



KNOWLEDGE AND ATTITUDE OF PREGNANT WOMEN AND MATERNAL HEALTH CARE TARGETS IN IJEBU-ODE LOCAL GOVERNMENT AREA OF OGUN STATE, NIGERIA

KEYWORDS

OSIBOYE OLUDARE O.

SCHOOL OF SCIENCE TAI SOLARIN COLLEGE OF EDUCATION, OMU-IJEBU OGUN STATE, NIGERIA.

ABSTRACT

Knowledge and attitude of pregnant women as regards Maternal Health Care targets is critical to the drive to achieve reduction in maternal and child mortality in Nigeria. Maternal health care services appeared underutilized in Nigeria particular among those who are in the greatest need. The concurrence of rise in preventive behaviour coupled with negative health outcomes, underscores the inadequacies of antenatal care and the communication gap between provider and patient, the government and the people. This study therefore examined the knowledge and Attitude of pregnant women and Maternal Health care Intervention targets in Ijebu-Ode Local Government Area of Ogun State with the aim of finding out the practises that frustrated the attainment of Maternal Health Care targets.

Ethnographic data were collected from purposively selected informants and respondents through qualitative methods of non-participant interview. In-depth Interview (IDI) key information Interview (KII) and Focus Group Discussion (FGD). A total of 328 interview, 10 focus group discussion, 8 key informants interview conducted. Data were subjected to descriptive content analysis.

Two Maternal Health Care Goals programme were revealed (i.e. Araya and Clip) during the study. Findings that were revealed as a result of the shortcomings of the two Maternal Health Care programmes as well as the health knowledge deficit of the pregnant women in Ijebu-Ode Local Government area were extensively discussed and recommendations were made. The need to crystallize health intervention programmes that will be all encompassing at the Local Government level was also highlighted.

INTRODUCTION

Maternal and child health still remain a challenging issue in Nigeria, despite the 2015 target of three-quarters reduction in maternal and child mortality as contained in the Millennium Development Goal Number 5 (MDG5). Though the global maternal mortality ratio declined by 45% between 1990 to 2003 from 380 deaths to 210 deaths per 100,000 live births, yet this decline reverted in some countries. Thus mortality rather than decreasing actually increased in those countries. Sub-Saharan African which represents 11 percent of the world's population, contributed 50 per cent to global maternal deaths annually (Adamu et al, 2013). While other regions of the world such as Europe, South America and Asia appeared to be making progress more American women die at childbirth than they were two decades ago, making the United States one of the few countries where the risk from childbirth have risen in the past two decade (Adesanya, 2013).

However, giving birth in the United States remains safer than in most countries, due to equitable locations of health care facilities. Despite this, United States had 28 maternal mortality death per 100,000 live birth in 2013 which is 136 percent higher than the 1990 maternal mortality rate (MMR) when only 12 mothers died in every 100,000 birth (Karmal, 2013).

The World Health Organisation posited that the increase in the United States mortality rate might be due to obesity, diabetes and older women above the age of 39 given birth (WHO-UFA Consultation 2010). Similar reason accounted for the increase in Canada's maternal mortality rate that rose from 6 to 11 per 100,000 birth between 1990 and 2013 (Karmal 2013).

Many European countries and Japan have mortality in single figures. The European profile for maternal mortality per 100,000 live birth show that in Italy Sweden, Spain and Germany only 3.9,4.6,6.7 and 7.0 maternal deaths per 100,000 live births respectively occurred in 2009 (WHO-UFA consultation 2010). Australia's maternal mortality rate in 2009 was

positively remarkable with 6.8 maternal deaths per 100,000 live births (WHO-UFA consultation 2010).

In Asia, China has made significant progress in the maternal mortality rates to 24.5 deaths per 100,000 live births. (Karmal 2013). Malaysia's maternal mortality rates have also declined dramatically over the past three and half decades. Current level are now comparable to those of highly develop countries with MMR of 27 per 100,000 live (Ronsmans et al 2010). In South America's Brazil, maternal mortality rates have reduced substantially, decreasing by 5.5 percent a year between 1980's and 1990's and by 4.4 percent a year since 2000 to reach 20 deaths per 100,000 live birth in 2008 (Shieh et al 2009). The maternal mortality rate in Argentina has remain steady during the last decade. In 2005, it was 46 per 100,000 live births, with remarkable differences between provinces in Buenos Aires, the maternal mortality rate was 14 per 100,000 live births, while in the province of Formosa, maternal mortality rate was 166 per 100,000 live; almost twelve time higher.

