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Understanding the role of traditional birth attendants (TBAs): What opportunities for inclusion into the primary health care system in Nigeria?

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Abstract
Basic Obstetrics Health care services (BOCs) is among the most important health systems components that requires urgent strengthening in order to abort the persistent and disappointing effect of high maternal mortality rate (MMR) in Africa. This is important for the achievement of the SDGs target 3.1. For most of the low and middle income countries (LMICs) in Africa – for instance – the community-based traditional birth attendant (TBAs) hold enormous potential for addressing this menace. Yet these potentials are largely untapped and almost always relegated by orthodox medicine practitioners including those from Africa. Yet the continuous - and perhaps- misleading sole reliance on outfox medicine practices particularly in the area of basic obstetrics cares services has yielded disgraceful result for many LMICs. For Nigeria – for instance – most of the maternal, neonatal and postpartum health indicators for the country are far below from the SDG-3 targets. Worse still, the needed research on the potential role of the TBAs and the possible strategies for integrating them into the mainstream orthodox obstetric health services appears to have remained largely in the black-box even. This study reviews the roles of TBAs in Nigeria and suggests strategies for integrating them into BOCs in Nigeria – using Lagos state as a reference point. The finding shows that home delivery which is an integral part of TBAs delivery hold potential for improvement in maternal and child health. As a result, it recommends that the panacea to high mortality rate is to harness the potentials of the TBAs especially via their strategic training and integration into the formal BOCs in particular and the primary Health Care Services in general.

Keywords: Primary health care system, traditional birth, TBAs

Introduction

In Sub-Saharan Africa and South Asia – which account for about 57% of total child deliveries in the low and middle income countries (LMCs) – up to 65% of births occur outside hospitals and are predominantly delivered by traditional birth attendants, TBAs (Olusanya. Inem. and Abosede. (2011:474/5) [17]. Yet the crucial potential role of TBAs in reducing maternal mortality and the strategies for integrating them into the mainstream primary health care services (PHCs) in general and BOCs in particular appears to have been sidelined and left in the black-box.

Understandably, the apparent dearth of targeted studies on the role of TBAs in reducing the menace of high MMR rate hinges on the hitherto erroneous believe the high MMR results mainly from births supervised by TBAs. However, despite of the emphasis on the role of trained birth attendants such as qualified nurse-midwife, doctors and auxiliary nurses, high mortality rate has persisted – making the achievement of the SDG target 3 elusive (Sibley, Marc and Wilson 2007; Costello, Azad, & Barnett, 2006) [5, 18]. Expectedly, this has resulted in the renewed focus on the role of trained TBAs. In fact, the potential positive effect that the training of TBAs could have in terms of reducing maternal and child mortality has been extensively documented (Amutah-Onukagha, *et al* 2017:131; Olusanya. Inem. and Abosede, 2011; Jokhio, Winter and Cheng, 2005; Sibley *et al*, 2007) [1, 5, 17, 18]. More interestingly, successful case studies of such training and capacity building models integrating trained TBAs into PHC services and basic obstetric cares (BOCs) has now begun to emerge in countries such as Guatemala, El Salvador, and Zimbabwe, among others. It is against this backdrop that this reviews focuses on the role of TBAs and the strategies for integrating them into BOCs in Nigeria.

1. Rationale for the study

Understanding the role of the TBAs in reducing the problem of high MMR and the strategies from integrating them into the BOCs in Lagos state, Nigeria, is important in many ways. First, while there is increasing effort to scale up skilled birth attendants, SBAs (doctors, nurses, midwifes) in line with global strategy, this goal appears to have yielded limited results – particularly in the low and middle income countries (LMICs). In fact, as the MMR (and the number of infant deaths) remains persistently far higher than SDG-3 targets for Nigeria (Figure 1) and as the number of deliveries by TBAs (many of whom operate the traditional maternity/healing homes, TMHHs) remains high, researchers has called for a paradigm shift, namely the integration of TBAs into SBAs (see e.g., Amutah-Onukagha, Rodriguez, Opara, Gardner, Assan, Hammond, Plata, Pierre, Farag 2017; Olusanya. Inem. and Abosede, 2011:475) [1, 17]. This is the so-called 'collaborative partnership' or 'paradigm partnership' described in Hernandez, Oliveira and Shirazian (2017:3) [9], Graham, (1999) [8] and Choguya, (2015) [4], among others. This set of authors argue for context-specific approaches and strategies for each countries to train, equip, and integrate its TBAs into BOCs so as to leapfrog the achievement of SDG-3.1 by addressing the menace of high maternal and child mortality.

Second, there are emerging evidence that the role and potential contribution of TBAs could be inevitable. This is because, although the services provided by the TBAs are widespread in the rural areas where poor access to modern health facilities are relatively scarce, there are growing evident that regardless of their socio-economic status, many mothers in urban areas (with minimal barrier to modern BOCs) still choose the services offered by TBAs either in their home or in the traditional maternity and herbal home

(TMHHs). This scenario – for instance - seems to explain the higher proportion of deliveries assisted by unskilled birth attendant (57%) vis-à-vis those assisted by SBAs (43%) observed in the recent DHS data for Nigeria (Figure 4; Nigeria DHS, 2018; USAID Demographic and Health Survey Database, 2023) [14, 22].

