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CHILD DELIVERY PREFERENCE AMONG PREGNANT WOMEN IN A RURAL COMMUNITY IN AKWA IBOM STATE, NIGERIA

CHIMAOBI OKORIE (PhD)
Department of Social Work,
University of Calabar, Calabar, Nigeria

Abstract
Many African cultures present conflicting options of place of delivery for pregnant women especially in rural communities. Often times, the option that seems more familiar and accessible to these women is preferred. This study was conducted in a rural community in Etim Ekpo, a remote Local Government Area of Akwa Ibom State, Nigeria. The study involved pregnant women, who had delivered at least three (3) children as at the time of this study, among Traditional Birth Attendants (TBAs) and health workers in the ten (10) wards in Etim Ekpo Local Government Area of Akwa Ibom State, Nigeria. The research adopted both quantitative and qualitative research methods. Simple percentages were used to analyze the socio-demographic characteristics of respondents, while the (χ^2) was used to test the hypotheses generated for the study. It was noted that over 60% of the pregnant population in rural Nigeria preferred the traditional birth options despite the regular campaigns and sensitization by government and other voluntary agencies to promote visits to modern health facilities for ante-natal and post-natal care. It can deduced from the study that the preferred patronage of TBAs by a higher population of rural women is predicated on certain identified factors such as poor quality medical services in modern hospitals, poor financial standing of the rural women, attitude of some medical personnel to pregnant women, and the trust they have on their TBAs. The study therefore recommended among others that there should be sufficient checks and control on the TBAs to ensure safety in their practices and integrate them into modern ante-natal health care in the rural areas.

Key Terms: Traditional Birth Attendants (TBAs), Child Delivery, Pregnancy, Ante-natal, Rural community, Deity of extra-marital relations.

Introduction

Safe child delivery has become an issue of great concern to many societies especially in recent times. It is more so because the success and continuity of any society depend largely on the number of safe deliveries it is able to achieve. Safe delivery in turn depends on the efficacy of the health institutions and the level of enlightenment of the populace. Ekpenyong (2003) believes that the concern for safe child delivery institutions in every society is in line with global standards in health provision. This falls under the coverage of maternal and child health as included in the Millennium Development Goals (MDGs) of 2000.

In order to ensure successful increase in population and continuity of the society, various governments, institutions and organizations have come up with policy measures and awareness mechanisms to help pregnant women to manage some of the common challenges associated with pregnancy and child delivery. Mathew (2009) believes that what is important is the safe delivery of the baby as well as the health of the mother whether in the choice of Traditional Birth Attendants or a modern hospital facility. Emeka (2008) argues that though there has been significant improvement in technology,

many pregnant women in Nigeria still insist on the choice of Traditional Birth Attendants sometimes against the wish of their spouses in some cases.

Adekoba's (2002) opinion is that pregnant women in developing countries should take advantage of modern health support services and general sensitization programs provided by modern health facilities towards safe pregnancy and child delivery processes. In spite of the availability of skilled and technically equipped manpower in the hospitals to handle complications that may arise in the course of pregnancy and child delivery, many pregnant African women are still skeptical about using modern health services even after child birth. Writing about the popularity of TBA patronage in medicinal and spiritual problem.

Okudi remarked in his research that:

> *Traditional Birth Attendants (TBAs) deliver about eighty (80%) of the women in the rural areas and forty percent (40%) in the urban areas, besides providing pre- and post natal care, they also provide spiritual assistance to free their clients from the claws of evils, as well as undertake genital operation using traditional method, etc. (Okudi, 1995;104).*

Although traditional birth practice as a cultural pattern in Africa has been under attack by both Christendom and orthodox medical practice, the non bureaucratic procedure involved in seeking the service of TBAs is a major factor that drives the consistent patronage by the rural women. The TBAs present their services as more of a humanitarian gesture than an economic endeavour, which endears them to their clients and, to a large extent, promotes admiration and confidence of their clients. Emeka (2008) and Akpanaenoh (2001) share in the opinion that much consideration should be given to this choice of obstetric care given its cultural attachment by culture bearers. Akpanaenoh submits that child-delivery in any human setting is a sensitive enterprise that demands the attention of researchers and care, energy and resources must be channeled to uncover the possible dangers in the practice, especially in the traditional aspect, which seems to be highly patronized among our people in the midst of civilization (Akpanaenoh, 2001: 205).