In 1990, twenty three countries had at least 1,000 maternal deaths per 100,000 live births. By 2013, only Sierra-Leone remained above that threshold. Two countries, India and Nigeria account for more than a third of the total number of maternal deaths globally. India has the largest number of births per year (i.e. 27 million) with high maternal mortality of 400 per 100,000 births India's progress in reducing maternal deaths is crucial to the global achievement of Millennium Development Goal Number 5. However the expenditure of India Government on health has been a mere 0.9% of the Gross Domestic Product while a large percentage of the budget is on defence and non-vital infrastructures (Karmal 2013).

In 2000, the maternal mortality ratio per 100,000 live births in Nigeria was 800 compared with 540 for Ghana and 240 for South Africa (Liskin 2002). By 2003, the maternal mortality ratio in Nigeria had raised to 948 in 100,000 live births (Lucas, 2005). Indeed Nigeria's maternal mortality rate was considered to be

one for the highest in the world (Lucas 2005). Though, Nigeria account for only 2% of the world's population, it account for 10% of the global estimate of maternal deaths. According to the World Health organization maternal mortality is defined as the death of a woman while pregnant or within 42days of its termination, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental cause (WHO-UFA consultation 2010). The high maternal mortality rate in Nigeria had been a cause for concern. This is more so because government at all levels yearly allocated mind-boggling amount of money running into hundreds of billions to maternal care (Liskin 2002).

An estimated thirty million women per year become pregnant in Nigeria and these women are constantly at risk (Adamu et al 2013). As at 2015, the statistics appeared worst with Nigeria accounting for about 13% of the global material death rates with an estimated 53,000 women dying in pregnancy or at child birth each year. The frightening estimates indicate that one woman dies in every 10 minutes as a result of pregnancy and child birth related issues. They die from complications of excessive bleeding or hemorrhage, infection; pregnancy induced high blood pressure that often leads to convulsion, malaria, obstructed labour and diabetes. The only country that has a higher absolute number of maternal deaths than Nigeria is India with 136,000 maternal deaths each year. (Shieh et al 2009). Underlying the above is the need for ethnographic study of Maternal Health Care in Nigeria in order to examine the specific health behaviours challenging health security of the pregnancy women. Therefore examining the myriads of factor influencing the behaviours of pregnant women in Ijebu-ode Local Government Area as a case in point will reveal the socio-cultural construct that has debilitated and decimated significantly the population of women.

Problem

The concurrence of rise in preventive health intervention over decades coupled with negative pregnancy health outcomes, alarmingly underscores the communication gap or cultural gap between the health provider and patient, the government and the people. A women's pre-natal health engagement is indeed the bedrock of birth outcomes and gives far reaching implications for mother and child in terms of the health outcome of the duo. It therefore stand to reasons that reducing Maternal Mortality in Nigeria to single figure will remain elusive without a deliberate focus on the health behaviour of the pregnant women.

Arising from the above are the following question that drive the motivation for this study:

1. What are the cultural beliefs influencing knowledge and attitude associated with pregnancy in Ijebu-ode Local Government Area?
2. What are the pregnancies related disease affecting women in Ijebu-Ode Local Government Area?
3. What are the available maternal health care facilities in Ijebu-Ode Local Government Area?
4. What are the interventions of government in pregnancy health care for pregnant women in Ijebu-ode Local Government Area?
5. How does the knowledge and attitude of women in Ijebu-ode Local Government Area influence government intervention on Maternal Health security.

Methodology

This study is a qualitative and ethnographic account of the knowledge and attitude of pregnant women to maternal health care intervention targets in Ijebu-Ode Local Government Area Ogun State. A qualitative approach was adopted deliberately to take account of actions and perceptions. The study explored health belief model as the theoretical framework for the knowledge and attitude displayed by pregnant women. The choice of Ijebu-Ode local government area was informed by the fact that it has a concentration of diverse ethnic groups and it happens to be one of the few metropolises in Nigeria where over 90% of the pregnant women engaged in mixed methods of faith based healing, traditional health care and orthodox care during pregnancy (Orububoye 2005).

