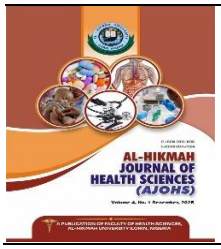
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Original Article

Traditional Birth Attendant Patronage, Spousal Decision-Making and Religious Beliefs in Relation to Maternal Healthcare-Seeking Behaviour in Asa Local Government Area, Kwara State, Nigeria

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ABSTRACT

Introduction: Cultural factors influence the use of maternal health services in Nigeria. This study examined traditional birth attendant (TBA) patronage, spousal and family decision-making, and religious beliefs in relation to maternal healthcare-seeking among women of reproductive age in Asa Local Government Area (LGA), Kwara State, Nigeria.

Methodology: A descriptive cross-sectional survey of 384 women aged 15–49 years used a structured four-point Likert questionnaire and multistage sampling, combining purposive and random selection, in five communities. Data were analysed using descriptive statistics, chi-square tests and one-sample t-tests against 2.50 ($\alpha = 0.05$).

Results: Formal service use was 49.8% among women with high TBA patronage versus 85.0% with low patronage ($\chi^2(1) = 51.65$, $p < 0.001$), and formal care-seeking was 50.6% under high versus 86.9% under low spousal/family control ($\chi^2(1) = 53.32$, $p < 0.001$). Religious belief items had a grand mean of 3.11; every item exceeded 2.50 ($p < 0.001$), highest for religious leaders' guidance (3.30). Association with care-seeking was not tested for religious beliefs.

Conclusion: High TBA patronage and strong spousal/family control were significantly associated with lower formal care use, and respondents largely agreed that religious beliefs influence care-seeking. TBA integration, male partner engagement and religious leader engagement are recommended.

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Introduction

Nigeria carries the world's largest burden of maternal deaths, with an estimated 82,000 in 2020, about 28.5% of the global total (World Health Organization et al., 2023). Haemorrhage, hypertensive disorders and sepsis are leading causes of maternal death worldwide (Say *et al.*, 2014). Maternal healthcare covers care from pre-conception through pregnancy, childbirth and the postnatal period and aims to prevent maternal and neonatal morbidity and mortality through skilled care (World Health Organization, 2016). Despite investments in skilled birth attendance, primary health care and antenatal care, maternal mortality in Nigeria remains very high, which suggests that demand-side cultural barriers also need attention (Opara et al., 2024).

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Patronage of traditional birth attendants (TBAs) is a prominent cultural factor in the use of maternal health services. Ntoimo et al. (2022) examined why women in rural Nigeria use traditional rather than skilled birth attendants, and Akeju et al. (2016) reported that women in Ogun State used multiple caregivers in pregnancy, preferring traditional providers, while high cost deterred care-seeking.

Household decision-making is a second cultural determinant. Akeju *et al.* (2016) reported that patriarchal structures influenced care-seeking in pregnancy in Ogun State, and in Kogi State husbands and other relatives were reported to decide whether, when and where women seek facility care, sometimes delaying emergency care (Opara et al., 2024). Interventions that involve men have been reviewed systematically (Tokhi et al., 2018).

Religious and spiritual beliefs are a third cultural dimension. In Kogi State, women described dependence on God as influencing, and prayer houses as limiting, their use of facility care (Opara et al., 2024). Al-Mujtaba et al. (2016) evaluated religious influences on maternal health service use among Muslim and Christian women in North-Central Nigeria.

The Health Belief Model (Rosenstock, 1966; Becker, 1974) is relevant because women's decisions to attend antenatal care, deliver in a facility, or seek traditional or spiritual care depend on perceived susceptibility to and severity of complications and on beliefs about the benefits and risks of each option.

Evidence on how these cultural practices jointly influence maternal healthcare-seeking in Asa LGA is scarce, which limits culturally appropriate, evidence-based planning by the Kwara State Ministry of Health and the Asa LGA health authority. This study therefore examined the association between TBA patronage and use of formal maternal health services, the association between spousal and family decision-making and maternal healthcare-seeking, and the influence of religious and spiritual beliefs on maternal healthcare-seeking among women of reproductive age in Asa LGA.

Research Methodology

Research Design

The study used a descriptive cross-sectional survey design, which allows data to be collected and analysed at a single point in time to describe variables and examine relationships between them without influencing the study environment (Setia, 2016).