The problem

Safe pregnancy and safe child birth are considered as very important obstetric issues in marriage relationships among communities in *Etim Ekpo* Local Government Area of Akwa Ibom State. Unsafe child delivery in African societies is seen as a wasted effort and unpleasant experience which often attracts some form of societal chastisement and wrath of the gods of the land. In *Etim Ekpo*, for instance, if a child dies at birth, the woman is suspected of marital unfaithfulness *(Nka-owo: literally meaning, courting many men in adulterous relationship)* and so must be punished by the ancestral spirit of extra marital relationship *(Ekpo Nka-owo).* The situation leads to mutual suspicion from both families in the marriage which could result in serial death of the husband and children gotten from the marriage. Such marital infidelity from the woman-wife often leads to termination of the marriage. A married woman who experiences such death in marriage is often accused of eating up her children and would be labeled "*Eka Ata Nto"* which literally translates as a woman that eats off her children. (Ndene, 2006).

The choice of modern hospitals is predicated on the assumption that it guarantees safe child delivery and the good health of the mother. However, there seems to be greater preference for the choice of TBAs in rural communities during obstetric care than the orthodox care. It is no longer an exaggeration to state that most rural women still patronize the TBAs irrespective of the availability of modern healthcare facilities in their domains. The fact that pregnant women in *Etim Ekpo* still patronize TBAs in spite of the modern health facilities located in close proximity to their homes calls for further analysis and discourse. What may be responsible for this choice? Is the cost of treatment more expensive in the orthodox than in traditional obstetric care? Are the pregnant women not sure of their matrimonial fidelity with their husbands and so avoid orthodox obstetric care in preference for the traditional for fear of crisis that could befall them and their babies during delivery.

Traditional Birth Attendants (TBAs): Views and Perspectives

Traditional Birth Attendants (or Independent Midwives as they are called in Australia) involves the use of indigenous technology and technicalities to care for pregnant women and ensure safety of mother and child. Davidson (1999) argues that TBAs should be recognized due to their long period of existence since, according to him, it is almost impossible to trace their historical emergence. The practice is seen to be as old as the history of man and society. It is believed that care should be taken in tracing the history of TBAs to avoid subjectivity. The emergence of the practice is regarded as a circumstance of necessity which came as a result of the need to rescue pregnant women from the challenges associated with child birth in the olden days. Pinker (1997) calls for deep research by historians and social researchers to determine the actual origin of Traditional Birth Practice. From the fore-going, there appears to be no established record on the history of Traditional Birth Attendants but, could be traced to process of man in given environments as they respond to health challenges. Today, TBA can be classified into Registered and Unregistered Birth Attendants. The registered ones are recognized by the government who update their practice from time to time through seminars and workshops (Ndene, 2006). The unregistered ones shy away from surveillance and regulation of the government, but practice their act all the same.

In Ghana, 68 % of births occur with the assistance of Skilled Birth Attendants (registered) (SBAs) and 67.4 % of births occur in health facilities. Just over half of all births (52.7 %) in rural areas occur in health facilities. Also, facility delivery is lowest in the Northern (37 %) and Central (61 %) regions of the country (Leslie, Clare, Kavita , Sodzi and Akalpa, 2015).

In a similar study carried out among urban dwellers in Nepal, it was reported that 41.9% of the pregnant population had undergone some delivery at the time of the study, and more than 50% of the home deliveries were attended by TBAs in partnership with medical personnel and neighbours (PrativaDhakal 2018).

