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Building Bridges and Exploring the Role of Traditional Birth Attendants in Community-Based Health Systems

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Abstract

Traditional Birth Attendants (TBAs) remain central to maternal and newborn care in many low- and middle-income countries, particularly in rural and underserved settings where skilled birth attendants and functional facilities are limited. In Nigeria, high fertility, rapid population growth, and persistent health system constraints intersect with an unacceptably high maternal mortality burden, reinforcing reliance on TBAs as culturally trusted, accessible, and affordable providers. This paper explores the evolution, roles, and cultural significance of TBAs and examines how their structured integration into community-based health systems can strengthen maternal and child health outcomes. Drawing on empirical and policy literature, the paper synthesises evidence that, when appropriately trained and supervised, TBAs can improve health promotion, facilitate earlier recognition of danger signs, increase timely referrals, and strengthen linkages between households and formal services. It further argues that exclusion of TBAs sustains fragmented care pathways, erodes community trust in formal interventions, and contributes to preventable maternal and neonatal deaths. The paper concludes that pragmatic integration anchored in role clarity, referral systems, supportive supervision, culturally competent collaboration, and enabling policy frameworks offers a context-sensitive pathway for advancing equitable maternal health and accelerating progress toward Sustainable Development Goal 3.

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Introduction

Traditional Birth Attendants (TBAs) have long played a central role in the provision of maternal and child health care especially in low-resource settings where access to skilled birth attendants has been poor. Across many low and middle-income countries (LMICs), TBAs are the first and sometimes the only person whom women will meet during the pregnancy period, childbirth period, and the postnatal period. Despite sustained, global, and national efforts to increase access to skilled birth attendance and to integrate TBAs in formal health systems, significant challenges remain in ensuring quality, safe, and effective maternal care. Traditional birth attendant is an individual who assists a woman during childbirth and whose skills are based on personal experience or apprenticeship and not formal medical education. Variations exist within this group, including family TBAs designated in extended families, trained TBAs who have short-term instruction from the modern health sector, and those who go through more extensive training of six months to one year and may in turn work as primary healthcare workers. While some people may occasionally help at deliveries, those called upon on a regular basis and recognised by their communities are the sole ones considered as TBAs. These distinctions illustrate the range in the diversity of practice within the TBA's field, and the range in exposure to formal healthcare standards.

Commonly, TBAs are trained in providing a variety of reproductive health services including: antenatal care, labour assistance and delivery, infertility treatment, treatment of threatening abortion, circumcision etc. Their services are highly preferred for more than just the reasons of availability. Women frequently have access, cost, cultural sensitivity, ease, and the freedom to assume traditional birthing positions as key motivations for patronage (Akute et al., 2023). These characteristics are especially relevant in rural and peri-urban areas, where health facilities can be far away, ill-equipped or where financial costs are prohibitive. As a result, TBAs play an integral and trusted role that is socially embedded and for which the formal healthcare systems have sensitive difficulty in replicating.

Nigeria is a best-known example of the setting where TBAs are still indispensable. Being the most populous nation on the continent with an estimated population of about 230 million and a fertility rate of 4.942 births per woman, Nigeria is a demographic and health priority in Africa (Macrotrends, 2025; Ministry of Foreign Affairs, 2025; National Bureau of Statistics, 2025). The country's rapid population growth, as well as significant socio-economic disparity, puts an enormous strain on a beleaguered health system. Globally, around 287,000 women died during and after childbirth in 2020, with 95% of them taking place in LMICs. Together sub-Saharan Africa and Southern Asia experienced 87% of these maternal deaths; setting aside that most were preventable (WHO, 2024). In 2024, maternal mortality in LMICs was found to be 430 per 100,000 live births compared with 13 in high-quality countries from 100,000 live births this reveals a profound inequality on access to quality care.

Nigeria shares an inordinate amount of this burden. According to the categorisation of countries by maternal mortality ratio (MMR) by the World Health Organization, Nigeria belongs to countries with extremely high maternal mortality rate (>1,000 deaths per 100,000 live births). Alongside South Sudan and Chad, Nigeria also saw an alarming increase in MMR, which went from 917 in 2017, to 1047 per 100,000 live births in 2020 (representing 14% increase in MMR), according to WHO (2023). This trend is very different from global commitments under Sustainable Development Goal 3, which aims to cut global MMR to under 70 per 100,000 live births by 2030. Although the global MMR has declined to 223/100,000 live births in 2020, to achieve the SDG target, there is need for an accelerated and context-sensitive interventions with an annual reduction rate of 11.6%, the implication being the need to act swiftly (Ekwuazi et al., 2023; Raina et al., 2023).