Third, another rationale for studying the role of TBAs and the strategies for its integration into BOCs is the utility and success of past training programs. Recent studies has shown that with formal training, TBAs are able to identify signs of delivery complications much early which would otherwise put both the mother and child at risk. Therefore, with training and proper collaborative partnership, not only will mortality of delivering at traditional maternity and healing homes, TMHHs (operated by some TBAs) decline, the number of hospital birth will increase (via timely referrals by trained TBAs). This would result in an overall decline in maternal and child mortality. Thus, a study of this nature is unique in the sense that it would provide the intellectual foundation (and conceptual guideline) for a health system development model that could help a developing country like Nigeria; achieve the SDG goal 3.

Fourth, eliminating TBAs – if it is possible – would be bad policy that is driven by a bad idea. This is because, such a policy cannot alleviate mortality but would likely increase it. In specifics, such a policy would leave some mothers and children with no access to any form of obstetrics health assistance. As a consequence, rather than design SDG that ignores the role of TBAs, the UNDP should recognize, incorporate, train, equip, foster and integrate TBAs that could address the problem of mortality and bride the rural-urban bias (gap) in maternal and child health care services, especially in a LMIC like Nigeria. It is against this backdrop that understanding the role of TBAs and the strategies for integrating them into the formal obstetric care services could hold immense potential for providing the needed panacea to the lingering menace of high neonatal and infant mortality in Nigeria.

2. Objective

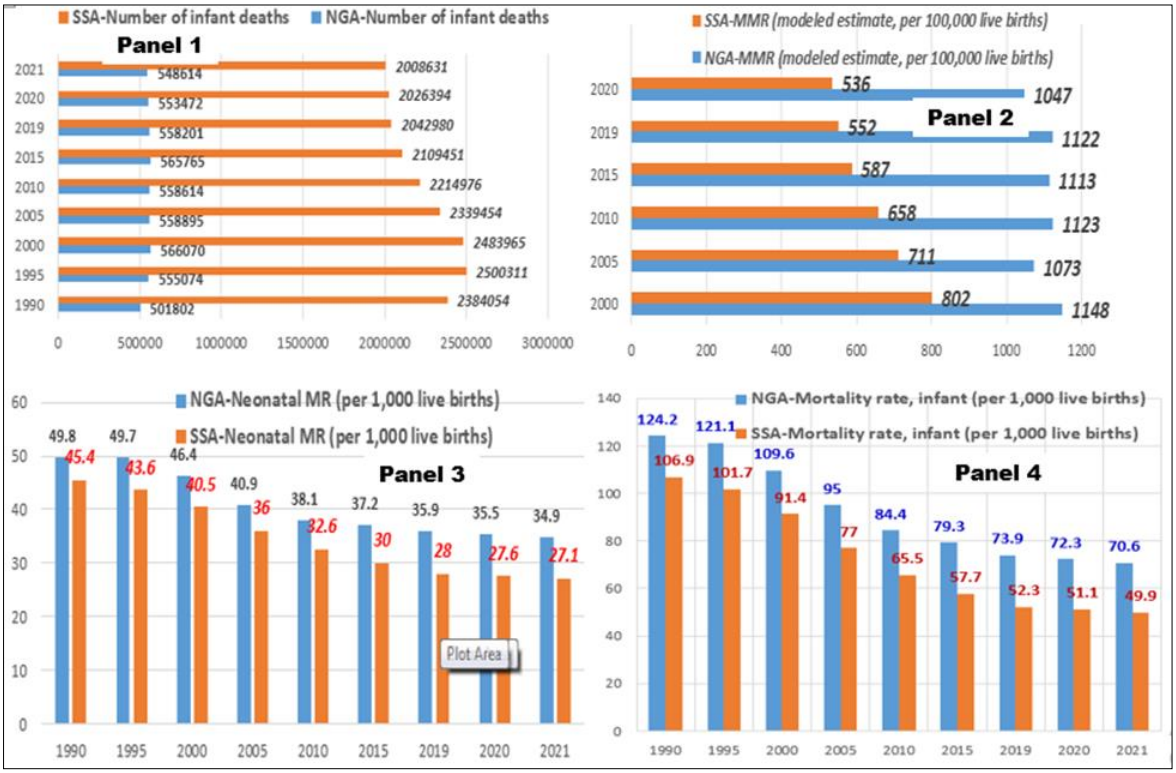
To main objective of this study is to explore the strategies for integrating the Traditional Birth Attendants (TBAs) into the basic Obstetrics care services in order to improve maternal health care outcomes in Nigeria. The specific objectives include, to:

a. examine the current role of TBAs
b. identify opportunities for inclusion of TBAs into Primary Health care services in Nigeria

Global Mainstream Initiatives on ending Mortality and their failing role

Over the last three decades, the task of reducing maternal mortality has been at the front-burner of the global health organization's discourses. This has been done through a number of effort such as the United States-based Safe Motherhood initiative, the then Millennium development goals (MDGs) and now the sustainable development goal (SDGs) which has come to replace and continue the unfinished works of the MDGs (Ogbo, Trinh, Ahmed, Senanayake, Rwabilimbo, Uwaibi, and Agho, 2020; United Nation's SDGs (2023); AbouZahr and Boerma, 2005) [2, 16].