Edem (2000) views Traditional Birth Attendants as persons who perform the function of saving lives of pregnant women and their babies using the efficacy of traditional medicine, spirit mediums and herbs. These persons are usually women who desire to care for pregnant women. Their expertise is built on number of years of practical experience through mentorship and apprenticeship which instill in them courage and self-confidence in the practice of their vocation. Traditional Birth Attendants are traditional health personnel either locally trained under apprenticeship or naturally endowed through family history of birth delivery practices to assist women during pregnancy without the use of orthodox medicine or the assistance of bureaucratic health personnel. They usually win the confidence of pregnant women due to the belief in their capacity to lead them to safe child delivery using indigenous technology, herbs and experience (Asemeafor, 1999). A Traditional Birth Attendant plays the combined role of a doctor, (gynecologist), a nurse, a midwife, psychotherapist and in some cases as a spiritualist in taking care of health problems of pregnant women to ensure their safe delivery in traditional way in rural communities. These days, however, trained TBAS have started to minimally combine orthodox remedy with the traditional in the care for pregnant women

Adada (2005) believes that Traditional Birth Attendants also mediate between the ancestors and the pregnant women if the pregnant woman is suspected to have been unfaithfully indulging in extra marital sexual relations, to pacify the ancestral spirits guiding marriages. To this extent, TBAs make strategic contributions to the healthcare system in many traditional African societies (Askia 2000). Their practice has also been infused into many rural cultures and since culture is transferred from generation to generation, the process of child birth deserves much attention as it is the only way of ensuring continuity of culture and society.

Traditional Birth Practice is an extension of the healthcare system par excellence (Emeka, 2008) and (Eleho, 2007). It is believed that pregnant women tend to entertain minimal fear because they believe the TBAs ensure safe delivery of pregnant women. (Anamsefor, 2001). Shofoluwe (2000) provides a cultural interpretation of the activities of Traditional Birth Attendants as custodians of indigenous obstetric procedures, steps and methods towards ensuring the well-being and safety of pregnant women and their children. The activities of TBAs expand and consolidate the lineage, kinship, culture and friendship in African societies. In Nigeria, the government recognizes their services and has incorporated them into Primary Health Care program and network through periodic trainings and supports. With government support and encouragement, Traditional Birth Attendants have successfully complimented modern medical efforts to care for the pregnant women and thereby ameliorating maternal and infant mortality rates.

The outcome of a cross sectional study carried out among women in semi-urban settlement in Giwa, Northern Nigeria showed that 76% of the women had their deliveries at home and were not supervised by skilled medical personnel (Idris SH, Sambo MN, and Ibrahim MS 2013). The findings in a similar study in Usman Dan Folio University Teaching Hospital Sokoto showed that some urban women end up having their deliveries at home even after receiving antenatal care at the Tertiary health institutions.
Factors that promote the patronage for Traditional Birth Attendants

In spite of the growing awareness and increasing campaigns for modern healthcare delivery system, many pregnant women still consult the services of the Traditional Birth Attendants for obstetrics care. A number of factors have been considered to be responsible for this consistent patronage. Many pregnant women prefer to deliver their babies in an environment that is conducive enough for them to express their pains and worries without being chastised or intimidated. Culturally too, it is believed that the immediate environment where a child is born influences the child's early socialization (Ndene, 2006); some pregnant women therefore believe that the Traditional Birth Attendant is the only expert who could deliver their babies and give them that cultural touch and socializing effect. Owing to these enduring interactions with TBAs, women especially in the rural areas have formed a cultural pattern that do not even believe that child delivery could be successfully done in the hospital (Okpokpo, 2007).