Maternal mortality is therefore a high priority as a public health issue with many countries (more than 45) still having high MMRs and slow progress achieved towards SDG 3 (notably, rather uneven). In response, renewed discussions have arisen of reorienting the safe

motherhood agenda. The World Health Organization regularly cites the scaling up of trained and educated personnel to support women during the antenatal, delivery, and postnatal periods as one of the pillars of a successful maternal health strategy (WHO, 2015; Kassie et al., 2022). Within this context the concept of incorporating the role of TBAs into the formal healthcare system has emerged as a key issue, especially in developing countries where there are shortages of health workers to address this problem.

The integration of TBAs into national health systems has a number of strategic advantages. TBAs are deeply embedded in the communities they live in with well-established trust and cultural legitimacy. Despite the absence of formal education and biomedical qualifications, they do have close relationships with women and families and are therefore powerful actors in maternal health behaviour (Smith, 2016; Aziato & Omeny, 2018). Their closeness to one another helps them to surmount logistical problems which often restrict skilled birth attendants from being available to women, such as high transportation costs, challenging terrain and scattered rural settlements (Kassie et al., 2022). In Nigeria, TBAs practice mostly as either faith-based practitioners, who work in mission houses, or private practitioners who manage delivery centres within or close to their homes and in some cases, deliver babies at home. These structures are, in turn, indicative of both cultural embeddedness and adaptive responses to scratches in the formal service provision.

Increasing empirical evidence is convincing of strategic engagement of TBAs. Studies show that targeted training and supportive interventions can help improve maternal and neonatal outcomes and reduce perinatal, neonatal and maternal mortality (Lassi et al., 2016). In many rural African settings, 60%-90% of women still use TBAs to deliver their babies and this underlines the continued relevance and reach of such facilities (Byrne & Morgan, 2011; Kassie et al., 2022). Their intimate knowledge of their communities allows them to serve well as intermediaries between households and health systems, to support referrals, foster health-seeking behaviour and strength trust in formal services (Nasir et al., 2020; Ngunyulu et al., 2020). There is evidence to further suggest that the integration of TBAs within health systems can increase rates of skilled birth attendance and therefore strengthen the continuum of care (Vierra, 2012).

Despite these potentials, major concerns with the services provided by TBAs abound because of their limited formal medical training and implications for the safety of their services with regard to maternal and neonatal outcomes. Globally about 295,000 women died in 2017 from pregnancy-related complications. Sub-Saharan Africa bears the brunt of the burden with close to two-thirds of these women dying in this geographical area (WHO, 2019). Shortage of skilled birth attendants, underground cultural values and financial constraints continue the reliance on TBAs, but unregulated practice and insufficient clinical competencies are threatening. This tension between access and safety highlights the complexity of intervention approaches in maternal health in LMICs.

Against this background, the present study is located at the Finnish space on the interaction of nursing, public health, and community development. It aims to analyse the role of TBAs in reducing moms and newborns death and identify pathways for boosting their contributions through DX based policy recommendations as well as community engagement strategies. By interrogation of the realities of TBA practice in high burden contexts such as Nigeria, the study accomplishes the need for pragmatic and culturally located feasible and scalable practices towards optimal maternal mortality reduction. In so doing, it promotes a subtle understanding of how the traditional and formal healthcare systems can be aligned to hasten progress towards equitable and sustainable maternal health outcomes.

Evolution, Roles, and Cultural Significance of Traditional Birth Attendants

Traditional Birth Attendants (TBAs) predates the existence of the modern biomedical systems and have been the mainstay of maternal care in many societies in the past. As early

as the 1950s, TBAs and powerful male figures were recognized as key players in maternal health outcomes in developing countries, especially because of highly entrenched cultural beliefs, norms, and practices that surrounded pregnancy and childbirth (Mullany et al., 2007; WHO, 2012). In these contexts, childbirth meant more than a biomedical event and it was viewed instead as a social and spiritual process that was situated within a communal life. TBAs grew out of the community and learned their trade from their own experiences and apprenticeship and were given the responsibility of protecting women during one of the most vulnerable periods in a woman's life.