Population of the Study

The target population was women of reproductive age (15–49 years) who had lived in the selected communities in Asa LGA of Kwara State for at least six months before the study. The population of women of childbearing age in Asa LGA was estimated at about 90,000 on the basis of National Population Commission projections.

Sample Size and Sampling Techniques

The minimum sample size of 384 was determined using Cochran's (1977) formula for large populations (95% confidence level, Z = 1.96; assumed proportion 0.50; margin of error 0.05). A multistage procedure combining purposive and probability selection was used, so it was not a fully random multistage design. In the first stage, Asa LGA was purposively selected. In the second, five communities (Alapa, Onire, Otte, Oloje and Laduba) were purposively selected with the Asa LGA Health Authority and community leaders to cover semi-urban and peri-urban settings and variation in TBA use, socioeconomic composition and cultural practice. In the third, households were chosen by simple random sampling and one eligible, consenting woman was recruited per selected household.

Research Instrument

The data collection instrument was a structured, researcher-designed questionnaire titled the Cultural Practices and Maternal Healthcare-Seeking Behaviour Questionnaire (CPMHSBQ). It had a socio-demographic section and five subsections related to the study objectives. Attitudinal and perception items were scored on a four-point Likert scale (Strongly Agree = 4, Agree = 3, Disagree = 2, Strongly Disagree = 1).

Validity of the Instrument

Face and content validity were established by a panel of three academic experts in the Department of Public Health, Al-Hikmah University, Ilorin, who reviewed each item for relevance, clarity, cultural appropriateness and comprehensiveness with respect to the study objectives. A content validity index (CVI) was computed, and items with CVI values below 0.78 were revised or replaced (Polit & Beck, 2021; Taherdoost, 2016).

Reliability of the Instrument

Reliability was assessed in a pilot study of 16 women of reproductive age in Ilorin East LGA, which has demographic, socioeconomic and cultural characteristics similar to the study area. Internal consistency was determined using Cronbach's alpha (Tavakol & Dennick, 2011), which was 0.82, indicating satisfactory reliability.

Method of Data Analysis

Data were coded, entered, cleaned and analysed using SPSS version 27.0. Frequencies, percentages, means and standard deviations summarised socio-demographic characteristics and answered the research questions; item means of 2.50 or above (the

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scale midpoint, (4 + 3 + 2 + 1)/4) were interpreted as agreement. For the chi-square analyses, TBA patronage and spousal/family control were each dichotomised into 'high' and 'low' using 2.50 benchmark. The hypotheses were: H01, no significant relationship between TBA patronage and utilisation of formal maternal health services; H02, no significant relationship between spousal and family decision-making patterns and maternal healthcare-seeking; and H03, religious and spiritual beliefs do not significantly influence maternal healthcare-seeking decisions (item mean = 2.50). H01 and H02 were tested using Pearson's chi-square test after confirming that expected cell counts exceeded 5 (Field, 2018), with the phi coefficient and odds ratios as effect sizes; H03 was tested with two-tailed one-sample t-tests of each item against 2.50. The significance level was 0.05.

Ethical Consideration

The study followed the Declaration of Helsinki. Ethical approval was obtained from the Faculty of Basic Medical Science Ethics Review Committee (FBMS-ERC) of Al-Hikmah University, Ilorin, Nigeria (approval ID: HUI/FBMS/ERC/2026/01/002; approval period: 27 September 2026 to 26 September 2027). Permission was also obtained from community leaders and the Asa LGA Health Authority. Participants received written information on the purpose, procedures, voluntary nature of the study and their right to withdraw without consequence, and informed consent was obtained from all participants, with verbal explanation for those who could not read. Questionnaires were anonymised with unique codes, and data were stored securely.