Also, many pregnant women are discouraged by the unfriendly disposition of some nurses and other health workers in the hospital. Most women desire a show of love and encouragement which they don't often get from a bureaucratic and secondary setting such as the hospital. Owing to cultural influence, many rural women prefer to deliver under the inspection and assistance of people from their informal and cultural group, who live in the same environment, speak the same language and whom they believe will provide the best emotional and spiritual succor to them in their situation (Summer, 2005). In some societies, giving birth in the hospital attracts a lot of negative interpretation against the mother. In some cases, the pregnant woman is accused of marital unfaithfulness while in other cases, the woman is suspected to have adopted the baby since they did not witness the delivery process especially where the woman is known to have had miscarriages in the past. Also, some rural women see delivery in hospital or any other orthodox health facility as a disregard for their culture and an unnecessary show of affluence as well as a way of ridiculing those who cannot afford hospital bills. Adekoba (2002) observed that delivery under Traditional Birth Attendants attracts enormous support, love, visits and care of fellow rural folks and well wishers as well as blessings from the ancestors. Such wives are ridiculed as women who intentionally want to impoverish their husbands because of high hospital bills.

Similarly, in an unpublished study carried out to determine the causes, prevalence rate and effects of Vesico Vaginal Fistula (VVF) in January 2016, among women in Akpabuyo Local Government Area of Cross River State, Nigeria, it was gathered that a good number of pregnant women still patronized the Traditional Birth Attendants (TBAs) based on a number of reasons ranging from cultural to psychological. Some of the respondents that participated during the indepth interview emphasized their confidence in the TBAs which is built on their long years of practice and the caring attitude of the TBAs. Some pregnant women believed that most antenatal visits to hospitals usually end in caesarean session, which further prevents them from having the number of children that they desire.

This finding is collaborated by a study in Bangladesh where, all the TBAs are traditionally women and delivery by TBA is an established cultural practice. Here, the older women like the mothers and mothers-in-law in most communities strongly advocate the patronage of Traditional Birth Attendants mainly due to cultural reasons. They argue that in the modern hospital, a male doctor can be scheduled to attend to an anti-natal patient and most of these women are not very comfortable to discuss their medical issues with a male doctor. (Bidhan , Musfikur , Tawhidur , Jahangir , Laura, Reichenbach and Kumar, 2016). This argument portrays the tenacity of TBAs in healthcare and brings a predominantly Muslim community, gender phobia will be heightened because of religious doctrine and practices having interaction between a female patient and a male doctor.

In spite of the tremendous cultural, social and economic supports given by Traditional Birth Attendants in maternal and child care, there are many observed dangers that are associated with this practice.

* Some TBAs do not understand the physiology of pregnancy
* TBAs may administer herbs and roots without knowledge of their specific dosages. (Emeka 2008).
* TBAs often use unsterilized instruments.
* Some TBAs often fail to refer complicated cases to hospitals in time (Ndene, 2006).
* TBAs do not test the pregnant women to determine if they have the capacity to withstand the demands of labour (Okpokpo, 2007).
* TBAs do not carry out caesarean session, but they rather wait for delivery until avoidable complications later occur.
* Some TBAs choose to carry out their activities in isolation which could endanger the lives of women under labour (Sylvanus, 2007).

Some of these criticisms may apply specifically to the unregistered TBAs who lack trainings offered free of charge by the government to foster their role as medical help mates in rendering healthcare services in the developing countries of Africa. In other situations, trained and registered TBAs could ignore the training and referred practices expected of them to become selfishly independent in their operations.

Cultural Perspectives on Pregnancy and Child birth in Etim Ekpo

Etim Ekpo is one of the thirty-one (31) Local Government Areas of Akwa Ibom State, Nigeria. The natives of *Etim Ekpo* are predominantly petty farmers and traders. They belong to *Annang* ethnic group, one of the micro-minority groups in Nigeria. They cultivate mainly food crops such as cassava, water-yam and sweet-yam. As a patrilineal cultural group, family members look up to the father as the patriarch and custodian of inheritance to male members of the family. Both polygamous and monogamous marriages are practiced. Marriage types depend not only on the economic but religious standing of the person. That means a not-well-to-do person could marry more than one wife. In such situation, number of wives is dictated by cultural demands. To have many wives and children was a mark of high social and cultural acceptability in the olden days. A man with many wives and children was a man who did the bidding of the ancestors to enlarge the family and flourish the clan with male children particularly for inheritance and female children to multiply prosperity through marriage. In modern times, polygamous marriage tends to give way to monogamy markedly because of economic constraints.

