals, and a positive prior experience (Nasir et al., 2022; Ariyo et al., 2017). The socio demographic makeup of the population being studied may be blame for this. Given their low socioeconomic and educational backgrounds, the majority of respondents are inclined to seek and support inexpensive birthing services. Other sociocultural factors include low educational attainment and gender interactions, including polygamous marriages and guardianship between spouses (Piane, 2019). Inadequate healthcare and a shortage of medical professionals are also major contributors to high fatality rates, particularly in rural regions where women are more likely to be exposed to dangerous delivery practices (Ojima et al., 2021; Maduka and Ogu, 2020; Amutah-Onukagha et al., 2017).

In addition, studies have shown that positive recommendations of TBA from previous users, fear of caesarian section, spiritual protection, socioeconomic and religious factors, knowledge of health facilities, the tactful and considerate nature of TBAs, the husband's power to authorize their use, and the affordability and accessibility of TBAs (Oluwole et al., 2024; Amutah-Onukagha et al., 2017). This was in line with

Ogbo et al. (2020) analysis of maternal health policies from 1999 to 2018, which found that the employment of TBAs during deliveries remained relatively constant between 1999 and 2018. In Nigeria, lower odds of utilizing a trained birth attendant were associated with lower levels of education, cultural values, religion, and women's autonomy (Agboyo et al., 2024; Opara et al., 2024). The WHO quickly came to the conclusion that TBA retraining programmes did not reduce maternal mortality in developing countries. It became evident that TBA retraining has been faced with a lot challenges affecting the progress (Harrison, 2011). The Nigerian Federal Ministry of Health consequently revised their TBA retraining plan and changed its focus to emphasize the usage of SBAs more widely throughout the country. This came about as a result of a rediscovered understanding that the use of TBAs is due less to cultural preference and more to women's lack of access to trained medical professionals and research-based maternity and child health services. the availability, acceptability, accessibility, and quality of care-all essential elements of the right to health-as barriers to using medical facilities (Homer et al., 2019).

According to UN estimates, most Nigerian women lack access to quality maternal health care because of the country's high rate of maternal mortality. Modern maternal health care must be accessible to women in order for them to have optimal maternal health. Despite governmental programmes aiming at improving mother and child health in Nigeria, data show that maternal mortality remain high. If women had access to or accessed maternal well-being services during pregnancy, childbirth, and the first month following delivery, the majority of maternal deaths may have been avoided or decreased. The Federal Ministry of Health (FMOH) and UNICEF found that because of prevailing cultural norms, women in Nigeria were dependent on the head of the household to make decisions about their access to health care service. Because of this, many women put off getting maternal health care during their pregnancies, which raises the nation's risk of maternal mortality. Owoseye (2017) affirmed that cultural influences have a detrimental impact on maternal mortality in Africa. He conclude that women in Africa are susceptible to a number of cultural barriers that not only restrict their access to medical facilities but also make them put off seeking care. The movement of women was entrusted to their male counterparts. Due to limited and delayed access to maternal health care services, the region has high rates of maternal death.

In Nigeria, It is unclear the extent to which women perceived usage of TMHCs and in relation to the high maternal mortality which may influences maternal health-seeking behaviours and decisions around place of childbirth. However, there are several maternal health research in Nigeria, to our knowledge, there is no known research that focuses on perceived level of maternal death associated with the use of TMHCs in the study area .The findings are thought to be helpful in developing suitable interventions and policies to lower the nation's maternal mortality rate in order to achieve SDG Goal 3, which calls for the global maternal mortality rate to drop to less than 70 per 100,000 live births by 2030.

Materials and Methods

Study area

The study included all expecting women and nursing mothers who went to traditional maternity healthcare facilities in southwest Nigeria. The study recruited pregnant

women and nursing mothers who had given birth within the last five (5) years at certain traditional maternal health centers in Southwestern Nigeria during the study period.