Recognising their ubiquity and influence, the World Health Organization in the early part of the 1960s actively promoted the provision of adequate and appropriate training for TBAs in the developing countries. This policy orientation was a pragmatic recognition of a shortage of the health workforce and rural and underserved health care realities. By the 1990s, around 85% of developing countries had some type of collaboration with TBAs (Fleming, 1994). During this time, TBAs were extensively trained in basic obstetric skills, hygiene and referral practices, and were seen as key forces in the field of maternal health programmes. However, as the global attention increasingly shifted to the prevention of maternal mortality through the use of emergency obstetric care, there was a shift in policy focus towards the promotion of skilled birth attendants, health professionals with formal competencies in midwifery, and the ability to manage obstetric emergencies (Kruske, 2004).

By the late 1990s, a new societal consensus was emerging within global leadership in maternal and child health regarding TBAs, such that rather than training them to conduct deliveries, TBAs had to be reoriented to their role as advocates for care at facilities. This was a major shift of policy based on evidence that skilled attendance and institutional delivery were more effective in reducing maternal deaths. Despite this shift, TBAs have been very much rooted in many communities in developing countries and have maintained their foothold thanks to cultural legitimacy, spiritual authority, financial accessibility, and constant availability. Their persistence is also strengthened by structural determinants such as poverty, low female education, and low female empowerment all of which continue to limit access to formal healthcare, and promote the use of TBAs as the primary maternal caregiver (Garces et al., 2019).

As we see with Nigeria the changing role and place of TBAs reflects this global development while adjusting to the country's policy frameworks. The National Primary Healthcare Development Agency (NPHCDA), the Federal Ministry of Health through standardised protocols and periodic monitoring by Local Government Primary Healthcare Departments (LGPHCDs) is in charge of regulating TBA practice (NPHCDA, 2012). Ministries of Health, both on state and local level are actively involved in the training and retraining of the TBAs, with annual programmes of achievement of the TBAs being made compulsory which include the strengthening of safe practices and referral mechanisms. Importantly, the financial burden of these training sessions is their own, reflecting both the commitment of the participating TBAs and the fact that these are integrating into the health system informally. These arrangements reflect a struggle between the two poles of regulatory control on the one hand and a practical engagement on the other, involving recognizing that TBAs remain relevant and to set their activities within the confines of public health objectives.

Beyond their clinical roles, TBAs have a complex social role that transcends into the cultural and relationship fabric of their communities. While their in-depth responsibilities differ from setting to setting, some tasks are consistent and include provision of antenatal guidance, intrapartum support, postnatal care, and emotional reassurance, all done through the indigenous knowledge systems (Rawe, 2011). TBAs are highly valued as they are available at all hours, are financially affordable and are culturally congruent with women's expectations

of care. Many are closely related to those they work with or imbedded in kinship networks, offering trust, continuity of care.

TBAs also fulfil broader social roles promoting functions beyond the childbirth. They often help in obtaining spousal involvement in supporting women in terms of communication between the women and their husbands by encouraging the emotional and material support to women and the husband both before, during, and after the delivery. In many communities, TBAs are seen as elders whose authority falls into the aspects of marital advices, conflict resolution, and morality. Their respected status helps them to mobilise community support and strengthen social cohesion with respect to pregnancy and childbirth (Turinawe et al., 2016). These roles make TBAs not only healthcare providers but the keepers of the cultural meaning and social stability.

Evolution of TBAs is thus an emergent dynamic of relationships involving tradition vs. modernity, community vs. institution, culture vs. policy. While there has been a growing globalization of health discourse that has placed a strong emphasis on skilled birth attendance and facility based delivery, the continued existence of TBAs is indicative of the limitations of technocratic solutions in environments characterized by poverty, inequality and cultural pluralism. Understanding TBAs as grounded in historical country contexts, affected by social and cultural expectations, and possessing the authority to act authority in those countries is an imperative for developing effective and context responsive maternal health strategies. Their evolution points to the need for building in the imperatives of biomedical concerns with community realities in strive for safer motherhood.

Current State of Maternal and Child Health

Maternal and child health remains a critical global health priority, characterised by stark disparities between high-income countries and low- and middle-income countries (LMICs). Globally, an estimated 287,000 women died during and following pregnancy and childbirth in 2020, with approximately 95% of these deaths occurring in LMICs, particularly in sub-Saharan Africa and South Asia (WHO, 2023; Mahada et al., 2023). The overwhelming majority of these deaths were preventable through timely access to quality antenatal care, skilled birth attendance, and emergency obstetric services. These figures underscore the persistent structural inequities that shape maternal and child health outcomes and highlight the fragility of health systems in resource-constrained settings.