Each family '*Ekpuk'* is protected by an ancestral shrine known as '*Iso ekpo'.* The '*Iso ekpo'* is preserved by a family high priest who makes propitiatory rites for appeasement of the ancestors. These propitiatory rites are done whenever two or three members are gathered to share in commensality of drink or food. The libation poured by the most elderly man in the gathering carries the message of the family chief priest to protect and prosper family members, and appeal to ancestral shrine - "Iso Ekpo" for the enforcement of marital morality in the *Ekpuk*. Extra marital sexual relations by married women in the family are punished supernaturally by the goddess of the shrine - *'Iso ekpo'* during child delivery (Charles, 2014). A married woman guilty of extra-marital sexual relations could die during delivery. This explains

why pregnancy period in *Annang* and *Ibibio* ethnic groups is always a period of sober reflection and atonement by women. A woman who does not confess to the husband and family members before onset of labour may meet with untimely death of both herself and the baby. In situations of this nature, the TBAs play an important role to mediate and cause the necessary ritual to be made on the pregnant woman's behalf. In short, the TBAs are the 'arbiters of last resort' in post natal period. They are those at the frontline of conflict resolution where confessions by married women under labour are made.

A wife who is unfaithful to the husband is expected by tradition guiding marriage relationship to promptly tell the husband. Since marriage is a family affair, the husband is under obligation to report the matter to the extended family where elders adjudicate . With a notice of sleeping with another man, the husband is expected to immediately withdraw every domestic affiliation and sexual relationship from the wife until propitiation rituals are performed by the head of the family. This means total ban from eating the wife's meals, sleeping on same bed or same room with her or satisfying his sexual desires with her. Failure to obey these restrictions, the husband could be tormented by "Ekpo Nka Owo" (literally, Deity of Adulterous Relationship) with a mysterious ailment that could lead to his death. Among the Ibibio and Annang of Nigeria, mortality at birth is often attributed to wife's matrimonial unfaithfulness and punitive acts of the family deity. Often times, due to shame, labeling and community gossip, women would fail to timely confess their deeds to the husband until symptoms of mysterious illness visit the husband or the children or both.

Theoretical Framework

Exchange theory is used to support the study.

The theory has the following basic principles;

(i) That "no one gives what he does not have"

(ii) The motive of actors in the exchange must be realized, satisfied and sustained.

(iii) Exchange must be voluntary. This means that an actor is free to go into an exchange and free to withdraw if unfavourable.

(iv) What is exchanged must be socially approved.

(v) Exchange involves the giving and receiving of goods or services visible or invisible. (Charles, 2014).

(vi) The question of *'Quid pro quo'* which means that each individual's expectations must be determined, ascertained and resolved before engaging in the exchange is foundational in any situation of giving and receiving.

The theory sees every human interaction, transaction and relationship as driven by the desire for benefit or to have reward. Exchange relationship is usually strengthened by gains and destroyed or weakened by disappointments, regrets and loses. According to Charles (2014), actors in an exchange situation have their individual values and expectations which they desire to be reciprocated in exchange relationship. Women in *Etim Ekpo* abhor trekking long distances, paying hospital bills, purchasing expensive drugs and facing abuses from nurses, doctors and other health workers. Their preference for Traditional Birth Attendants became an unavoidable voluntary option where they are assured of a rewarding and realistic exchange relationship where less bills are paid. Trekking for long distances is also avoided because delivery homes are nearby; they are equally assured of tender customary care and understanding under the watch of traditional health care providers.