Study design and sample population

A descriptive design approach was used in this investigation. The study had a sample size of 1020 expectant and nursing mothers. Initially, three states from Nigeria's southwest geopolitical zone were chosen using a purposive approach. According to Onyeji (2020) as well as Meh et al. (2019), these states have the highest rates of maternal mortality in Southwest Nigeria. The sampling process was multi-stage. Using a simple random sampling, the Local Government Areas (LGAs) in each state are chosen in the first step. There are 18 LGAs in Ondo State, 33 in Osun State, and 30 in Oyo State. Twenty-five percent (25%) of the LGAs were selected from each State using a simple random sampling technique. In total, twenty-two (22) LGAs were chosen for the research. The second step involved selecting traditional maternal health centers from the chosen LGAs using simple random sampling. Ten percent of all traditional maternal health centers in each of the chosen LGAs were sampled, for a total of fifty-two traditional maternal health centers. Using a systematic sampling technique, women are chosen from the traditional maternity health centers that have been chosen for the third stage. At the time of the survey, respondents were selected from the center at Nth (1st, 2nd, 3rd, etc.) intervals.

Data collection instrument and data analysis

A self-designed validated questionnaire was used for data collection. The content validity index was calculated by tallying the results of the experts based on the degree to which the experts agreed on the relevance and clarity of the items. The reliability of the instrument was assessed with the test-retest method which was conducted on fifty (30) respondents based on convenient sampling in Ekiti State. It was re-administered to the same group of participants after a 4-week break (only 18 were obtainable). The scores obtained at both time periods were analysed with Pearson Moment Correlational Analysis (PPMC), the reliability test score of r=0.78 was obtained, this ascertain that the instrument was deemed reliable for the study. A total of 1020 copies of questionnaire were administered to the participants to fill out where appropriate. In the course of data collation, 145 questionnaires were discarded because the data were mutilated, resulting into 875 questionnaires used in the analysis. Data were entered and analysed using SPSS Version 20. Descriptive statistics, such as measures of frequencies were used to analyse factors influencing and causes and perceived level of maternal death related with patronage of traditional maternal health care services in the study area. Inferential statistics of percentages, Cross-Tabulation, frequency distribution ANOVA, Correlation and Linear Regression Analysis were employed in describing the characteristics of the study sample.

Results and Discussion

Table 1 presents factors influencing patronage of traditional birth centres in the study area. The table showed that a large number of the respondents disagreed that people without education like them are meant to patronise traditional health care services (25.9%), women with little education like them are meant to patronise traditional health

care services (25.5%) and Delay in making medical decisions (27.5%). This implies that being educated do not influence their choice of patronizing TBCs. The table also shows that the majority of respondents agreed that the following factors influence the study area's traditional birth center patronage: incompetence of the birth attendant (30.5%), delay in seeking health care (25.4%), family refusal to be referred to a modern health care facility (27.3%), lack of personnel (28%), inadequate personnel (28.6%), and ignorance of the patient's underlying health conditions (26.2%). More so, the results showed that there are a number of factors that influence the patronage of traditional birth centers in the study area. These include: Lack of adequate funds (31.4%), delay in mobilizing funds (28.8%), initial decline in undergoing the right procedure (25.9%), patient refusal to be referred to a modern health care facility (30.1%), and lack of facilities and equipment (27.5%). The majority of respondents somewhat agreed that as young women, they can easily deliver their baby (29.5%), even at home, without even considering attending traditional health care (31.7%). This suggests that poor income and low educational attainment were not the main drivers of TMHC patronage.

Table 1. *Factors influencing patronage of traditional birth centres in the study area (N=875).*