While the SDG–3.1 which aims to reduce global maternal mortality ratio (MMR) to lower than 70 per 100,000 live births (by 2030) is highly desired, statistics for Nigeria as with many other lower and middle income countries (LMICs) in sub-Saharan African (SSA) appears to be a gloomy picture of this SDG aims and target. In 2020, Nigeria posted a MMR of 1047 live births-vis-à-vis the target of 70 – a figure that is more than double the average for sister sub-Saharan African countries which stood at 536 per 100,000 live birth (Figure 1)



Source: World Bank's World Development Indicators, WDI (2023) [23]

Fig 1: Number of Infant Deaths versus MMR in Nigeria (2000-2021)

Note: the bar charts in panels 1 and 3 of Figure 1 compare Nigeria's MMR and number of infant death with the regional averages for countries in Sub-Saharan Africa's (SSA). Conversely, the bar charts in Panels 3 and 4 of Figure 1 compare Nigeria's neonatal mortality rate (neonatal MR) and Nigeria's infant mortality rate (infant MR) with the regional averages for sister countries in Sub-Saharan Africa's (SSA). The sustainable development Goals (SDGs) target for MMR is to reduce maternal mortality to less than 70 per 100,000 live births by 2030.

Notwithstanding Nigeria's relatively lower number of infant death 548, 614 deaths - compared to the average for SSA which is 2,008,631 deaths as at year 2021 (Figure 1) - the country continues to post unacceptable and highly disturbing neonatal and infant mortality rates. Nigeria neonatal mortality rate and infant mortality rate has persistently and unfortunately surpassed the Sub-Saharan Africa's average over the past three decades (1990-2021) as panels 3 and 4 of Fig 1 shows.

In this regard, therefore, bolstering the women's access to basic Obstetrics care services (BOCs) such as ante-natal, child birth. and post-partum cares remains a key strategy to reducing maternal mortality rate and achieving the SDG-3.1 (World Health Statistics, 2023) [24]. However, to fast-rack this, appropriate training (and capacity building) as well as integration and utilization of traditional birth attendant (TBAs) becomes compelling.

The World Health Organization defines the TBA is a person who assists women to deliver their babies and who gain their skill and acquire their experience by understudying older and more experienced TBAs. According to WHO, the TBAs speaks the language common in the community and forms an integral part of the local religious and cultural setting (World Health Statistics 2023) [24]. As widely documented, through appropriate capacity building and training, the unskilled TBAs can gain improved skills and knowledge in modern health care sector for basic or primary health cares services and appropriate and timely referrals regarding complications during and after childbirth (Ogbo, *et al*., 2020; WDI 2023) [16, 23].

Conceptual Model for Strengthening Health System and the Roles of TBAs in BOCs?

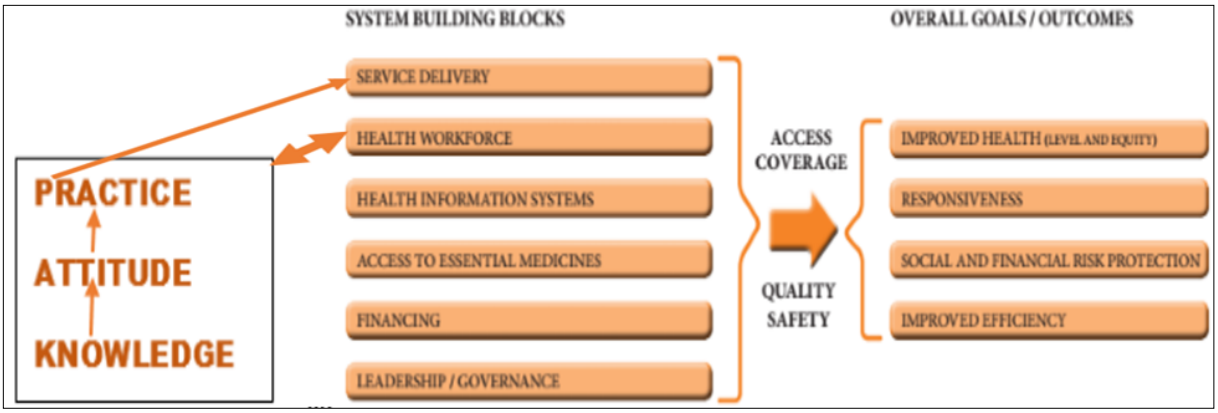
1. Setting: Lagos State and Nigeria

Nigeria is Africa's largest economy, the most populous country in the continent, and the sixth most populous nation in the world, the country has an estimated population of 221 million people as at 2024 with a land mass area of approximately 923,768 km2. (cite) As at 2021 Nigeria has a total fertility rate of 5.24 against a fertility rate of 5.31 in 2020 and 5.38 in 2019 (National Demographic and Health Survey Database, 2023; Nigerian DHS, 2018).

