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ASSESSING THE NATURE OF PATRONAGE FOR TRADITIONAL MATERNAL HEALTH CARE SERVICES IN SOUTHWESTERN NIGERIA

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Abstract:
Background: The study assessed the nature of patronage for traditional maternal health care services in Southwestern Nigeria. These were in view of providing information on the nature of patronage of traditional maternal health care services (TMHCs) in Nigeria, thus assisting in meeting the 2030 target of the Sustainable Development Goals (SDGs). **Methods:** The study adopted a descriptive research design method approach. The study population was comprised of all pregnant women and nursing mothers attending TMHCs in Southwestern. The sample size consisted of 1020 pregnant women and nursing mothers. A self-designed questionnaire was used to gather information from the respondents. Data collected were analysed using frequency count, percentage, mean, standard deviation and ANOVA. **Results:** It showed that respondents patronized centre owned by a tradition and culture 351(41.1%), respondents attended their preferred TMHCs on Wednesdays (738), and respondents were introduced to using TMHCs by their in-laws, religious leaders and friends, respectively. However, a large number of the respondents agreed that they use TMHCs because of the passionate care shown towards them (28.9%), spiritual reasons (26.6%), belief in the efficacy of service (30.2%), accessibility (29.7%) and offer of good and quality service (31.2%). Also, the study shows that there is a significant influence of the husband's age ($df=3,870$, $F=5.909$, $p<0.05$), husband's income ($df=4,869$, $F=3.747$, $p<0.05$) and husband's education level ($df=3,870$, $F=64.70$, $p<0.05$) on the reasons for patronizing TMHCs in the study area. **Conclusion:**

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The study concluded that nature patronage is a contributing factor to the high usage of TMHCs, which encourages maternal mortality in Nigeria.

Keywords: traditional maternal health care; pregnant women; nursing mothers; nature; patronage

1. Introduction

Several causes of human fatalities, including natural death, accidents, and disasters, are common to both men and women all over the world. However, there is a particular one that is specific to women, which is maternal mortality. Many women of childbearing age face problems throughout these transition times, particularly in relation to labour and childbirth, ill health, and even mortality. A generally accepted definition of maternal death refers to the death of a woman during pregnancy, childbirth, or in six weeks of evacuation of pregnancy, not minding the period and location of the pregnancy after any basis related to or worsened by pregnancy or its administration, nonetheless not resulting from incidental or accidental causes (World Health Organization [WHO], 2010).

In order to arrest the situation over the past decades, several initiatives have evolved to reduce maternal mortality at home-grown, nationwide, regional, and global stages. Emerging nations, particularly Southern Asia and Sub-Saharan Africa, still experienced high maternal mortality, with an estimated 86% (295,000) of worldwide maternal mortality recorded in 2017 (WHO, 2019). The African continent is highly affected as 17 of the 22 countries with the highest maternal mortality ratios in the world are in Africa (Vandana, Willa, Muhammad, Jessica & Martina, 2017). Sub-Saharan Africa is known to devise the uppermost maternal loss proportions of about 56% of global maternal deaths (Ogu & Ephraim-Emmanuel, 2018).

The menace in Africa calls for the need to critically consider the situation of a country like Nigeria, being the most populous in the continent and having such a high rate of maternal deaths. Precisely, Nigeria contributed 14% to global maternal deaths in 2010, having recorded the highest proportion of annual maternal deaths, while as of 2015, a maternal death percentage of 19% of 814 per 100,000 live births was recorded (United Nations, WHO & World Bank, Gildas, Henshaw & Susheela, 2017). In 2021, Nigeria produced 23% of maternal deaths worldwide. This was affirmed by Oluwafemi Kuti, a Professor of Obstetrics and Gynecology, during his inaugural lecture in May 2021 at Obafemi Awolowo University in Ile-Ife, Osun State, where he lamented the high rate of maternal mortality in the nation. According to her, the global stakeholders' initiatives had not resulted in the anticipated drop in maternal mortality, leading the WHO to give Nigeria a "No progress" rating (Punch Newspaper, 2022).