Nigeria exemplifies this global crisis. The country accounts for nearly 20% of maternal deaths worldwide, with a maternal mortality ratio of approximately 512 per 100,000 live births and an under-five mortality rate of 102 deaths per 1,000 live births (NPC & ICF, 2019). These indicators reflect enduring deficiencies in health infrastructure, workforce capacity, and community-level service delivery. Although the World Health Organization recommends that at least 90% of births be attended by skilled health personnel, this benchmark remains far from attainable in many parts of Nigeria. In rural communities, fewer than half of all births occur in health facilities, and a substantial proportion are attended by unskilled providers (WHO, 2023; NPC & ICF, 2019). Such patterns expose women and newborns to avoidable risks and perpetuate cycles of preventable morbidity and mortality.

Several interrelated challenges constrain progress in maternal and child health. These include acute shortages of skilled birth attendants (SBAs), particularly in rural and underserved areas; poor physical infrastructure; weak referral systems; and socio-cultural barriers that discourage women from seeking formal care. The unequal distribution of healthcare workers, especially midwives and physicians, has created vast service gaps, leaving rural populations reliant on informal and community-based providers (Campbell & Graham, 2006). Even where health facilities exist, distance, transportation costs, and perceptions of poor-quality care frequently deter utilisation. Consequently, the expansion of SBA coverage has not translated

into equitable access, as geographic, economic, and cultural barriers continue to mediate women's health-seeking behaviour.

Within this context, Traditional Birth Attendants (TBAs) continue to play a significant yet contested role. In many remote communities, TBAs represent the first and often only point of contact for pregnant women. While global health strategies increasingly emphasise facility-based deliveries and skilled attendance, evidence suggests that TBAs remain trusted, accessible, and culturally acceptable in settings where formal services are scarce or socially distant (Wilson et al., 2011). Their exclusion from formal health systems has, however, generated missed opportunities for collaboration, referral, and harm reduction, particularly in areas experiencing critical shortages of skilled personnel.

Given the complex and layered challenges confronting maternal and child health systems in LMICs, achieving universal coverage requires more than the expansion of formal services alone. It necessitates context-sensitive strategies that bridge formal and informal health systems. Reimagining the role of TBAs within community-based maternal health frameworks offers a pragmatic and potentially transformative pathway for improving outcomes in resource-limited settings, especially where conventional models of care remain structurally inaccessible.

Integration into Community-Based Health Systems

Traditional Birth Attendants (TBAs) continue to play a central role in maternal and newborn care across many low- and middle-income countries, particularly in rural and underserved communities where access to health facilities and skilled professionals remains limited. Despite sustained global advocacy for skilled birth attendance, structural constraints such as geographical isolation, poverty, and shortages of trained health workers have preserved the relevance of TBAs. Integrating TBAs into community-based health systems therefore represents a pragmatic and culturally responsive strategy for improving maternal and neonatal outcomes while bridging the divide between traditional practices and biomedical care. In many remote settings, TBAs are the most accessible and trusted providers of maternity care. Their proximity to households and constant availability position them as critical entry points into the health system. Integration enables TBAs to link women with formal services, especially in contexts where skilled birth attendants are scarce. Beyond accessibility, TBAs are deeply embedded within local belief systems and customs. Their involvement ensures culturally sensitive care, increasing the likelihood that women will engage with health interventions that might otherwise be perceived as alien or intrusive. Cultural acceptability remains a decisive factor in care-seeking behaviour, and the presence of TBAs within structured systems enhances the legitimacy of formal maternal health programmes.

When adequately trained and supervised, TBAs can contribute meaningfully to early detection of complications. They are often the first to observe labour progress and maternal wellbeing, positioning them to identify danger signs and initiate timely referrals. Strengthening referral pathways through TBA integration can reduce the first and second delays in accessing emergency obstetric care, which are major contributors to maternal mortality. Moreover, integration fosters community engagement and trust in the formal health system, promoting a shared sense of responsibility for maternal and newborn health and reducing resistance to facility-based services. Several facilitators support effective integration. TBAs are often more trusted than formal providers because they are embedded within their communities, speak local languages, and understand prevailing norms (Wilson et al., 2011). Their cultural competence enhances the acceptability of care, particularly in conservative settings where childbirth is governed by ritual and tradition (Sibley & Sipe, 2004). TBAs are also relatively affordable, making their services accessible in low-income contexts where cost remains a significant barrier. Importantly, many TBAs demonstrate

willingness to collaborate with formal systems, including participation in training and referral of high-risk cases (Byrne & Morgan, 2011). This openness provides a foundation for structured partnerships and community mobilisation.