Politically, the country gain independence from British Colonial government in 1960 (became a Republic in 1963) and currently operates a presidential system of government. Nigeria has 774 local government areas, 6 geopolitical zones, 36 states in the federation with Abuja as its National political capital while Lagos is – arguably -its most outstanding financial and economic capital aside Kano and Onitsha.

The choice of Lagos as the reference state for this review is informed by the following facts. First, although Lagos is the smallest state in land mass area among the 36 state of Nigeria, it is the financial capital of Nigeria with the largest population density. Second, Lagos is also the most populous city not only in Nigeria but also in the continent of Africa (Lagos State Bureau of Statistics, 2023) [11]. Lagos state in 2022 has a gross domestic product ($84 billion) that is larger than the GDP of countries like Ghana ($75 billion), and Anglo (($70 billion). Third, despite been overcrowded with disgusting traffic situation, Lagos has the highest literacy rate and Human Development Index (HDI) among all the state in Nigeria as 2022 (Lagos Bureau of Statistics, 2023) [11].

2. Conceptual Model



Source: Adapted from the WHO Health System Framework (and Building Block) (WHO, 2010:7; and the KAP (WHO, 2012; Hernandez, Oliveira, and Shirazian,2017) [9, 25, 26, 27,].

Figure 2: Conceptual Model of TBAs Integration into BOCs: The Augmented KAP-Health System Framework

The WHO's Health System Framework and Building Block (HSFBB) comprise of six main components or building blocks. These include: (a) service delivery; (b) health workforce; (c) health information system; (d) access to essential medicines; (e) financing; (f) and leadership and governance. Two of the building block-leadership/governance and health information system are cross-cutting as they provide the source of policy and regulations for the remaining four health system blocks. Two of the building block-namely; financing and health workforce constitutes the core inputs into the framework. The remaining two building blocks- service delivery and access to medicine show the immediate output of the health

system because the indicates the availability and distribution of health care.

The adaption and novelty that the current study brings into the WHO (2010) [26] health system framework is the infusion or incorporation of the WHO (2012) [27] KAP (knowledge attitude, and practice model into workforce input blocks. It is notable that the KAP model provided the intellectual foundation and conceptual framework behind the success stories of the School of POWHER (Providing Outreach in Women's Health and Educational Resources) in Guatemala. The school of POWHER was initiated following the recognition of the great importance of training comadronas (TBAs) in rural Guatemala to become experts BOCs (Hernandez, Oliveira, and Shirazian,2017) [9].

My rationale for the augmentation is that the output of the KAP model, namely best health practices, constitutes an essential input into the health system model - specifically into its 'Service Delivery' block. In particular, the knowledge (K) which feeds into the KAP model via training and capacity building of TBAs would engender positive change in attitude (A) for trained TBAs namely the dropping of harmful and obnoxious cultural, religious obstetrics health practices. This would lead to better output of the KAP model namely modern and best practices in basic obstetrics care services (P). Thus, best practices (P) – an output of the KAP framework – now forms an essential input (into the Service Delivery block). This would result in better service delivery and improvement in health goals and outcome shown in the right-hand side of the augmented framework (Figure 5).

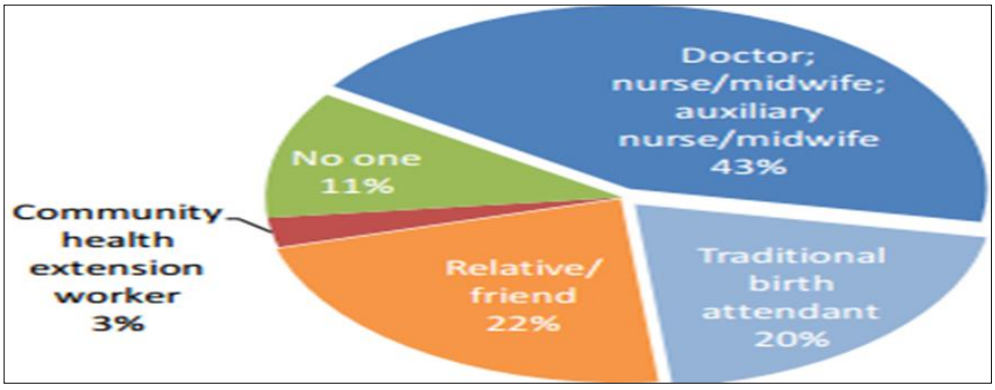
3. What are the Roles of TBAs in BOCs?

What then are the roles of the TBAs vis-à-vis Basic Obstetric Care (BOCs) service – especially as it has to do with the achievement of the SDG-3.1 in curbing the menace of maternal and child mortality rate in Lagos state (in particular) and Nigeria (in general)? First, in general, the TBA has often served as a bridge in primary and basic obstetrics services between the community/socio cultural and government healthcare services provision (Amutah-Onukagha *et al* 2017:132; Agbo. 2013) [1, 3]. Second, and in specifics, TBAs provide a wide array of reproductive health services at the prenatal, childbirth and postpartum stages. Third, the TBAs are also known to offer various kinds of fertility treatment to women who find it difficult to conceive and to those who has difficult in retaining pregnancy. Fourth, TBAs are also usually engaged in the implementation of abortion and in the management of threatened abortion.