Several reasons have been identified as associated with the use or non-use modern maternal care services for maternal care by women in Nigeria, the consent and preferences of husbands are among the most prominent (Okonofua, Ntoimo, Ogungbangbe, Anjorin, Imongan and Yaya 2018). Studies indicate that the limited decision-making power of women influences their ability to seek health care from skilled

attendants (Chol, Negin, Agho and Cumming, 2019; Ntoimo, Odusina, Nwokocha and Fayehun, 2019). Furthermore, Ogbo, Trinh, Ahmed, Senanayake, Rwabilimbo, Uwaibi, and Agho (2020) research revealed that the use of Traditional maternal healthcare services (TMHCs) during deliveries was largely unchanged between 1999 and 2018 in Nigeria during the country's period of democratic governance. Low levels of education, cultural values, religion, and the autonomy of women were all linked to decreased probabilities of using a skilled birth attendant in Nigeria. Other reasons for women's patronage of TMHCs include cultural customs, the role of the household's decision-makers (the husband, the mother-in-law, and others), educational attainment, and other factors that are also in play, such as culture and religion (Acceleration of the Reduction of Maternal and New-born Deaths Policy, 2022).

There is an urgent need to direct our attention towards the nature of patronage of TMHCs in order to understand pregnant women's health-seeking behaviour. This information is vital in building responsive maternal health care systems and reducing maternal death percentage in the country in meeting global Goal 3 of the SDGs, which anticipates the decrease of the global maternal death percentage to fewer than 70 per 100,000 live births by 2030.

1.1 Objective of the Study

- Reckoning the nature of patronage for traditional maternal health care services in southwestern Nigeria.

2. Research Question

This research question was asked from the objective of the research:

- What is the nature of patronage of traditional maternal health care services in the study area?

2.1 Hypothesis of the Study

The hypothesis was formulated for this study:

1) There is no significant influence of the husband's age on the reasons for patronising traditional maternal healthcare services in the study area.
2) There is no significant influence of husband's income on the reasons for patronising TMHCs in the study area.
3) There is no significant influence of the husband's education level on the reasons for patronising TMHCs in the study area.

3. Method

This study adopted a descriptive design approach. All pregnant women and nursing mothers who visited traditional maternity healthcare centres in Southwestern Nigeria were included in the research. Pregnant women and nursing mothers who gave birth in

the previous five (5) years at selected traditional maternal health centres in Southwestern Nigeria during the period of the research were included.

3.1 Sample and Sampling Technique

The study included a sample size of 1020 pregnant and nursing mothers. At first, purposive was used to select three States from the Southwest geopolitical zone of Nigeria. The rationale behind this is that these States have the highest number of maternal mortality deaths in Southwest Nigeria (Premium Times Newspaper, 2020; Catherine, Amardeep, Bridget & Amanda, 2019. For the current investigation, a multi-stage sampling procedure was used. The first stage involves the selection of Local Government Areas (LGAs) in each of the States using simple random sampling. Ondo, Osun and Oyo States have 18, 33 and 30 LGAs, respectively. A simple random sampling technique was used to select LGAs, and twenty-five percent (25%) of them were chosen from each state. This amounts to twenty-two (22) LGAs being selected for the study.