This theory has been criticized for only recognizing human beings as seeking to display their selfish motive in every transaction and exchange while failing to provide security against the behavioural traits of partners in social exchange, since "give and take" is an indispensible characteristic of human society. It has been also blamed for its failure to acknowledge the existence of fundamental human rights and civic responsibilities as basic components of society whether there is gain or not. The theory only presents humans as rational creatures and homo-economicus only conscious of gains in a relationship

without recognizing other social components of a relationship (Charles, 2014). For instance, marriage is conceptualized by anthropologists as exchange of women where gains are made for the family of the men-husband in form of procreation, economic, domestic and or sexual services. This posture ignores that gains of marriage are two ways as women-wife also reap a higher social status and enjoy the protection of the husband, among others.

Social Learning Theory (Social Cognitive Theory)

In the theory, Albert Bandura builds upon B. F Skinner's behavioural Theories. The theory explains the effect of the social environment on the reinforcement of behaviour. The theory also posits that individuals' choices and preference are largely influenced by their contact and interaction with their social environment. In this context, individuals tend to behave in ways similar to that of the people in close contact with.

The choice of place of delivery among pregnant rural women in Akwa-Ibom State, Nigeria is often influenced by the friends, family members, neighbours, church members and so on that observe in their natural social environment. Such people often exert greater control of the younger pregnant ones among them and they become more resistant to information on modern and conventional antenatal practice.

Social workers use social learning theory to discern the significant other in each individual client's network of social relationship and also use the information to help correct possible destructive behaviour arising from such interactions and influence.

Methodology

The study adopted the survey research design. The population consisted of pregnant women, health workers and Traditional Birth Attendants (TBAs) as well as women who have experienced pregnancy for at least three times as at the time of this study in the ten wards that make up *Etim Ekpo* Local Government Area.

A sample size of two hundred and fifteen (215) respondents was selected through a combination of quota and stratified sampling methods. The quota system was done by grouping respondents in the area according to their political wards for the ease of administering of questionnaire and conducting Focus Group Discussion (FGDs) and In-depth Interviews. These instruments were adopted in order to accommodate both the literate and non-literate members of the study communities. Data gotten from respondents were analyzed using simple percentages and chi-square (χ^2) test of significance.

Findings and Discussions

Table 1: Socio-Demographic Characteristics of Respondents

Variable	No of Respondents	Percentage
Female	215	100
Total	215	100
Age	No of Respondents	Percentage
26-30	18	8.4
31-35	36	16.7
36-40	46	21.3
41-45	47	21.9
46 and above	68	31.6
Total	215	99.9%
Marriage	No of Respondents	Percentage
Married	121	56.27
Widowed	38	17.87

Divorced	19	8.83
Separated	37	17.20
Total	215	100%
Religion	No of Respondents	Percentage
Christianity	137	63.72
Traditional	52	24.18
Islam	15	6.97
Others	11	5.11
Total	215	100%
Occupation	No of Respondents	Percentage
Business	38	17.67
Farmers	98	45.58
Students	42	19.53
Civil Servant	22	10.23
Others	15	6.67
Total	215	100%

Table 1 indicates that 215 female (100%) respondents participated in the study.

Most of the respondents were above 46 years old (31.6%) followed by those between 41-45 years old (21.9%). Those between 36-40 years old were (21.3%), while those between 26-30 years old were (8.4%). The distribution also showed that, 56.27% of the respondents were married, 17.7% widows, while divorced and separated were 8.83% and 17.20% respectively. The distribution shows that 63.72% of the respondents were Christians, 24.18% practiced Traditional religion while Muslims and others were 6.97% and 5.11% respectively. The distribution also shows that (45%) of the respondents were farmers, those engaged in business were 17.67%, students were 19.53%, while civil servants made up 10.23% and others were 6.97%.

Table 2: Which birth delivery option do pregnant women prefer?

Variable	No of Respondents	Percentage
TBAs	190	88.37
Hospital/Health Centers	25	11.63
Total	215	100%

Is health care bill a major reason why pregnant women prefer Traditional Birth Attendants (TBAs) to modern Health facilities (Hospital/Health Centers?)