In search of explanation for the preponderance of their roles, a number of studies (Uneke, Sombie, Uro-Chukwu, and Johnson 2019; Uneke, Sombie, Keita, Lokossou, Johnson and Ongolo-Zogo. 2017) [20, 21] has identified several reasons for the popularity of the TBAs. The reasons for the preference of the TBAs in both the rural and urban region of many developing countries indeed points especially to gaps in the formal health care and basic obstetric services that the trained TBAs has come to address (Ebuehi and Akintujoye, 2012) [6]. These include greater accessibility by pregnant women, better care and relationship with patients and clients; lower cost; convenience, and respect to cultural and religious believe, among others. Other roles of TBAs include: (i). registering pregnant women in the community, linking them to a skilled birth attendant (SBAs), arranging transportation for a woman in labour, arranging for blood transfusion when needed, and making timely referrals to appropriate health facilities; (ii). Serving as contact persons under maternal and child health intervention programmes such as the birth preparedness and complications readiness programme.

In the rural area of Nigeria in general and Lagos state in particular, reduction in MMR has become compelling in many folds. First, the rural areas play host the most TBAs who operates the traditional Maternity/Herbal Homes (TMHHs) in the areas that is grossly lack skilled health facilities and skilled birth attendants, SBAs (doctors, nurse-midwifes, health officers).

Seconds, reliance and use of unskilled birth attendants such as untrained TBAs, relatives and friends can lead to morbidity or death of mother and child. Third, the problem appears to be compounded because recent statistics from the Nigeria demographic and Health survey (NDHS, 2018; 2021) shows that less than half of the total birth (43%) are assisted by skilled birth attendants (SBAs), namely; doctors, nurse/midwife, and auxiliary nurses. (Figure 2). This suggests a higher a larger proportion or all live birth in Nigeria (57%) are either non assisted al all (11%) or assisted by people who are untrained and ill equipped – including the untrained TBAs (46%).



Source: NDHS (2018:178)

Fig 3: Proportion of Birth Assistance (SBAs versus TBAs)

Note: As Figure 3 shows, the proportion of births assisted by the skilled birth assistants (SBAs), namely; doctors, nurse/midwifes, auxiliary nurse/midwife which account for a total of 43% of all births over the 5-year period (2013-2018?) is lower than half of the total assisted births (89%). As the figure also shows, about 11 percent of birth are

entirely none-assisted while double of this statistics (22%) is assisted by relatives. A paltry 3% is assisted by community health extension workers while the remaining 20% is assisted by TBAs.

The implications of these is few folds. First, more than 33% (11% plus 22%) of all live birth are exposed to situation of little or no assistance (outside the traditional birth attendants). Secondly, it would be erroneous to assume, therefore, that the growing level of neo-natal death in Nigeria can be attributed to the deliveries by the TBAs. Indeed, most TBAs mid-wives are largely experienced although the lack training and access to modern health facilities. Third, there is an obvious gap for integrating the TBAs into the BOCs in Nigeria. As 20% of total birth are assisted by TBAs and 33% are largely unassisted, training TBAs on modern BOCs hold enormous potential for reducing neonatal and infant mortality rate in Nigeria and other LMICs across Africa and beyond.

Therefore, this shows that a major gap currently existing in Nigeria's primary health care sector in general and BOCs in particularly is existence of a avalanche of untrained and unskilled community-based potential health care provider whose potentials could be properly harnessed through training and capacity building to tame the tide of high neonatal and maternal mortality as well as mobility in Nigeria.

To the best of my knowledge there are very limited works attempting to explore the strategies for integrating the TBAs into the basic obstetrics services in Nigeria with the aim of curbing the disturbing menace of high maternal and infant mortality rate in Nigeria. This review therefore sets out to fill this research gap.

4. Health System Limitation and the Rise of TBAs: The Case of Lagos State, Nigeria

For Lagos state, there has been instances where health authority had made a case for traditional approach to obstetrics services given the persistent inability of orthodox approach to achieved desired result of target set by the SDGs especially as regards maternal and child mortality. In 2020, the head of the Lagos State College of Health Technology - in a public statement - argued that about six of every live birth in the state takes place at facilities owned by the TBAs, some of whom own and operates the Traditional maternity/healing home (TMHHs).