The second stage involves using simple random sampling in the choice of traditional maternal health centres from the selected LGAs. In each of the selected LGAs, ten per cent (10%) of the total number of traditional maternal health centres was sampled, amounting to 52 traditional maternal health centres. The third stage involves the selection of women from the selected traditional maternal health centres through a systematic sampling technique. Respondents were chosen at every N^{th} (1th, 2th, 3th, etc.) interval from the centre at the time of the survey. A self-designed questionnaire titled "Pregnant Women and Nursing Mothers Patronizing Traditional Maternal Health Care Services-Survey (PWNMPTMHCS-S)" was used for this study. The instrument was validated by two professors from the Department of Kinesiology, Health Education, and Recreation, who assessed the instrument's content validity. Other experts from the related field of study and the supervisor for this research read and made necessary corrections. The test-retest pilot study was conducted among fifty (50) respondents based on convenient sampling in Ekiti State, being a Southwest State. The questionnaire was administered to the 50 respondents. It was re-administered to the same group of participants after a 2-week break (only 18 were obtainable). The two pairs of results were compared. Using Pearson Moment Correlational Analysis (PPMC), the reliability test revealed a value of r = 0.78. On this basis, the questionnaire was deemed reliable for the research. Certain methods were used to guarantee that correct and trustworthy data was collected. These tasks involve recruiting and training research assistants in the art of administering questionnaires. In each state, three research assistants (for a total of 9) were hired to assist with questionnaire distribution. Although the assistants are graduates, it became necessary to offer them lessons on interview tactics, pitch measures, and a thorough examination of the questionnaire items for the sake of precision. They are well-versed in the subject field and can communicate effectively in English, Yoruba, and Pidgin. Multilingualism in this context enabled them to communicate effectively.

The initial stage in administering the questionnaire was to inform the respondents about the study's goal and objectives, as well as a courteous request for their participation throughout the data collection process. Most respondents were persuaded to fill out the

questionnaire or answer the questions when they are confronted with them. The administration of the instrument took place for three months. On average, 51 respondents were engaged each week. The questionnaire was supplied to the participants to fill out where appropriate. Otherwise, the interviewer posed the questions to the respondents and filled in the blanks on their behalf. Answering the questions took between 15 and 25 minutes. In the course of data collation, 145 questionnaires were discarded because the data were mutilated, resulting in 875 questionnaires used in the analysis.

Data collected for the study were analysed using both descriptive and inferential statistics of percentages, Cross-Tabulation, frequency distribution and chi-square were employed in describing the characteristics of the study sample.

4. Results

Research question 1: What is the nature of patronage of traditional maternal health care services in the study area?

Table 1: Type of Traditional Maternal Health Care Service Centre

State	Centre established and owned by a traditional individual	Community-owned centre established by tradition and culture	Centre established and owned by a Christian group	Centre established and owned by a Muslim group	Total
Ondo State	126 (42.6)	31 (10.5)	134 (45.3)	5 (1.7)	296 (100.0)
Osun State	69 (24.5)	188 (66.7)	23 (8.2)	2 (.7)	282 (100.0)
Oyo State	139 (46.8)	132 (44.4)	24 (8.1)	2 (.7)	297 (100.0)
Study Area	334 (38.2)	351 (41.1)	181 (20.6)	9 (1.0)	875 (100.0)

Table 1 revealed that Osun State respondents patronize community-owned centres established by tradition and culture more than other study locations; Oyo people patronize centres established and owned by a traditional individual more, while the people of Ondo state use community-owned centre established by tradition and culture.

Table 2: Booked Attendance by Traditional Maternal Health Care Services

Table 2: Booked Attendance by Traditional Maternal Health Care Services								
			How often are you booked to attend traditional maternal health care services?					**Total**
			Weekly	**Bi-Weekly**	**Monthly**	**Bi-Monthly**	**Quarterly**	
State of origin	Ondo	Count	182	39	36	24	15	296
		Within state of origin	61.5	13.2	12.2	8.1	5.1	100.0
	Osun	Count	164	42	34	30	12	282
		Within state of origin	58.2	14.9	12.1	10.6	4.3	100.0
	Oyo	Count	161	35	60	19	22	297
		Within state of origin	54.2	11.8	20.2	6.4	7.4	100.0
Total		**Count**	**507**	**116**	**130**	**73**	**49**	**875**
		Within state of origin	**57.9**	**13.3**	**14.9**	**8.3**	**5.6**	**100.0**

Table 2 shows that of 875 Ondo respondents, 182 (61.5%) are booked to attend the traditional maternal health care services weekly, 39 (13.2%) biweekly, 36 (12.2%) monthly, 24 (8.1%) bi-monthly and 15 (5.1%) quarterly. Among Osun residents, 164 (58.2%) of the respondents are booked weekly to attend the traditional maternal health care services, 42 (14.9%) biweekly, 34 (12.1%) monthly, 30 (10.6%) bi-monthly and 12 (4.3%) quarterly. 161 (54.2%) of Oyo respondents are booked weekly to attend the traditional maternal health care services, 35 (11.8%) biweekly, 60 (20.2%) monthly, 19 (6.4%) bi-monthly and 22 (7.4%) quarterly. The traditional maternal health care services are booked weekly in Ondo, Osun, and Oyo.