Sample and Sampling Techniques

The total sample for this study were the pregnant women attending antenatal care in registered Orthodox Hospitals and Clinics, Traditional Medical centers and Faith based clinics in Ijebu-Ode Local Government Area. Simple random sampling was used to select respondent each from government orthodox hospital, private orthodox hospital, traditional medical center, Christian faith based clinic and Muslim faith based clinic. The interviews were conducted on one to one basis. Respondents were asked questions about their age, marital status, their educational level and their reasons for engaging the particular antenatal care facilities where they were located.

Data Collection

Multiple data collection methods were adopted for this study. The method's that were adopted for data collection for a comprehensive approach in this study included key-informant interview (KII). In Depth interview (IDI) Non Participant observation and Focus Group Discussion.

RESEARCH FINDINGS SOCIAL DEMOGRAPHIC CHARACTERISTIC OF THE RESPONDENTS

The data gathered from the field resulted in engaging 328 respondents. The respondents have the following characteristics which are presented below:

Table 1: Distribution of respondent by Age

Age	Respondents	Percentage
11-20	62	18.9
21-30	113	34.5
31-40	84	25.6
41-50	69	21
TOTAL	328	100

The data collected shows that 53.4% of the population of the respondents falls within the ages of 21-40 which constitute two age categories (113 + 84 = 197). This can be explained by the fact that these are the critical ages of child birth. A small proportion of women are married under the age of 20years and this represent 18.9%. The age range 11-20 captures a number of cases of women (4) that were raped. 2 of these women were girls of ages 12 and 13.

Table2: Distribution of respondent by number of children

No of children	Respondents	Percentage
0	46	14.02
1	53	16.16
2	57	17.38
3	49	14.94
4	106	32.32

5	15	5.18
TOTAL	328	100

Table 2 above shows that 46 of the respondents are yet to have any children. They were expectant mothers looking forward to their first delivery. 53 respondents had one child each representing 16.16%. 59 respondents and 2 children each, representing 17.38%. Another 49 of the respondents had 3 children each representing 14.94%. Also 106 of the respondents already had 4 children each representing 32.32% and 17 of the respondents had given birth to 5 children representing 5.18%. All the mothers were pregnant and expecting delivery in the period of five months to seven months.

Table 3: Distribution of the respondents by level of education

Level of Education	Respondents	Percentage
With informal Education	96	29.3
With primary education	77	23.5
Secondary Education	53	16.2
Post-secondary education	102	31.0
Total	328	100

From table 3 above the level of non-formal education is significant which reveals 96 respondent representing 29.3%. The orientation of the people with regards to education may be responsible for this. This factor may have the potential of affecting their knowledge, attitude towards the MDGs targets. Those without formal education are most likely to be ignorant of the advantage of the Maternal Health Care intervention targets and they are most likely to hold to the belief in the efficiency of traditional health care.

Table 4: Distribution of respondents according to religious belief

Religion	Respondents	Percentage
Christian	190	57.9
Muslim	100	30.5
Traditional	38	11.6
TOTAL	328	100

From table 4.1.4 above most of the respondents are Christians. 190 respondents were Christians representing 57.9% while Muslims totaled up to 100 representing 30.5%. The African traditional believe are 38 in numbers representing 11.6%.

WOMEN'S KNOWLEDGE AND ATTITUDE ABOUT PREGNANCY

Most pregnant women utilize orthodox health institution in Ijebu-ode local government area for their health. Unlike in the past when most pregnant women rely purely on traditional medicine for their health needs; indeed this is because for most of the people, all diseases are no longer perceived to be of supernatural origin. Through education and enlightenment, many are now aware that certain practices and behaviour like poor sanitation and inadequate competencies can result in ill-health. The high patronage of orthodox health institution is evident in number of those who participate in the government's immunization programme against the six deadly diseases (i.e cholera, diphtheria, whooping cough, tetanus, marasmus and poliomyelitis). This gives credence to the utilization of modern health care system by the pregnant women. The high and increasing pressure on these health institutions has made the facilities in adequate and expensive, particular in the private health facilities. Thus, many pregnant women resort to the TBA as a result.

Indeed, in few cases the belief in the supernatural causes of disease still persists hence the intervention of the TBA is actively sought in view of such beliefs. In other cases, some pregnant women stick to the orthodox facilities for as long as they are able to received prompt curative services for their complaints. However these same categories of women still rush to the TBA after delivery for different concoctions particularly when a particular health condition persists. This is borne out of the belief that some maternal ill health may be beyond the scope of orthodox health care system. Yet, there are also those who still rely purely on traditional medicine for their maternal health needs inspite of the presence of orthodox hospital in the local government area. The reliance according to them is due to their belief in the efficacy of the TBA as well as the relative affordability and accessibility of the TBA's to them.