Variable	SD	D	SlA	A	StA
I am a young woman and can easily delivery my baby.	117	233	258	208	59
	13.4%	26.6%	29.5%	23.8%	6.7%
Young woman could deliver by themselves even at home not to talk of attending traditional health care.	107	224	277	191	76
	12.2%	25.6%	31.7%	21.8%	8.7%
My income is too low to afford modern health care services.	152	214	231	202	76
	17.4%	24.5%	26.4%	23.1%	8.7%
Even with high income, I will still attend traditional birth centres.	114	163	247	244	107
	13.0%	18.6%	28.2%	27.9%	12.2%
People with low profile occupation like me attend traditional birth centres and I have to.	132	196	179	266	102
	15.1%	22.4%	20.5%	30.4%	11.7%
People without education like me are meant to patronise traditional health care services.	164	227	148	220	116
	18.7%	25.9%	16.9%	25.1%	13.3%
People with little education like me are meant to patronise traditional health care services.	159	223	168	222	103
	18.2%	25.5%	19.2%	25.4%	11.8%
Patient's delay in seeking health service.	127	212	208	222	106
	14.5%	24.2%	23.8%	25.4%	12.1%
Lack of adequate funds.	92	213	275	182	113
	10.5%	24.3%	31.4%	20.8%	12.9%
Delay in mobilising funds.	79	203	252	204	137
	9.0%	23.2%	28.8%	23.3%	15.7%
Initial decline in undergoing the right procedure.	87	222	227	220	119
	9.9%	25.4%	25.9%	25.1%	13.6%
Patient's refusal to be referred to modern health care facility.	99	181	263	224	108
	11.3%	20.7%	30.1%	25.6%	12.3%
Family's refusal to be referred to modern health care facility.	121	194	230	240	90
	13.8%	22.2%	26.3%	27.4%	10.3%
Unavailability of personnel.	79	222	214	245	115
	9.0%	25.4%	24.5%	28.0%	13.1%
Inadequate personnel.	94	229	183	250	119
	10.7%	26.2%	20.9%	28.6%	13.6%
Incompetence of birth attendance.	105	222	159	267	122
	12.0%	25.4%	18.2%	30.5%	13.9%
Unawareness of patient's underlying health conditions.	108	214	216	229	108
	12.3%	24.5%	24.7%	26.2%	12.3%
Delay in making medical decisions.	100	241	228	198	108
	11.4%	27.5%	26.1%	22.6%	12.3%
Delay in initiating medical treatment.	120	210	215	244	86
	13.7%	24.0%	24.6%	27.9%	9.8%
Lack of facilities and equipment.	109	192	241	225	108
	12.5%	21.9%	27.5%	25.7%	12.3%
Lack of drugs.	122	205	213	229	106
	13.9%	23.4%	24.3%	26.2%	12.1%
Traditional attendant's refusal to refer patient to modern health care facility.	185	191	143	216	140
	21.1%	21.8%	16.3%	24.7%	16.0%

Note: SD=Strongly Disagree; D=Disagree; SlA=Slightly Agree; A=Agree; StA=Strongly Agree.

The Causes and Perceived Level of Maternal Mortality Associated with Traditional Birth Center Patronage in the Study Area were displayed in *Table 2*. According to the table, the majority of respondents believe that maternal mortality in TMHCs has been caused by traditional attendants' extremely low (28.6%) resistance to refer patients to modern healthcare facilities, while the delay in raising cash is moderate (24.6%). In addition, the majority of respondents believe that the following factors are unlikely to have contributed to maternal mortality in TMHCs: delay in seeking medical attention (25.1%), lack of adequate funds (24%), initial decline in undergoing the appropriate procedure (25.8%), patient's refusal to be referred to a modern health care facility (24.9%), family's refusal to be referred to a modern health care facility (25%), lack of personnel (29%), inadequate personnel (33%), incompetence of the birth attendant (37.8%), delay in making medical decisions (28.5%), delay in starting medical treatment (29.8%), lack of facilities and equipment (26.9%), and lack of medications (26.7%).

Table 2. *Causes and perceived level of maternal mortality associated with patronage of traditional birth centres in the study area (N=875).*

Variable	VL	L	M	H	VH
Patient's delay in seeking health service.	220	190	168	148	149
	25.1%	21.7%	19.2%	16.9%	17.0%
Lack of adequate funds.	153	210	185	179	148
	17.5%	24.0%	21.1%	20.5%	16.9%
Delay in mobilising funds.	129	192	215	189	150
	14.7%	21.9%	24.6%	21.6%	17.1%
Initial decline in undergoing the right procedure.	134	226	196	177	142
	15.3%	25.8%	22.4%	20.2%	16.2%
Patient's refusal to be referred to modern health care facility.	152	218	205	173	127
	17.4%	24.9%	23.4%	19.8%	14.5%
Family's refusal to be referred to modern health care facility.	161	219	199	161	135
	18.4%	25.0%	22.7%	18.4%	15.4%
Unavailability of personnel.	157	254	187	138	139
	17.9%	29.0%	21.4%	15.8%	15.9%
Inadequate personnel	147	291	183	125	129
	16.8%	33.3%	20.9%	14.3%	14.7%
Incompetence of birth attendant.	164	278	172	128	133
	18.7%	31.8%	19.7%	14.6%	15.2%
Unawareness of patient's underlying health conditions.	147	250	205	127	146
	16.8%	28.6%	23.4%	14.5%	16.7%
Delay in making medical decisions.	155	249	210	129	132
	17.7%	28.5%	24.0%	14.7%	15.1%
Delay in initiating medical treatment.	138	261	189	130	157
	15.8%	29.8%	21.6%	14.9%	17.9%
Lack of facilities and equipment.	153	235	197	142	148
	17.5%	26.9%	22.5%	16.2%	16.9%
Lack of drugs.	144	234	197	137	163
	16.5%	26.7%	22.5%	15.7%	18.6%
Traditional attendant's refusal to refer patient to modern health care facility.	250	219	162	122	122
	28.6%	25.0%	18.5%	13.9%	13.9%