Results

Demographic Characteristics of Respondents

Table 1: Demographic Characteristics of Respondents (N = 384)

Variable	Category	Frequency (%)
Age (years)	15-19	22 (5.7%)
	20-24	68 (17.7%)
	25-29	97 (25.3%)
	30-34	89 (23.2%)
	35-39	63 (16.4%)
	40-49	45 (11.7%)
Marital Status	Single	52 (13.5%)
	Married	278 (72.4%)
	Divorced/Separated	18 (4.7%)
	Widowed	36 (9.4%)
Highest Level of Education	No formal education	74 (19.3%)
	Primary education	96 (25.0%)
	Secondary education	131 (34.1%)
	Tertiary education	83 (21.6%)
Occupation	Unemployed/Housewife	128 (33.3%)
	Self-employed/Trader	112 (29.2%)
	Civil/Public servant	59 (15.4%)
	Private sector employee	48 (12.5%)
	Student	37 (9.6%)
Parity	None	61 (15.9%)
	1-2	118 (30.7%)
	3-4	134 (34.9%)
	5 and above	71 (18.5%)

Table 1 shows that the largest age groups were 25–29 years (25.3%) and 30–34 years (23.2%). Most respondents were married (72.4%), 34.1% had completed secondary education, 33.3% were unemployed or housewives, and 53.4% had a parity of three or more.

Research Question One: How does traditional birth attendant patronage affect the utilisation of formal maternal health services among women of reproductive age in Asa LGA?

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Table 2: Descriptive Statistics of Traditional Birth Attendant Patronage and Utilisation of Formal Maternal Health Services

Item	SA	A	D	SD	Mean	S.D.
Women in my community prefer to deliver with a TBA rather than at a formal health facility.	161 (41.9%)	178 (46.4%)	31 (8.1%)	14 (3.6%)	3.27	0.76
TBAs in my community are trusted because of their cultural familiarity and social proximity.	194 (50.5%)	159 (41.4%)	22 (5.7%)	9 (2.3%)	3.40	0.70
The affordability of TBA services compared to formal facilities makes women prefer TBA-assisted delivery.	207 (53.9%)	143 (37.2%)	24 (6.3%)	10 (2.6%)	3.42	0.73
TBAs in my community are believed to possess spiritual competence that protects mothers and newborns.	138 (35.9%)	163 (42.4%)	58 (15.1%)	25 (6.5%)	3.08	0.88
Women who deliver with TBAs are more likely to experience complications such as excessive bleeding or infections.	117 (30.5%)	148 (38.5%)	74 (19.3%)	45 (11.7%)	2.88	0.98
Grand Mean					**3.21**	**0.81**

SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree; S.D. = standard deviation (grand S.D. = mean of the item S.D.s). Decision mean = 2.50.

Table 2 shows that respondents generally agreed with the statements on TBA patronage (grand mean = 3.21; every item significantly above 2.50, $p < 0.001$). Affordability of TBA services had the highest mean (3.42), followed by trust based on cultural familiarity (3.40), indicating that economic and cultural factors both reinforce preference for TBA-assisted care.

H_{01}: There is no significant relationship between traditional birth attendant patronage and the utilisation of formal maternal health services among women of reproductive age in Asa LGA.

Table 3: Chi-Square Test of Independence for TBA Patronage and Utilisation of Formal Maternal Health Services

TBA Patronage Level	Uses Formal Services n(%)	Does Not Use n(%)	Total	χ^2 / p-value
High TBA Patronage (n=217)	108 (49.8%)	109 (50.2%)	217	$\chi^2(1) = 51.65$, $p < .001$, $\varphi = 0.37$
Low TBA Patronage (n=167)	142 (85.0%)	25 (15.0%)	167	
Total	**250 (65.1%)**	**134 (34.9%)**	**384**	

There was a statistically significant association between TBA patronage and use of formal maternal health services, $\chi^2(1) = 51.65$, $p < .001$, $\varphi = 0.37$. Only 49.8% of women with high TBA patronage used formal services, compared with 85.0% of those with low patronage (odds ratio for use with low versus high patronage = 5.73, 95% CI 3.47–9.47). H01 is therefore rejected: high TBA patronage was significantly associated with lower formal service utilisation.

Research Question Two: To what extent do spousal and family decision-making patterns influence maternal healthcare-seeking behaviour among women of reproductive age in Asa LGA?