Table 3: State of Origin * Which day of the Week?

			Which day of the week?		**Total**
			Wednesday	**Thursday**	
State of origin	Ondo	Count	252	44	296
		Within the state of origin	85.1	14.9	100.0
	Osun	Count	254	28	282
		Within the state of origin	90.1	9.9	100.0
	Oyo	Count	232	65	297
		Within the state of origin	78.1	21.9	100.0
Total		**Count**	**738**	**137**	**875**
		Within the state of origin	**84.3**	**15.7**	**100.0**

Table 3 shows that 252 (85.1%) of Ondo respondents attend their preferred traditional maternal health care services when booked by the centre on Wednesdays while 44(14.9%) attend on Thursdays. 254 (90.1%) of Osun respondents attend their preferred traditional maternal health care services when booked by the centre on Wednesdays while 28 (9.9%) attend on Thursdays. 232 (78.1%) of Oyo respondents attend their preferred traditional

maternal health care services when booked by the centre on Wednesdays while 65 (21.9%) attend on Thursdays. The overall result showed that majority of the respondents attend their meeting days every Wednesday.

Table 4: State of Origin * How did you Know About Traditional Maternal Health Care?

			How did you know about the traditional maternal health care?						Total
			Father and mother-in-law	Parent	Husband	Friends	Other family members	Religious leader	
State of origin	Ondo	Count	54	61	72	54	24	31	296
		Within the state of origin	18.2	20.6	24.3	18.2	8.1	10.5	100.0
	Osun	Count	47	58	62	32	10	73	282
		Within the state of origin	16.7	20.6	22.0	11.3	3.5	25.9	100.0
	Oyo	Count	44	40	62	76	24	51	297
		Within the state of origin	14.8	13.5	20.9	25.6	8.1	17.2	100.0
Total		**Count**	**145**	**159**	**196**	**162**	**58**	**155**	**875**
		Within the state of origin	**16.6**	**18.2**	**22.4**	**18.5**	**6.6**	**17.7**	**100.0**

Table 4 indicated that 54 (18.2%) of Ondo respondents know about the traditional maternal health care from their father and mother-in-law, 61 (20.6%) from their parents, 72 (24.3%) from their husbands, 54 (18.2%) from friends, 24 (8.1%) from other family members and 31 (10.5%) from religious leaders. 47 (16.7%) of Osun respondents know about the traditional maternal health care from their father and mother-in-law, 58 (20.6%) from their parents, 62 (22%) from their husbands, 32 (11.3%) from friends, 10 (3.5%) from other family members and 73 (25.9%) from religious leaders. 44 (14.8%) of Oyo respondents know about the traditional maternal health care from their father and mother-in-law, 40 (13.5%) from their parents, 62 (20.9%) from their husbands, 76 (25.6%) from friends, 24 (8.1%) from other family members and 51 (17.2%) from religious leaders. From this result, we can conclude that Ondo, Osun and Oyo respondents were introduced to using TMHCs by their in-laws, religious leaders and friends, respectively.

Figure 1 revealed that 79.1% of Ondo state respondents recorded 3 or fewer births at a traditional birth centre, 15.9% had 4 to 6 births, while 5.1% had 7 or more births. 70.2% of Osun state respondents had 3 or fewer births at a traditional birth Centre, 19.5% had 4 to 6 births and 10.3% had 7 or more births. For Oyo respondents, 58.9% had 3 or fewer births at a traditional birth Centre, 32% had 4 to 6 births and 8.1% had 7 or more births. In total, 69.4% had 3 or less birth, 22.5% had 4-6 birth, while 8.1% had 7 or more

birth. It was concluded that respondents in the study area recorded 3 or fewer births using TMHCs.