Note: VL=Very Low; L=Low; M=Moderate; H=High; VH=Very High.

Hypothesis 1: There is no significant variation in the factors influencing the patronage of traditional maternal health centres across the selected states.

The ANOVA result shows that there was a significant variation (0.00) in the factors influencing the patronage of traditional maternal health centres across the selected states. $F_{(2872)}=6.932$, $P<0.05$. So it is appropriate to proceed to a posthoc (a posteriori)

test (*Table 3*). *Table 4* showed the Bonferroni and Tamhane Post hoc analysis identify that mean value of factors influencing the patronage of traditional maternal health centres across the selected states was significantly different between Ondo, Oyo and Osun. Factors influencing the patronage of traditional maternal health centres tend to be significantly higher among Ondo residents and Osun residents (-.14738, p<0.05) and not significant among Oyo residents (.07504, p<0.05). Finally, mean value of factors influencing the patronage of traditional maternal health centres between osun and Oyo (.22242, p<0.05) was significantly different and higher than Ondo. These results show that the factors influencing the patronage of traditional maternal health centres across the selected states is higher in Oyo. These result also reject the null hypothesis.

Table 3. *The factors influencing the patronage of traditional maternal health centres across the selected states.*

Category		Sum of squares	Df	Mean square	F	Sig.
Composite_Factors influencing patronage	Between groups	7.373	2	3.687	6.932	0.001
	Within groups	463.780	872	.532		
	Total	471.154	874			

Table 4. *The Post Hoc test of the variations in the reasons for patronising traditional maternal health centres across the selected states.*

Category		I	J	MD-IJ	SE	S	CI	
							LB	UB
Composite_Factors influencing patronage	Bonferroni	Ondo	Osun	-.14738*	.06069	.046	-.2929	-.0018
			Oyo	.07504	.05990	.632	-.0686	.2187
		Osun	Ondo	.14738*	.06069	.046	.0018	.2929
			Oyo	.22242*	.06064	.001	.0770	.3679
		Oyo	Ondo	-.07504	.05990	.632	-.2187	.0686
			Osun	-.22242*	.06064	.001	-.3679	-.0770
	Tamhane	Ondo	Osun	-.14738	.06264	.056	-.2974	.0026
			Oyo	.07504	.05762	.475	-.0629	.2130
		Osun	Ondo	.14738	.06264	.056	-.0026	.2974
			Oyo	.22242*	.06132	.001	.0756	.3693
		Oyo	Ondo	-.07504	.05762	.475	-.2130	.0629
			Osun	-.22242*	.06132	.001	-.3693	-.0756

Note: I=(I) state of origin; J=(J) state of origin; MD-IJ=Mean Difference (I-J); SE=Standard Error; S=Significant; CI=95% Confidence Interval; LB=Lower Bound; UB=Upper Bound; *=the mean difference is significance at the 0.05 level.

Hypothesis 2: There is no significant relationship between the reasons for patronising traditional maternal health centres and the perceived level of maternal death.

Table 5 reveals significant joint contribution of the independent variables (reasons for patronising TMHCS) to the prediction of perceived level of maternal death. The result yielded a coefficient of multiple regressions R=.252 and multiple R-square=0.064. This suggests that all the reasons for patronising traditional maternal health centres combined accounted for 6.3% (Adj.R^2=.063) variance in the prediction of perceived level of maternal death. The other factors accounting for the remaining variance are beyond the scope of this study. The results of the ANOVA indicate that the reasons for using TMHCs had a significant impact on the prediction of the perceived level of maternal death ($F_{(1,873)}$=56.188, P<0.05). *Table 6* reveals that composite reasons for patronising traditional maternal health centres were potent predictors of perceived level of maternal death (β=.252, t=7.699, p<0.05). This shows that increase in

composite reasons for patronising traditional maternal health centres will increase perceived level of maternal death by 25.2%.