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Table 4: Descriptive Statistics of Spousal and Family Decision-Making Patterns and Maternal Healthcare-Seeking Behaviour

Item	SA	A	D	SD	Mean	S.D.
Women in my community require their husband's permission before attending antenatal care or seeking delivery care.	198 (51.6%)	152 (39.6%)	24 (6.3%)	10 (2.6%)	3.40	0.72
Mothers-in-law or elder female relatives significantly influence women's choices about delivery location.	172 (44.8%)	163 (42.4%)	35 (9.1%)	14 (3.6%)	3.28	0.78
Husbands or male relatives are the primary decision-makers regarding where a woman delivers her baby.	181 (47.1%)	157 (40.9%)	29 (7.6%)	17 (4.4%)	3.31	0.79
Women often experience delays in reaching health facilities because they must wait for a family member's approval.	189 (49.2%)	148 (38.5%)	33 (8.6%)	14 (3.6%)	3.33	0.78
The need for spousal consent before seeking emergency obstetric care has resulted in preventable maternal complications or deaths.	156 (40.6%)	162 (42.2%)	44 (11.5%)	22 (5.7%)	3.18	0.85
Grand Mean					**3.30**	**0.79**

SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree; S.D. = standard deviation (grand S.D. = mean of the item S.D.s). Decision mean = 2.50.

Respondents generally agreed with statements on spousal and family decision-making (grand mean = 3.30; every item significantly above 2.50, $p < 0.001$), indicating that husbands' and family members' decisions are perceived to influence maternal healthcare-seeking in Asa LGA.

H_{02}: There is no significant relationship between spousal and family decision-making patterns and maternal healthcare-seeking behaviour among women of reproductive age in Asa LGA.

Table 5: Chi-Square Test of Independence for Spousal and Family Decision-Making Patterns and Maternal Healthcare-Seeking Behaviour

Decision-Making Authority	Seeks Formal Care n(%)	Does Not Seek n(%)	Total	χ^2 / p-value
High Spousal/Family Control (n=231)	117 (50.6%)	114 (49.4%)	231	$\chi^2(1) = 53.32$, $p < .001$, $\varphi = 0.37$
Low Spousal/Family Control (n=153)	133 (86.9%)	20 (13.1%)	153	
Total	**250 (65.1%)**	**134 (34.9%)**	**384**	

Table 5 shows a statistically significant association between spousal and family decision-making control and formal care-seeking, $\chi^2(1) = 53.32$, $p < .001$, $\varphi = 0.37$. Only 50.6% of women under high spousal and family control sought formal care, compared with 86.9% under low control (odds ratio for seeking care with low versus high control = 6.48, 95% CI 3.79–11.08). H02 is therefore rejected: high spousal and family control was significantly associated with lower formal healthcare-seeking.

Research Question Three: How do religious and spiritual beliefs shape the maternal healthcare-seeking decisions of women of reproductive age in Asa LGA?

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Table 6: Descriptive Statistics of Perceptions of the Role of Religious and Spiritual Beliefs in Maternal Healthcare-Seeking Decisions

Item	SA	A	D	SD	Mean	S.D.
Religious beliefs encourage women to rely on prayer and faith rather than seeking formal medical care during obstetric emergencies.	147 (38.3%)	162 (42.2%)	52 (13.5%)	23 (6.0%)	3.13	0.86
Fatalistic beliefs that pregnancy outcome is entirely determined by God discourage women from attending antenatal care.	139 (36.2%)	158 (41.1%)	61 (15.9%)	26 (6.8%)	3.07	0.89
Islamic or Christian teachings in my community are interpreted to discourage the use of formal maternal health services.	108 (28.1%)	143 (37.2%)	89 (23.2%)	44 (11.5%)	2.82	0.97
Local religious leaders' guidance significantly influences women's decisions to attend formal health facilities or seek traditional care.	176 (45.8%)	161 (41.9%)	32 (8.3%)	15 (3.9%)	3.30	0.78
Women who attribute obstetric danger signs to spiritual attacks tend to seek spiritual healing before accessing formal care.	163 (42.4%)	158 (41.1%)	43 (11.2%)	20 (5.2%)	3.21	0.84
Grand Mean					**3.11**	**0.87**

SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree; S.D. = standard deviation (grand S.D. = mean of the item S.D.s). Decision mean = 2.50.

The grand mean for Research Question Three was 3.11, indicating general agreement that religious and spiritual beliefs influence maternal healthcare-seeking decisions. Local religious leaders' guidance had the highest mean (3.30; 87.8% agreement) across the three domains, and attribution of obstetric danger signs to spiritual attack, followed by spiritual help-seeking before formal care (3.21), points to a pathway that may delay emergency obstetric care. Table 7 shows that every item mean was significantly above 2.50 (all $p < 0.001$), so H03 is rejected at the item level. These tests show agreement above the scale midpoint, not an association with actual care-seeking behaviour.