Figure 1: Number of Births by Respondents at the TMHCs

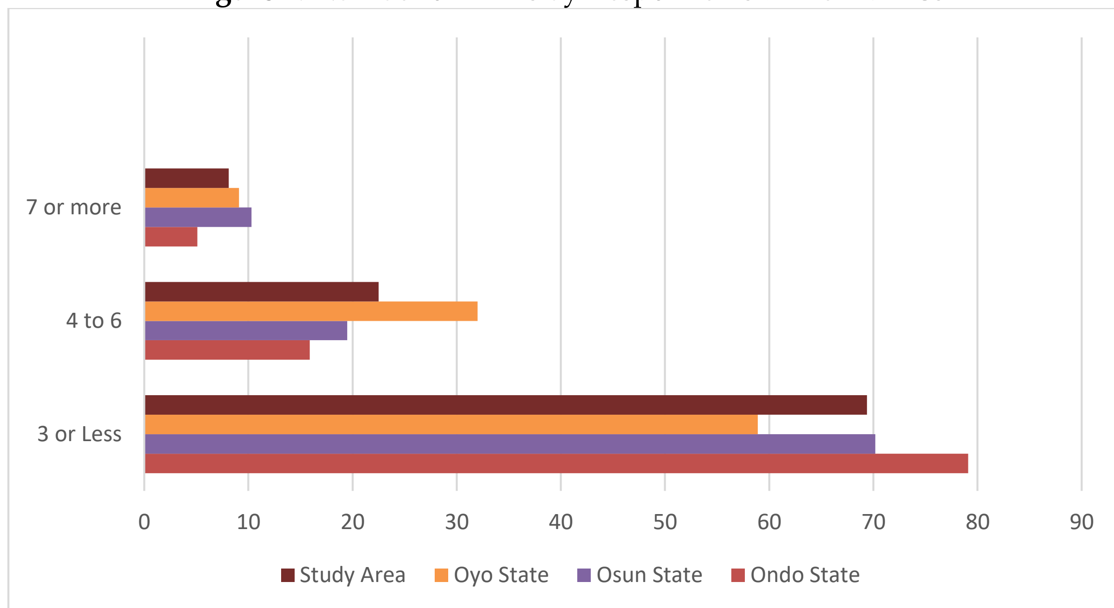

Table 5 presents the reasons for patronizing traditional birth centres in the study area. In all the study locations, they generally disagreed that they patronise traditional maternal health care services because their service cost is cheap (23.1%) and it is culturally acceptable in their environment (28.2%). However, a large number of the respondents agreed that they use TMHCs because of the show of passionate care towards them (28.9%), spiritual reasons (26.6%), belief in the efficacy of service (30.2%), accessibility (29.7%) and offer of good and quality service (31.2%) while some agreed not to patronize modern maternal care facilities because of low number of staff (31.1%) and unavailability of facilities (24%); difficulties in accessing of modern maternal care facilities (21.5%) and poor service delivery (26.9%). Some respondents slightly agreed that they use TMHCs because of the influence of parents in law and husbands, poor behaviour of staff and high cost.

Table 5: Reasons for Patronage of Traditional Birth Centres in the Study Area

Variable	Strongly Disagree	Disagree	Slightly Agree	Agree	Strongly Agree	Total
I patronise traditional maternal health care services because it is cheap	202	179	199	187	108	875
	23.1%	20.5%	22.7%	21.4%	12.3%	100.0%
I patronise traditional maternal health care services because it is culturally acceptable in my environment	139	247	222	209	58	875
	15.9%	28.2%	25.4%	23.9%	6.6%	100.0%
I patronise traditional maternal health care services because my husband prefers it	150	165	265	222	73	875
	17.1%	18.9%	30.3%	25.4%	8.3%	100.0%
I patronise traditional maternal health care services because they provide passionate care	140	208	198	253	76	875
	16.0%	23.8%	22.6%	28.9%	8.7%	100.0%