Indeed, the practices of the TBA's are also evolving in to a more acceptable health care system. Pregnant women previously barred in the past from eaten certain kinds of foods like banana, snail, egg and so on based on taboos that were attached to such foods are now encourage to eat them. For example it was believed in the past by the TBA's that if a woman eat snail, the child when delivered may have the problem of salivating abnormally. Also, the taboo attached to the consumption of banana in pregnancy that a baby delivered by a woman that ate banana in pregnancy may become impotent has also being jettisoned.

Indeed, the myriads of taboos associated with the pregnancy states are fast fading away in Ijebu-Ode Local Government Area because of the immediate and remote influence of modern health care and availability of scientific nutritional knowledge.

Table 5: Distribution of respondent according to the methods of pregnancy care engaged in.

S/N	Pregnancy Health Care	Respondents	Percentage
1	Strictly orthodox	68	20.7
2	Traditional health care Christian faith health care and orthodox hospital	65	19.8
3	Traditional health care, Islamic faith health care and orthodox hospital	58	17.7
4	Hospital and Christian faith based health care	72	22.0
5	Hospital and Islamic based health care	65	19.8
	Total	328	100

Table 5 above shows that only 68 out of the 328 respondents make use of strictly orthodox hospitals which represents 20.7%, 65 respondents engages the mixed services of Traditional pregnancy healthcare, Christian faith pregnancy health care and orthodox hospital pregnancy health care representing 19.8%. 58 respondents, representing 17.7% engages in the mixed health care method of Traditional health care, Islamic faith based health care and orthodox hospital. 72 respondents representing 22% also engaged in hospital and Christian faith based health care. 65 respondents representing 19.8% also engaged in hospital and Islamic based health care. The total number of respondents engaged in mixed methods was 260. None of the respondents falls into the category of engaging traditional maternal health care alone or Christianity based maternal health care alone. Also there were no respondents that could be captured as engaging traditional and orthodox health care alone as well as Islamic faith based health care alone.

INTERVENTION TARGET TOWARDS MATERNAL CARE

Community level intervention for preeclampsia and Enclampsia is one of the Health Intervention towards maternal care. The programme commenced on the 1st of April, 2015 with the collection of data from wide range of women including those with child delivery experience, peculiar health challenges and even the ones that are not pregnant. The data was collected for women between the ages of 14 to 44 years. The main focus was on pregnant women and women within reproductive age. Community Level Intervention Preeclampsia and Enclampsia CLIP was introduced to the Nigeria by University British Columbia (UBC) in partnership with Bill Gates Foundations.

All over the world, the four (4) nations where this intervention is presently being introduced are Nigeria, Mozambique, Indian and Pakistan. The choice of these countries could be a pointer to the prevailing challenges of Maternal Health Care in these Nations.

In Nigeria, the CLIP Programme exists in only 10 Local Government and all these 10 Local Government are in Ogun State. The Local Governments involved are Ijebu-North East Local Government, Ijebu Water Side Local Government, Ijebu-Ode Local Government, Odogbolu Local Government, Sagamu Local Government, Odeda Local Government Imeko Local Government, Ewekoro Local Government, Yewa North Local Government, Yewa South Local Government and Remo North.

Basically, the women within the reproductive age were initially uncooperative but became excited with the Programme later on. Under the watch of field officers, and surveillance officers the registration of the women took place. In addition to the enlightenment given to the women on preeclampsia and Enclampsia which are the major prevailing diseases affecting pregnant women in Ijebu-Ode Local Government.

The field officer also visit the TBA's to educate the practitioners on the dangers of Preeclampsia and Enclampsia. Often times the TBA's are advised to refer such cases to specific hospitals once the CLIP teams detect the onset of preeclampsia and Enclampsia using their microfile kits.

A follow up strategy was also deployed even after the women gave birth with reports being written 24hours after birth, 3days after birth, 7days and 14days post birth.