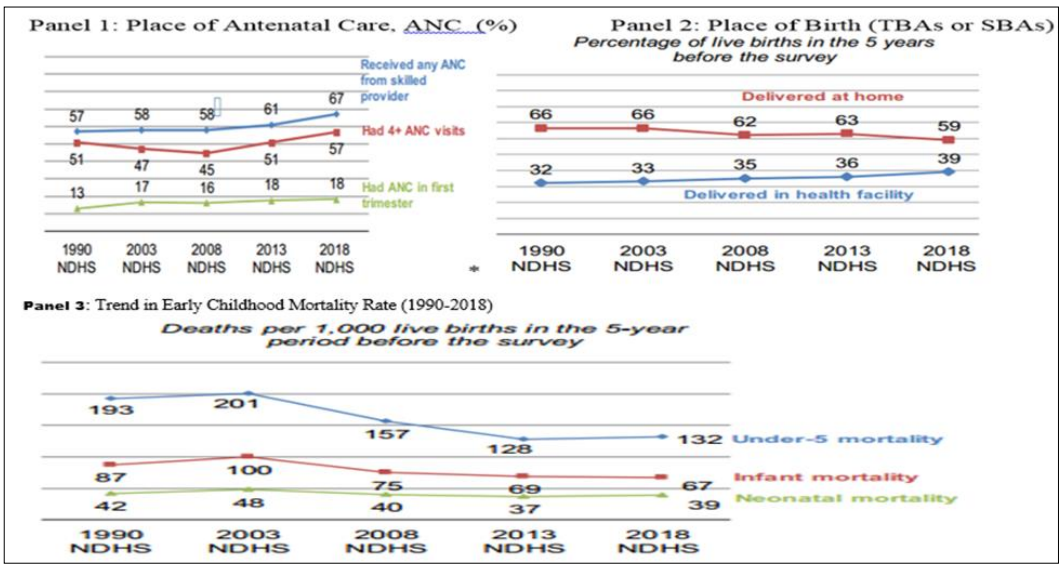
However, as Figure 3 shows, giving birth at home does not imply giving birth at TBAs facilities. Therefore, it becomes erroneous to conclude that TBAs is responsible for the high mortality rate. Indeed as statistics has shown that the TBAs accounts for 20% of all live birth in 2018, sidelining the critical role the TBAs play in reducing maternal and child mortality would imply increase – rather than decrease – in mortality ratio. It is against this backdrop that a review of this nature that aims at evaluation the roles that the TBAs play as well as the strategies for integrating them into the obstetrics cares services becomes apt and compelling.

Health System Problems and Opportunities for incorporating TBAs in Maternal cares services

1. Problems of Disparity in Place of Ante-Natal Care (ANC) versus Place of Birth (Delivery)

The quality of health care services during ante-natal, childbirth (delivery) and the post- partum period are critical for both the survival and well-being of both the mother and newborn. In ensuring continues access to BOCs services, location (place of antenatal care as well as delivery), availability of care, as well as quality of care are important. Analysis of the place of care (ANC) and place of delivery are important for informed or evidence-based strategies for result-oriented integration of TBAs with SBAs (USAID Demographic and Health Survey Database (2023, Nigerian DHS 2018) [15].

Figure 4 shows the trend of place of antenatal care, vis-à-vis place of delivery of pregnant women between 1990 and 2018 in panel 1 and 2 respectively. Panel 1 indicates the trend of percentage of women who received antenatal care from SBAs vis-à-vis those who had at least 4 ANC visit. On the other hand, Figure 6 shows the trend of the percentage of live births delivered at home vis-à-vis the trend of live births delivery at health facilities. Notably, by TBAs is an integral part of delivery at home because the former does not account for the total percent of deliveries at home. In other words, certain components of home deliveries (e.g., those done by relatives) are not necessarily done by TBAs.



Source: Nigerian DHS (2018: 154173, 174, 176). Note: Panels 1 and 2 of Figure 4 shows place of antenatal care (ANC) versus place of birth (TBAs or Health facilities).

Fig 4: Place of antenatal care, vis-à-vis place of delivery (1990 and 2018)

The Neonatal mortality is he probability of dying within the first month of life. Postneonatal mortality: The probability of dying between the first month of life and the first birthday (computed as the difference between infant and neonatal mortality). Infant mortality: The probability of dying between birth and the first birthday. Child mortality: The probability of dying between the first and the fifth birthday. Under-5 mortality: The probability of dying between birth and the fifth birthday.

Overall, although a higher percentage (67%) of women age 15-49 (who gave birth in the 5 years preceding the survey year, 2018) received ante-natal care (ANC) from SBAs or skilled provider during the pregnancy for their most recent birth, only 39% of these who actually delivered their babies in health facilities during the same year (2018). The implication of this is at least two folds. First, over the entire three decades or more, the proportion of home deliveries had surpassed the deliveries in health facilities. Second, despite effort to scale up delivery at health facilities, the large proportion of mother choose home deliveries. Third, home delivery which is an integral part of TBAs delivery hold potential for improvement in maternal and child. Fourth, and therefore, solution to high mortality rate could lie in harnessing the potentially inherent in the TBAs especially via their strategic training and integration

2. Review of Health System Problems and Strategies for Integrating TBAs into BOCs

1. Stark scarcity of health workers and rise of alternative delivery methods: Studies has shown that there are multiplicity of reasons why a larger proportion of home deliveries – particularly in the rural areas. These include: i) the rise of alternative method of delivery following the persistent and stark shortage of skilled birth attendants (obstetrician and gynecologist, pediatrics, and nurse midwifes). The WHO (2021) shows that Nigeria's physician-to-patient ration is four doctors per 10,000 patients. This is a gloomy situation when compared with the WHO standard of 1 doctor per 600 patients. This problem trickles to down to poor quality of primary health care services in general and obstetrics care services in particular. Expectedly, this account for poor health outcome reflected in high maternal mortality and morbidity rate in Nigeria. Thus, the adoption. Given this challenges, a feasible option to deal with the acute scarcity of orthodox medical staff is to trained and integrate the TBAs into BOCs
2. Lack of effective coordination and training of TBAs and other community-based health workers. For Lagos state, there umbrella body of traditional and community based health workers is called the Lagos State Traditional Medicine Board (LSTMB) which include: (a) the TBAs; (b) bone setters (c) Ifa diviners; and (d) faith-based birth attenders and healers. According to LSTMB, there are over 7,000 registered traditional medicine practitioners (Lagos State Government Official website; https://lagosstate.gov.ng/blog/2020/02/26/traditional-birth-attendants-charged-on-safe-delivery/;Maternal Figure).