I patronise traditional maternal health care services because of spiritual reasons and protection from demonic attack	162	204	195	233	81	875
	18.5%	23.3%	22.3%	26.6%	9.3%	100.0%
I patronise traditional maternal health care services because I believe in the efficacy of the services compared to modern health care services	94	217	218	264	82	875
	10.7%	24.8%	24.9%	30.2%	9.4%	100.0%
I patronise traditional maternal health care services because it was my mother in law and parent's choice	131	232	239	192	81	875
	15.0%	26.5%	27.3%	21.9%	9.3%	100.0%
I patronise traditional maternal health care services because it is accessible	92	204	221	260	98	875
	10.5%	23.3%	25.3%	29.7%	11.2%	100.0%
I patronise traditional maternal health care services because they provide good and quality service	109	188	228	273	77	875
	12.5%	21.5%	26.1%	31.2%	8.8%	100.0%
I patronise traditional maternal health care services because there is inadequate staff in modern maternal care facilities	107	211	188	272	97	875
	12.2%	24.1%	21.5%	31.1%	11.1%	100.0%
I patronise traditional maternal health care services because there of poor attitudes and behaviour of staff in modern maternal care facilities	106	203	256	233	77	875
	12.1%	23.2%	29.3%	26.6%	8.8%	100.0%
I patronise traditional maternal health care services because of the unavailability of modern maternal care facilities	102	196	212	253	112	875
	11.7%	22.4%	24.2%	28.9%	12.8%	100.0%
I patronise traditional maternal health care services because of difficulties in accessibility of modern maternal care facilities	96	164	202	210	203	875
	11.0%	18.7%	23.1%	24.0%	23.2%	100.0%
I patronise traditional maternal health care services because of the high cost of modern maternal care facilities	109	223	247	180	116	875
	12.5%	25.5%	28.2%	20.6%	13.3%	100.0%
I patronise traditional maternal health care services because of poor service delivery in maternal care facilities	122	219	180	235	119	875
	13.9%	25.0%	20.6%	26.9%	13.6%	100.0%

Hypothesis one: There is no significant influence of the husband's age on the reasons for patronising traditional maternal healthcare services in the study area.

Table 6: Influence of husband's age on the reasons for patronage of traditional birth attendants

Age (in years)	N	Mean	Std. Deviation							Std. Error	95% Confidence Interval for Mean	
					Sum of Squares	df	Mean Square	F	Sig.		Lower Bound	Upper Bound
0-20	17	38.76	9.776		2172.134	3	724.045	5.909	.001	2.371	33.74	43.79
21-40	594	43.76	10.050	Between Groups	106609.838	870	122.540			.412	42.95	44.57
41-60	255	46.70	13.140	Within Groups	108781.973	873				.823	45.08	48.32
61 and above	8	47.25	13.792	Total						4.876	35.72	58.78
Total	**874**	**44.55**	**11.163**							**.378**	**43.81**	**45.29**

Table 6 showed that there is a significant influence of the husband's age on the reasons for patronizing traditional birth attendants in the study area (df=3,870, F=5.909, p<0.05). The table further shows where the variation lies within the age groups based on their mean values. Men within the age group 61 years and above (47.25) tend to exhibit greater influence on their wives regarding the reasons for patronizing traditional birth attendants in the study area, while husbands less than 20 years (38.76) tend to exhibit lesser influence on their wives regarding the reasons for patronizing traditional birth attendants in the study area.

Hypothesis two: There is no significant influence of the husband's income on the reasons for patronising TMHCs in the study area.