ARAYA

The Araya programme commenced on the 1st of October 2012. The programme was established essentially by Government to partner financially with pregnant women in the course of nurturing their pregnancy for 9months and for 3months post-delivery. However, ARAYA programme excludes caesarian operation and this appears a challenge to the poor pregnant women needing such surgical intervention. The ARAYA programme challenge is fundamentally premised on the exclusion of caesarian session in the scheme. Despite this challenge, it is very clear that many pregnant women were cared for with deposit of five thousand naira throughout the period of pregnancy and 3 months after delivery of the baby. The state government deposits a counterpart subvention to take care of the pregnancy and normal delivery.

Table 6: Distribution of respondent according to source of information about MDGs target intervention

Source of Knowledge on Maternal Health Care Intervention	Respondent	Percentage
Mass media	71	21.5

Friends/relatives	110	33.5
CLIP	78	24
Hospital	69	21
Total	328	100

The above table shows that the highest percentage of the respondents (110 representing 33.5%) got MHC intervention information (Araya and CLIP) through friends and relatives. This shows the importance of relationship in the society. It is evident from the above that a list of information is disseminated through interaction.

71 out of the 328 respondents representing 21.5% got their information through mass media, 78 respondents representing 24% got the MDGs information through the activities of CLIP while only 69 respondents representing 21% got their information about MHC Intervention from the hospitals.

Table 7: Level of education and attitude towards the maternal health targets

Level of education	Maternal Health Care Intervention	Positive attitude	%	Negative attitude	%	Total
Informal Education	ARAYA	90	93.8	6	6.2	96
	CLIP	38	39.6	58	60.4	96
Primary Education	ARAYA	22	28.6	55	71.4	77
	CLIP	27	35	50	65	77
Secondary Education	ARAYA	23	43	30	57	53
	CLIP	40	75.5	13	24.5	53
Post-Secondary Education	ARAYA	80	78.4	22	21.6	102
	CLIP	95	93.1	07	6.9	102

The table above shows that education is a basic socio-economic variable and to a great extent determines individual status. It goes a long way in determining the knowledge and attitudes to Ijebu-Ode pregnancy women towards the maternal Health targets.

It is clear that 58 of the woman without formal education representing 60.4% have the highest percentage of negative attitude towards the CLIP. (An MDG intervention instituted in Ijebu-Ode Local Government to curtail ignorance of pregnancy health challenges).

However, it is surprising that the same category of non-formal education has the highest positive attitude 93.8% towards ARAYA (an MDG5 intervention instituted to addresses the poverty challenges of the women during pregnancy and after child birth).

The sharp difference between the negative and positive attitudinal disposition towards ARAYA and CLIP reduces noticeable as the level of education increase. This shows that education status is an important factor that influences utilization of Maternal Health care Services among the respondents. Since the association is positive, it shows that the higher the level of education the more likely they will utilize maternal health care services.

Table 8: Religion and attitude toward MDG5 Intervention

Religion	MDG5 Intervention	Position	%	Negative	%	Total
Christianity	ARAYA	110	58	80	42	190
	CLIP	35	18	155	82	190
Muslim	ARAYA	13	13	87	87	100
	CLIP	80	80	20	20	100

African traditional religion	ARAYA	08	21	30	79	38
	CLIP	05	13.2	33	86.8	38

Diseases or illness are variously referred to as "aisan" i.e. lack of wellness or "ailera" (state of weakness). This conception of health and ill health is culturally based, talking about knowledge and attitude of pregnant women, there are beliefs that are associated with pregnancy and child bearing among the women.

Various factors implicated in maternal ill health of the women in Ijebu-ode Local Government Area are Gestational Diabetes Mellitus (GDM) Hypertension, Preeclampsia, and Enclampsia GDM is the diabetes that occurs primarily during pregnancy.

Enclampsia and Pre-champsia are of major prevalence in Ijebu-ode Local Government area. Enclampsia is the occurrence of convulsions in association with hypertension and Edema during Pregnancy, while Preeclampsia is a medical condition precipitated by high blood pressure leading to high level of protein in the urine which later causes kidney damage. Hypertension through preeclampsia is grossly implicated in complications associated with adverse fetal outcomes, increased in perinatal morbidity and mortality as well as maternal ill health that often lead to maternal deaths.

Table 9 – Percentage of reported prevalent diseases in 2015 in Ijebu-Ode Local Government Area.