As the LSTMB Coordinating Director stated, the aim of the umbrella body is to train all traditional medicine practitioners – including TBAs – on modern health care delivery as well as best practices basic maternal health care services. Although, LSTMB is already involved in training TBAs, the problem of poor coordination, lack of qualified instructor, poor funding, among other problem remains rife. In 2019, LSTMB trained over 346 TMP across the state and over 200 people in 2020. The training covers, among others, early detection of signs of potential complications, and each successful trainee is given a referral cards for prompt referrals to general hospital. Overall, data from Lagos state government's official website suggest that LSTMB has trained over 7000 of its members yet many TBAs are not even aware of the existence of LSTMB or its training program in the state. Thus, effective coordination of trained TBAs with the skilled birth attendant presents incredible option for integration of TBAs into BOCs

3. Poor communication and Health information System

In spite the LSTMB's lofty goals training its members and ensuring its integration with the public health infrastructure particularly with obstetrics care services, many TBAs have not received training and many of them are not even aware of the existence of LSTMB or its training program.

4. Lack of an Effective Linkage Framework between TBAs and Public Maternity Care Provider: Although with very limited capacity and poor financing, LSTMB is currently serving as a linkage platform between the state government health departments/institutions (e.g., State ministry of health, college of health technology, schools of nursing and midwifery, school of health technology, Lagos state university teaching hospital) and the TBAs. In October 2019, for instance, LSTMB held an immersion training program for the TBAs in the state. This consisted of the first 6 weeks of general training at the board; and another 6 weeks of General Hospital Immersion Programme. Another set of such a program was also conducted in January 2020. While acknowledge the important and potential effect of such training, LSTMB has regularly acknowledged it clear limitations in conducting such training- particularly in the areas of funding, dearth of qualified health care instructor, limited support from leadership/governance stakeholders in the health sector such as the government, Health oriented NGOs, international development partners (UNICEF, Safe Mother Initiative, WHO), among others.
5. Poor Health Facilities: As at 2019, Nigeria has a paltry 24,600 medical doctor for a population of over 210 million people (Nigerian Medical and Dental council, 2022). In Lagos state, the government has made modest effort in tackling the problem. The state government – over the last decade - has fortified the Primary Health Care (PHC) facilities especially the Lagos State flagship health centres that operates 24 hours full service. This is meant to complement the services rendered by the 288 PHCs in Lagos state. With these in place, trained TBAs could be easily integrated into BOCs.

Findings and Conclusions

The finding from this review are as follows:

1. less than half of the total birth are assisted by skilled birth attendants SBAs (43%), namely; doctors, nurse/midwife, and auxiliary nurses. a higher a larger proportion or all live birth in Nigeria (57%) are either non assisted al all (11%) or assisted by people who are untrained and ill equipped – including the untrained TBAs (46%);
2. it would be erroneous to assume, therefore, that the high level of neo-natal death in Nigeria can be attributed to the deliveries by the TBAs;
3. a major gap currently existing in Nigeria's primary health care sector in general and BOCs in particularly is existence of a avalanche of untrained and unskilled community-based potential health care provider whose potentials could be properly harnessed through training and capacity building

Conclusions and Lessons for Policy

This study concludes that despite effort to scale up delivery at health facilities, the large proportion of mother choose home deliveries. Therefore, home delivery which is an integral part of TBAs delivery hold potential for improvement in maternal and child. As a consequence of this, the solution to high mortality rate could lie in harnessing the potentially inherent in the TBAs especially via their strategic training and integration into the mainstream BOCs in particular and the primary Health Care Service in general