Table 7: Influence of husband's income on the
reasons for patronage of traditional birth attendants

Husband's income (in naira)	N	Mean	Std. Deviation							Std. Error	95% Confidence Interval for Mean	
					Sum of Squares	df	Mean Square	F	Sig.		Lower Bound	Upper Bound
0-30000	378	45.93	12.901	Between Groups	1844.456	4	461.114	3.747	.005	.664	44.63	47.24
31000-100000	436	43.62	9.557	Within Groups	106937.516	869	123.058			.458	42.72	44.52
101000-200000	52	42.71	7.862	Total	108781.973	873				1.090	40.52	44.90
201000-300000	6	37.67	12.894							5.264	24.13	51.20
401000-500000	2	56.50	21.920							15.500	-140.45	253.45
Total	**874**	**44.55**	**11.163**							**.378**	**43.81**	**45.29**

Table 7 showed that there is a significant influence of husband's income on the reasons for patronising traditional birth attendants in the study area (df=4,869, F=3.747, p<0.05). The table further shows where the variation lies within the income range of the husband based on their mean values. Men who earn over #400,000 in a month (56.50) tend to exhibit greater influence on their wives regarding the reasons for patronising traditional birth attendants in the study area, while husbands who earn between #200,000 and #300,00 per month (37.67) tend to exhibit lesser influence on their wives regarding the reasons for patronising traditional birth attendants in the study area.

Hypothesis three: There is no significant influence of the husband's educational level on the reasons for patronising TMHCs in the study area.

Table 8: Influence of husband's educational level on
the reasons for patronage of traditional birth attendants

Husband's educational level	N	Mean	Std. Deviation							Std. Error	95% Confidence Interval for Mean	
					Sum of Squares	df	Mean Square	F	Sig.		Lower Bound	Upper Bound
No formal education	120	56.36	12.391	Between Groups	19590.322	3	6530.107	63.696	.000	1.131	54.12	58.60
Primary	66	44.23	11.152	Within Groups	89191.650	870	102.519			1.373	41.49	46.97
Secondary	274	42.80	10.056	Total	108781.973	873				.607	41.60	43.99
Tertiary	414	42.35	9.236							.454	41.46	43.24
Total	**874**	**44.55**	**11.163**							**.378**	**43.81**	**45.29**

Table 8 showed that there is a significant influence of husband's education level on the reasons for patronising traditional birth attendants in the study area (df=3,870, F=64.70, p<0.05). The table further shows where the difference lies within the educational level of the husband based on their mean values. Men who had no formal education (56.36) tend to exhibit greater influence on their wives regarding the reasons for patronizing traditional birth attendants in the study area, while husbands who are graduates (42.35) tend to exhibit lesser influence on their wives regarding the reasons for patronizing traditional birth attendants in the study area.

5. Discussion of findings

A large number of the respondents patronize the community-owned centre established by tradition and culture, which is owned by a traditional individual once a week, especially on Wednesdays. This may be a result of their belief in traditional medicine and for spiritual reasons, which modern-day hospitals may not be able to detect.

In addition, the study respondents were introduced to using TMHCS by their in-laws, religious leaders, and friends. Their neighbours, church or mosque people do not patronize TMHCS, but they patronize centres with religious affiliations. Having had about 3 births or more in their chosen TMHCS successfully, they also in turn, return the favour by telling their friends about it yet maintaining their membership in those centres they have registered. The reasons for this are not far-fetched. They patronize these centres for the show of passionate care towards them, spiritual reasons, good quality service rendered, accessibility, and to avoid the high cost of modern healthcare facilities and poor behaviour of their staff toward pregnant women. The findings were in line with the findings of the Acceleration of the Reduction of Maternal and New-born Deaths Policy, (2022), which confirmed in their investigation that many women agreed that they would rather give birth at home than in a hospital across all states. The reason for this decision includes cultural customs, the role of the household's decision-makers (the husband, the mother-in-law, and others), educational attainment, and other factors that are also in play such as culture and religion.