Table 5. *Regression analysis between the reasons for patronising traditional maternal health centres and the perceived level of maternal death.*

Model	Sum of square	Df	Mean square	F	Sig.
Regression	56.188	1	56.188	59.277	.000b
Residual	827.505	873	.948		
Total	883.693	874			
R=.252ᵃ					
R square=.064					
Adjusted R-square=.063					
Standard error of estimate=.97359					

Table 6. *Regression of the relationship between the reasons for patronising traditional maternal health centres and the perceived level of maternal death.*

Model	Unstandardized coefficients		Standardized coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	1.843	.136		13.588	.000
Composite_Reasons for patronage	.341	.044	.252	7.699	.000

The study investigated reasons and perceived level of maternal death associated with the use of TMHCs in the study area. On factors influencing the patronage of traditional maternal health care services. The study revealed that the level of education of the respondents is not a determining factor as to why they patronize TMHCS as there is no calibre of people who are segregated from the others before they are attended to. This is in contrast with the findings of Ogbo et al. (2020), who found that during Nigeria's democratic era, the employment of TBAs during births remained relatively constant between 1999 and 2018. In Nigeria, a lower likelihood of employing a trained birth attendant is associated with lower educational attainment. The current economic situation, ethnicity, and familial influence could all contribute to this discrepancy. On causes and perceived level of maternal mortality associated with patronage of traditional maternal health services in the study area. The major causes of maternal deaths as perceived and reported by the respondents in TMHCs are a delay in mobilising funds and delay in seeking health care, all other reasons were not capable enough to lead to maternal death during pregnancy or childbirth. This was in agreement with the findings of the Federal Ministry of Health [FMOH] and UNFPA (2019) according to the findings the women in Nigeria were reliant on the domestic head for decision-creating related to access to healthcare services due to existing cultural norms. As a result, many females delay seeking maternal health care during their pregnancies, increasing the risk of maternal death in the country. Furthermore, the study's findings concurred with those of Owoseye (2017), who investigated the issue of cultural influences that have a detrimental impact on maternal mortality in Africa and produced some intriguing results. It was discovered that women in Africa were susceptible to a number of cultural barriers that hindered their access to medical services and made them put off seeking care.

Findings of this study showed that there is a significant variation in the factors influencing the patronage of traditional maternal health centres across the selected states. Factors responsible for patronizing TMHCs in Ondo state were they think they are capable of taking delivery by themselves, inadequate personnel and incompetent birth attendants at the modern health care centres. Regardless of respondents' educational status (with or without the education) and level of income (low, middle or

high) does not restrict them from patronizing TMHCs. Furthermore, the result indicates that there was a significant variation in the reasons for patronising traditional maternal health centres across the selected states. The study found a significant relationship between the perceived number of maternal deaths and the reasons for using TMHCs.

Conclusion

According to the study, their decision to use TMHCs is unaffected by their level of education. The ability to give birth on their own, even at home, is another consideration, not to mention going to a typical medical facility. They will still go to traditional birth centers even if they have a lot of money. The primary motivations for using TMHCs were their demonstration of fervent concern, spiritual beliefs, belief in the effectiveness of their services, accessibility, and provision of high-quality, reasonably priced services. The study also showed that, in relation to the causes and perceived amount of maternal death associated with the use of TMHCs, traditional attendants and family members' reluctance to refer patients to contemporary medical facilities was regarded as being extremely low. Women and newborns must have access to high-quality, affordable maternal and newborn services that do not cause financial hardship, regardless of their geographic location. This can only be achieved by the government working with other stakeholders, including community and traditional leaders at all levels. To promote community support for TBA practices, policies, training programmes, and collaboration between TBAs and healthcare facilities should be reviewed. The eventual integration of the formal health system and the resulting legislative framework will govern their practices, reducing mortality rates of mothers and children. This study only addressed TBAs patronage in Southwestern, Nigeria with its precursors, challenges and probable recommendations. However, the Southwestern is a geopolitical zone in Nigeria specifically known to be dominated by Yoruba culture. Therefore, this study might not be generalised for the whole of Nigeria because of its multi-cultural system.

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Conflict of interest

The authors confirm that there is no conflict of interest involve with any parties in this research study.

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