References

1. Amutah Onukagha N, Rodriguez M, Opara J, Gardner M, Assan MA, Hammond R, *et al*. Progresses and challenges of utilizing traditional birth attendants in maternal and child health in Nigeria. International Journal of MCH and AIDS,2017:6(2):130-138. DOI: 10.21106/ijma.216.
2. Abou Zahr C, Boerma T. Health information systems: The foundations of public health. Bulletin of the World Health Organization,2005:83:578-583.
3. Agbo MAE. Training of traditional birth attendants: a strategy for reduction of maternal and infant mortality. West African Journal of Nursing, 2013, 42-52.
4. Choguya NZ. Traditional and Skilled Birth Attendants in Zimbabwe: A Situational Analysis and Some Policy Considerations. Hindawi Publishing Corporation Journal of Anthropology, 2015, Article ID 215909, 11 pages.
5. Costello A, Azad K, Barnett S. An alternative strategy to reduce maternal mortality. Lancet,2006:368(9546):1477-9. doi: 10.1016/S0140-6736(06)69388-4. PMID: 17071268.
6. Ebuehi OM, Akintujoye I. Perception and utilization of traditional birth attendants by pregnant women attending primary health care clinics in a rural Local Government Area in Ogun State, Nigeria. International Journal of Women's Health,2012:4:25-34.
7. Gilbert J, Yan J, Hoffan S. A WHO report: framework for action on interprofessional education and collaborative practice. J Allied Health,2010:39(1):196–7.
8. Graham S. Traditional birth attendants in Karamoja [Ph.D. thesis], South Bank University, Kampala, Uganda, 1999.
9. Hernandez S, Oliveira JB, Shirazian T. How a training Program is transforming the Role of traditional Birth attendants from Cultural Practitioners to unique Health-care Providers: a Community Case study in Rural Guatemala. Frontiers in Public Health. Community Case study published, 2017. doi: 10.3389/fpubh.2017.00111.
10. Jokhio A, Winter H, Cheng K. An intervention involving traditional birth attendants and perinatal and maternal mortality in Pakistan. Obstetrical & Gynecological Survey,2005:60:641-642.
11. Lagos State Bureau of Statistics, LBS. Lagos State Bureau of Statistics, 2023. https://en.wikipedia.org/wiki/Lagos_Bureau_of_Statistics
12. Lagos State Government Official website, 2021. https://lagosstate.gov.ng/blog/2020/02/26/traditional-birth-attendants-charged-on-safe-delivery/; Maternal Figure.
13. National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF) Multiple Indicator Cluster Survey 2016-17, Survey Findings Report. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund, 2017. https://www.unicef.org/nigeria/sites/unicef.org.nigeria/files/2018-09/Nigeria-MICS-2016-17.pdf.
14. National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF). Nigeria Multiple Indicator Cluster Survey, MICS of 2021. Nigeria 2021 Multiple Indicator Cluster Survey (MICS) & National Immunization Coverage Survey (Nics), 2022. http://ngfrepository.org.ng:8080/jspui/handle/123456789/5382.
15. Nigeria DHS. Nigeria Demographic and Health Survey, DHS 2018. Maternal Health Care, 2018, 173-220. https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf.
16. Ogbo FA, Trinh FF, Ahmed KY, Senanayake P, Rwabilimbo A, Uwaibi NE, Agho KE. Prevalence, Trends, and Drivers of the Utilization of Unskilled Birth Attendants during Democratic Governance in Nigeria from 1999 to 2018.International Journal of Environmental Research and Public Health, 2020. DOI: 10.3390/ijerph17010372.
17. Olusanya BO, Inem VA, Abosede OA. Infants Delivered in Maternity Homes Run by Traditional Birth Attendants in Urban Nigeria: A Community-Based Study, Health Care for Women International,2011:32:6:474-491, DOI: 10.1080/07399332.2011.565531.
18. Sibley CG, Marc S, Wilson JD. Effects of Dangerous and Competitive Worldviews on Right-Wing Authoritarianism and Social Dominance Orientation over a Five-Month Period. Political Psychology, Wiley,2007:28(3):357-371. https://doi.org/10.1111/j.1467-9221.2007.00572.x.
19. United Nations' SDGs. The Sustainable Development Goals Report 2023: Special edition Towards a Rescue Plan for People and Planet. https://unstats.un.org/sdgs/report/2023/The-Sustainable-Development-Goals-Report-2023.pdf
20. Uneke CI, Sombie I, Keita N, Lokossou V, Johnson E, Ongolo Zogo P. Improving maternal and child health policymaking processes in Nigeria: an assessment of policymakers' needs, barriers and facilitators of

evidence-informed policymaking. Health Research Policy and Systems,2017:15(1):125-135. DOI 10.1186/s12961-017-0217-5.
21. Uneke CI, Sombie I, Uro Chukwu HC, Johnson E. Developing equity-focused interventions for maternal and child health in Nigeria: an evidence synthesis for policy, based on equitable impact sensitive tool (EQUIST). The Pan African Medical Journal,2019:34:158. doi:10.11604/pamj.2019.34.158.16622.
22. USAID Demographic Health Survey Database, 2023. https://dhsprogram.com/Methodology/survey-search.cfm?pgtype=main&SrvyTp=country
23. WDI. World Bank's World Development Indicators, Databank, 2023. https://databank.worldbank.org/source/world-development-indicators.
24. World health statistics monitoring health for the SDGs, Sustainable Development Goals. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO, 2023. https://reliefweb.int/attachments/abce65b9-f465-44ea-888f-2c913e23723b/world-health-statistics-2023_20230519_.pdf.
25. WHO. Everybody's business — strengthening health systems to improve health outcomes. WHO's framework for action. Geneva, World Health Organization, 2009, 2007. Available at: https://courses.edx.org/c4x/KIx/KIGlobalHx/asset/Health_systemEverybodys_Business_1_.pdf
26. WHO. Monitoring The Building Blocks Of Health Systems: A Handbook Of Indicators And Their Measurement Strategies, 2010. Retrieved via: https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf?sequence=1&isAllowed=y.
27. WHO. Health Education: Theoretical Concepts, Effective Strategies and Core of Health Educators, 2012. Available from: http://www.who.int/iris/handle/10665/119953.