Table 7: One-Sample t-Tests of Religious and Spiritual Belief Items against the Criterion Mean (2.50)

Item	Mean	S.D.	t	p	95% CI
Religious beliefs encourage reliance on prayer and faith rather than formal care in emergencies	3.13	0.86	14.26	< 0.001	3.04–3.21
Fatalistic beliefs discourage antenatal care attendance	3.07	0.89	12.52	< 0.001	2.98–3.16
Religious teachings interpreted to discourage formal maternal services	2.82	0.97	6.47	< 0.001	2.72–2.92
Religious leaders' guidance influences decisions to use facilities or traditional care	3.30	0.78	19.97	< 0.001	3.22–3.38
Obstetric danger signs attributed to spiritual attack; spiritual healing sought first	3.21	0.84	16.55	< 0.001	3.12–3.29

Decision mean = 2.50. S.D. = standard deviation; CI = confidence interval of the item mean; df = 383.

Discussion

Patronage of TBAs was significantly associated with lower use of formal maternal health services in Asa LGA. Akeju et al. (2016) similarly found that women in Ogun State preferred traditional providers and that high cost deterred care-seeking, consistent with affordability having the highest mean (3.42) here; Ntoimo et al. (2022) also examined why rural Nigerian women use traditional rather than skilled birth attendants. The 35-percentage-point gap between women with high (49.8%) and low (85.0%) patronage shows the size of the utilisation gap, but the design is cross-sectional, so this is an association and not evidence of causation.

Spousal and family decision-making was significantly associated with formal healthcare-seeking: 50.6% of women under high control sought formal care, compared with 86.9% under low control. This agrees with Akeju et al. (2016), who found that patriarchal structures influenced care-seeking in pregnancy, and with Opara et al. (2024), who reported that husbands and other relatives, including the woman's own family,

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could decide whether and when women seek facility care, delaying emergency access.

Respondents agreed that religious and spiritual beliefs influence maternal healthcare-seeking, with religious leaders' guidance the highest-rated item. Opara et al. (2024) reported that prayer houses limited the use of facility care and that dependence on God influenced women's approach to it, whereas prayers from pastors and imams were described as supportive without clearly enhancing or limiting facility use. The influence attributed here to religious leaders supports engaging them in maternal health messaging. Attributing danger signs to spiritual attack and seeking spiritual help first is concerning because such delays can be life-threatening. These findings are descriptive; association with care-seeking behaviour was not tested.

Conclusion

This study concludes that TBA patronage and strong spousal and family decision-making control are significantly associated with lower use of formal maternal healthcare in Asa LGA, and that affordability and cultural familiarity are the aspects of TBA care most strongly endorsed. Respondents largely agreed that religious and spiritual beliefs influence maternal healthcare-seeking and that local religious leaders are the most influential source of guidance, although this domain was assessed descriptively and not for association with care-seeking.

Recommendations

The following recommendations are made on the basis of the findings:

- The Kwara State Government should consider a structured programme that engages TBAs as community-level maternal health promoters and referral agents, without delivery management, rather than a blanket elimination programme.
- The Asa LGA Primary Health Care Authority should organise community dialogues with male household heads and elder female relatives on supporting antenatal care, facility-based delivery and prompt emergency obstetric care.
- The Asa LGA Health Authority should work with Islamic scholars, Christian pastors and traditional religious leaders to develop messages supporting formal maternal health service use within a religious context.
- Community health workers and ward-level health promotion officers should provide culturally specific education on the delays caused by attributing obstetric danger signs to spiritual causes, in partnership with religious leaders.

Limitations of the Study

The study covered five purposively selected communities in Asa LGA, so findings may not be generalisable and purposive selection may introduce selection bias. The cross-sectional design does not permit causal inference, and the chi-square analyses were unadjusted for confounders such as education, income and parity. Dichotomising composite scores loses information and the results depend on the cut-off used. Religious beliefs were assessed descriptively, with item-level tests against the scale midpoint only. Self-reported data from a researcher-designed questionnaire may be affected by social-desirability bias, especially on spousal authority and religion.

Conflict of Interest

None encountered.

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