Variable	No of Respondents	Percentage
Yes	198	92.09
No	17	7.90
Total	215	100%

Do you feel women are discouraged by the quality of health services rendered by health workers in the area?

Variable	No of Respondents	Percentage
Yes	168	78.13
No	47	28.86
Total	215	100%

Do you think pregnant women are discouraged by lack of availability of medical facilities in the various health institutions in the area?

Variable	No of Respondents	Percentage
Yes	179	83.25%
No	36	16.75%
Total	215	100%

Do you feel there is a relationship between financial demands/expectations of hospital/health Centers and preference for child delivery under birth attendants

Reponses	Pregnant Women	Those who have delivered	Total
Yes	120	79	199
No	11	5	16
Total	131	84	215

Do you think there is relationship between the availability of medical facilities in hospital/health Center and child delivery preference under Traditional Birth Attendants

Reponses	Pregnant Women	Women with 3 children before the study	Total
Yes	103	87	190
No	5	20	25
Total	108	107	215

Table 2 shows that 190 respondents which represent 88.37 of the sampled population believe that the pregnant women prefer the services of TBAs to Hospitals or Health Centers. Only 17 (7.90%) of respondents said that health care bill was not a major reason that pregnant women prefer Traditional Birth Attendants (TBAs) to delivery in the Hospital. A total of 198 respondents (92.09%) however answered affirmatively that pregnant women prefer Traditional Birth Attendants (TBAs) to delivery in the Hospital because of health care bill or money spent during pregnancy and delivery.

Greater proportion of the respondents (83.25%) asserted that pregnant women are discouraged by lack of availability of health facilities in the various health institutions.

The calculated (χ^2) value = 79.97

(2-1) (2-1) = 1 x 1 = 1 = 3.841

The calculated (χ^2) value (76.74) is greater than the table (χ^2) value.

The statistical outcome reveals that there is a significant relationship between financial demands on pregnant women in health facilities and child delivery under the TBAs in *Etim Ekpo* Local Government Area. The research indicated that most women in *Etim Ekpo* Local Government Area were unable to make use of modern medical facilities as a result of their inability to shoulder the financial demands in the modern health facilities in the area. During an FGD session with the women, it was revealed that lack of money was the principal cause of their patronage of the Traditional Birth Attendants. According to them, there is nothing we can do than go to the Traditional Birth Attendants, they do not charge much, besides they always attend to us even without any deposit, they save the situation first before taking about money. Also, we always negotiate what to pay, but in the hospital, it is not like that, and they (TBAs) are nearer to us.

Similar responses from other women interviewed tended to corroborate this view. The amount of money paid to TBAs was generally very minimal compared to orthodox health facility. Deferred payment was also tolerated as long as few consumables for delivery were available for use during labour. Generally TBAs were after safe delivery of their clients so as to promote clientship in the community. They saw themselves as though they were always in a remedial and emergency mission for their clients.

The calculated (χ^2) value = 29.10

Level of significance = 0.05

(2-1) (2-1) = 1 x 1 = 1 = 3.841

The calculated (χ^2) value (29.10) is greater than the table (χ^2) value. The statistical calculation showed that there is a significant relationship between the quality of medical facilities and child delivery under TBAs. During the Focus Group Discussion, women lamented, *"Though we have health centers, there are not enough qualified staff and other facilities that would encourage us. At times you may go there, no nurses, only auxiliaries, so that is the situation".* This means that pregnant women patronize TBAs because of the absence or inadequate number of medical personnel at the various health posts at the time of need, whereas TBAs are always available to attend to their health problems as and when need arises. This situation is a further confirmation that government tends to pay more attention to health facilities and health care of urban people above the health needs of rural dwellers. This result also portrays the general reluctance and inertia by health workers to work in rural areas where there is lack of modern infrastructure and reasonably furnished accommodation.