Diseases	Percentage Reported
Enclampsia	38%
Preeclampsia	42%
Hypertension	12%
Gestational Diabetes Mellitus (GDM)	8%

Also, from the information gathered, most people in Ijebu-ode Local Government believe in supernatural causes of diseases part from natural causes.

Thus, the belief that maternal death causing diseases may result from the affliction from spiritual agents such as spirits of the dead, witchcraft and sorcerers among others are common. From the data collected 65% of respondents believe in both supernatural and natural causes of maternal mortality. Another 20% believe that maternal mortality are caused supernaturally only, while 15% say that the cause of maternal mortality are natural.

Table 10: Perception of the causes of maternal mortality

Variables	Number sample	%
Natural	49	15
Supernatural	66	20
Both	213	65

The concept of maternal ill health determines to a large extent the health seeking behavior of pregnant women. Thus even when the Maternal Health are available, some pregnant women do not access these facilities but rather engage the services of TBAs.

Table 11: Engagement of available maternal health services

Awareness of Maternal Health by Hospital and health care centers	Preconception care	Antenatal care	Delivery care	Postnatal care	Immunization
Respondents	12	122	142	28	2.0
Percentage %	3.70	37.65	43.83	8.64	6.0

Out of the 324 respondents (89.78%) who claimed to have engaged in maternal health care services, only 12 (3.70%) indicated they had engaged preconception care prior of getting pregnant. While 122 respondents (37.65%) were engaged the antenatal care services. 142 respondents (48.83%) engaged the delivery services of hospital facilities; 28 respondents (8.64%) explored the postnatal care services of the hospital while 20 respondents (6%) took advantage of the immunization scheme.

Table 12: Barrier to utilization of Maternal Health Intervention

Barrier	Frequency	Percentage
Negative attitude of the health care provider	72	21.95%
Lack of knowledge about any of the existing maternal health services	4	1.2%
Language Barrier	12	3.66%
Previous history or complication during pregnancy labour or post delivery	23	7%
Unaffordability of maternal health care services	29	8.8%
Culture acceptance	38	11.6%

Table 4.5.3 shows that the majority of the 72 (4.95%) respondents stated that the negative attitude of the health care provider (Nurses) constitute a barrier to the utilization of the Maternal Health Care intervention. 4 of the respondents constituting 1.2% were not aware of any Maternal Health intervention facilities while 12 of the respondents (3.66%) complained about language barrier. 23 (7%) of the respondents were discourage from utilizing the maternal health care intervention programme because of their previous history of complication during pregnancy, labour or post-delivery. 29 respondents constituting 8.8% sighted financial constraints as reasons for not utilizing the maternal health care intervention facilities. 38 respondents constitution 11.6% sighted cultural incompatibility as the reasons for their refusal to access the maternal health care programmes.

CONCLUSION

This study has revealed the challenges of maternal health care in Ijebu-ode Local Government Area. The various dimensions of the challenges are well documented. In view of being an heterogeneous society, the cultural complexity has orchestrated changes in conception of health attitudes. This has also resulted in the plurality of maternal health care in the community.

Though the government has taken some steps in intervening in sliming the challenge of maternal mortality, the Maternal Health Care invention of ARAYA and CLIP has recorded marginal success. Indeed, the integration of the Traditional Birth Attendant practice remains the challenge of the two Maternal Health Intervention programme in Ijebu-ode Local Government Area. The need to dispel the fears of the TBA's is critical to the successful implementation of interventions. Therefore to combat the problem of maternal health that have resulted in the decimation of large population of women in our society, the

following steps are recommended.

The need to enlarge the scope of the ARAYA intervention to encompass all maternal health issues including caesarian operating should be given paramount priority by government. It appears that there is an apparent disconnect in government intervention to financially partner with pregnant woman in taking care of their pregnancy and withdrawing the assistant at the point of delivery, when the delivery requires caesarian operation.

It is also important to capture the planning stages, the implementing stages and evaluation stages of maternal health intervention targets within the purview of the local governments in order that the machinery of government at that level will be able to drive the programme effectively since it is the closest tier of government to the people. It is also necessary that government should endeavour to crystalise and all inclusive programme that will allay the fears of the TBA's. This inclusive approach will go a long way in assuring the TBA's of the advantage of aligning with government's intervention since it is obvious that the challenges of maternal health care is overwhelming the available orthodox hospital. The aforesaid recommendation should indeed guide any kind of intervention the government may be having in its pipeline for maternal health sustenance in future.

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