This was consistent with the maternal health policy review from 1999 to 2018 conducted by Ogbo, Trinh, Ahmed, Senanayake, Rwabilimbo, Uwaibi, and Agho (2020),

whose research revealed that the use of TBAs during deliveries was largely unchanged between 1999 and 2018 in Nigeria during the country's period of democratic governance. Low levels of education, cultural values, religion, and the autonomy of women were all linked to decreased probabilities of using a skilled birth attendant in Nigeria. Also, these current findings were in line with the previous studies of Adeleke, 2017; Ogu, Agholor & Okonofua, (2017), who affirmed that the domination of traditional and outmoded practices of women in different ethnic groups in Nigeria is one of the country's biggest maternal health concerns. Furthermore, this study added to the previous findings of Eshiet, Jackson, and Akwaowoh (2016) that patronage of traditional birth attendant services is high and influenced by the aforementioned rationales, which consist of caring nature, ready accessibility, and religious and traditional beliefs.

6. Conclusion and Implications

The study focused on the nature of patronage of traditional maternal Health care services in Southwestern Nigeria. The study established the nature of patronage of traditional maternal health care services in the study area as a community-owned centre established by tradition and culture. Respondents were introduced to using TMHCs by their in-laws, religious leaders and friends, respectively, and respondents recorded 3 or fewer births using TMHCs, the majority of the total respondents had family members and friends who patronize TMHCs. The study further revealed that the significant influence of the husband's age, income and educational level are the reasons for patronizing TMHCs in the study area. Based on the findings, it is crucial that the government, in collaboration with other stakeholders, including community and traditional leaders at all levels, ensure that women and new-born babies have access to high-quality, affordable maternal and new-born services, regardless of where they live, at a price that will not put them in financial hardship while using the services. There must be strong political will on the part of the government at all levels to help in reducing maternal mortality in Nigeria.

Finally, the peculiarities of Southwestern Nigeria in terms of cultural practices, religion, and civilization, among others, might have contributed to the variation that is evident in this study. Further studies are therefore required to confirm the underlying factors in another geo-political zone.

The findings of this study shed light on the intricate dynamics surrounding the patronage of traditional maternal health care services in southwestern Nigeria. It is evident that these services are deeply embedded within the cultural fabric of the communities, serving as community-owned centers established by tradition and culture. Moreover, the influential roles played by in-laws, religious leaders, and friends in introducing women to traditional maternal healthcare practices highlight the importance of social networks in shaping healthcare decisions.

One notable finding is the relatively low number of births recorded using TMHCs, with many respondents reporting three or fewer births utilizing these services. This suggests a nuanced approach to understanding the utilization patterns and preferences of women in the study area.

Importantly, the study identified significant influences of husbands' age, income, and educational level on the patronage of TMHCs. This underscores the need for targeted interventions that address socio-economic factors to improve access to quality maternal health care services.

In light of these findings, it is imperative for the government and stakeholders to collaborate to ensure equitable access to high-quality, affordable maternal and newborn services for all women, irrespective of their geographic location. This necessitates policies and programs that prioritize maternal health, with a focus on addressing the specific needs of communities in southwestern Nigeria.

Furthermore, the call for strong political will underscores the urgency of addressing maternal mortality in Nigeria. Sustainable efforts must be made to implement and enforce policies that prioritize maternal health, backed by adequate resources and commitment from government authorities.

Ultimately, while this study provides valuable insights into the patronage of traditional maternal health care services in southwestern Nigeria, it also highlights the need for further research. Exploring the underlying factors influencing healthcare decisions in other geopolitical zones will contribute to a more comprehensive understanding of maternal health practices across the country, thereby informing targeted interventions and policy initiatives.

In summary, the findings of this study identified the complexity of maternal healthcare utilization in southwestern Nigeria and emphasized the importance of multi-sectoral collaboration, targeted interventions, and ongoing research efforts to address maternal mortality and improve maternal health outcomes nationwide.

Ethical Statement

Ethical consideration is of importance to this study and was observed. A written agreement was obtained from the research participants (who were the selected childbearing women and the TBAs). The study participants were requested to sign a consent form contained in each questionnaire and interview guide. Confidentiality of the information was also ensured during statistical analysis and discussion of outcomes as contained in the consent form. The Institute of Public Health at Obafemi Awolowo University in Ile-Ife, Nigeria, provided the ethical (IPH/OAU/12/1903) clearance for this study.

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Conflict of Interest Statement

The authors declare no conflicts of interest.

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