Table 4: Would you say that the attitude of health workers towards pregnant women in child delivery under encourage patronage of Traditional Birth Attendants in this community

Reponses	Pregnant Women	Women with 3 children before the study	Total
Yes	150	20	170
No	40	5	45
Total	190	25	215

χ^2 = 4.23
Level of significance = 0.05
(2-1) (2-1) = 1 x 1; χ = 3.841

The calculated (χ^2) value (4.23) is greater than the table (χ^2) value. The result of the statistical calculation shows that there is a significant relationship between the attitude of nurses towards pregnant women and the choice of child delivery under TBAs. A 46 year mother during the in-depth interview revealed that nurses are always hostile and indifferent to the plight of pregnant women, and that pregnant women are always subjected to undue humiliation and harsh treatment. For an effective practice, health workers especially nurses need to show empathy and tolerance towards pregnant women in order to encourage women to visit the healthcare facilities provided by the government in line with the health policy of the Government under the Millennium Development Goals (MDG). Pregnant women were eager to experience improved standard of medical facilities as well as the promotion of empathetic attitude of nurses to pregnant women who seek their services in rural areas.

Discussion, Conclusion and Recommendation

According to the findings, most of women who participated in reported that hospital bill is a major cause of their preference to deliver in TBAs over hospital facilities. Most of the rural women sampled believed that hospital bill is a major barrier that hinders them from seeking antenatal services in hospital facilities whereas the Traditional Birth Attendants who are mostly fellow rural residents usually provide same antenatal services almost at no cost.

Also, there are cultural inhibitions that promote the patronage of TBA and minimize the utilizations of hospital; facilities by pregnant women. This is connected to the fact that both men and women attend to pregnant women in hospital facilities while in TBAs antenatal services are provided by women who are often familiar with these pregnant women. However, delivery at TBAs is associated with high risk of complications and this study recommends that rural women should be educated to insist on utilization of institutional facilities for The their antenatal care.

The study concludes that Traditional Birth Attendants (TBAs) still enjoy considerable patronage from rural women in Nigeria even in the face of modern healthcare system. High medical bills and the unfriendly disposition of health workers in many modern health care facilities account for the major reasons for choice of TBAs as revealed in the study. The sampled respondents reported high and often nonnegotiable hospital bills as a major consideration frustrating seeking ante-natal care in modern health facilities. Pregnant women tended to prefer the services of Traditional Birth Attendants whose charges were more considerate and affordable. Furthermore, the women believed that healthcare personnel in modern health facilities were usually too formal and hostile in their approach to ante-natal care and relationship with their patients. This is a major source of discouragement for rural women whose pregnant condition and vagaries of rural area were already enough burdens for them. Therefore, it is recommended that the government and other organizations should create special intervention to further empower rural women by increasing their economic capacity to enable them afford modern medical services. Government should also provide free medical services to pregnant women especially in the rural areas to enable them access improved healthcare services. Such policy which may already exist in theory as a political tool for patronage should be made to have foundational backing and legal/administrative enforcement. Adequate empathy training should be given to the health workers in the hospitals and health centers to forge patient's confidence in their ability to care for them and attend to their needs in pregnancy. Incorporating the TBAs into the mainstream of medical practice should also be considered especially enlisting their services in the health centres and other rural medical facilities. The existing health centres should be integratively upgraded to attract some TBAs in rural areas through workshops and seminars as partners in ante-natal health care.

The findings made in the study strengthen the need for skilled resident social workers to become integral part of the healthcare team in all healthcare facilities in both rural and urban centres in Akwa Ibom State, Nigeria. Social workers apply competence in dealing with clients in diverse social and cultural formations. Through appropriate case work interventions strategies, the social worker creates a unique relationship with each client which enables him to gain client's confidence. Social workers in healthcare practice setting should identify the clusters of pregnant women and conduct group counseling using empathic communication skills. This process will enable the social worker to most effectively apply the enabler role in his intervention strategies by exploring each pregnant mother's social situation and the most effective strategy to adopt.

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