Evidence further indicates that when TBAs are trained, equipped with clean delivery kits, and supervised, integration contributes to improved maternal outcomes (Gazi et al., 2005). Structured programmes establish accountability and strengthen referral networks. In health systems facing acute workforce shortages, integrating TBAs aligns with task-shifting policies and supports service delivery by relieving overburdened facilities (WHO, 2008). Within such frameworks, TBAs can also function as health promoters, encouraging antenatal attendance, facility delivery, breastfeeding, and family planning, thereby reinforcing the continuum of care at the community level.

Dangers of Non-Integration of Traditional Birth Attendants

The neglect of Traditional Birth Attendants (TBAs) to be more integrated in formal health care systems is very dangerous as it affects maternal and neonatal health, especially in low resource areas where they are the main providers of childbirth-related care. In many communities, TBAs continue to deliver babies without any formal supervision and standardised training. When such practice goes on in isolation from the health system, TBAs may attend to high-risk pregnancies and complicated deliveries beyond their competencies and thereby increase the probability of obstetric complications, maternal morbidity and neonatal mortality. Without structured guidance and supervision and with no ongoing education, the sole knowledge TBAs may have is experiential, which is often not applicable to the management of emergencies such as postpartum haemorrhage, obstructed labour, pre-eclampsia, or neonatal distress. The persistence of the unregulated sector of TBAs is thus perpetuating the avoidable risks in already vulnerable groups.

One of the major consequences of non-integration is the loss of opportunity for timely referral. TBAs who are not formally included in systems may lack the knowledge as well as the institutional support needed to recognise the danger signs and trigger rapid referral to health facilities. Even when the TBAs perceive complications, weak linkages with health services often lead to delayed transfer, prolonged labour at home and avoidable deaths. These delays follow the well-documented "three delays" model by which two key factors, the decision to seek care and the ability to access appropriate care services, which play such an important part in survival. In the context where TBAs function separately, these delays are reinforced in a vicious cycle, perpetuating paradigms of preventable maternal and infant mortality. Exclusion of TBAs also shuts down parallel and fragmented systems of care. Rather than being part of a coherent continuum of maternal health services TBAs are outside the formal health architecture which creates a dual system and defeats coordinated strategies in community-based areas. Such fragmentation prevents national efforts to develop adequate integrated primary medical healthcare platforms that can track pregnancies and standardise their care while providing continuity at the antenatal, delivery and postmodern periods. The persistence of parallel systems further adds to the challenges of collecting data, planning and allocating resources, as there is a large proportion of births are out of reach of health information systems.

Beyond structural inefficiencies, the risks of not integrating are that it erodes community trust in the formal healthcare. In many rural and peri-urban areas, TBAs are part of the cultural makeup, are socially embedded and widely regarded as good custodians of reproductive health. Community perceptions of formal health services as culturally insensitive or imposed from outside may deter communities from using them when TBAs are present. This perception can create resistance towards institutional interventions, discourage facility-based deliveries, and increase scepticism towards biomedical care. Rather than

causing behavioural change, exclusionary approaches may serve to increase allegiance to traditional systems, further segregation of women from skilled care.

Perhaps most important of all, failure to integrate TBAs is a waste of opportunity for outreach, health promotion, and communication on behavioural change. TBAs have intimate and sustained relationships with the women and families whom they work with, in some cases across multiple pregnancies and even generations. This close proximity places them as strong agents for dissemination of health information, ante-natal attendance, immunisation and reinforcement of post-natal care. When these relational assets are not leveraged, health systems lose the benefit of an effective channel to reach populations who otherwise are difficult to reach. In settings where formal HWs are available in more, TBAs could provide an essential bridge that would help translate public health messages into a culturally relevant form of practices. Their inability to do so therefore limits the reach and effectiveness of maternal health programmes, and reproduces inequities in access and outcomes. Collectively, these dangers serve to highlight the fact that non-integration of TBAs is not an apolitical policy response but an active cause of continued vulnerability among mothers and even neonates. Continued uncontrolled work conditions, delayed referrals, fragmented care, loss of community trust, and underutilisation of community networks fall together to perpetuate the culture of avoidable mortality. In the high burden contexts, and especially Sub-Saharan Africa, the costs of exclusion are not only in terms of inefficiencies but in terms of lives original.

Barriers to Integration and Ways for Systemic Inclusion

Despite the strong case to be made to integrate TBAs into healthcare systems, several barriers exist that hinder working towards systemic inclusion of TBAs in formal healthcare systems. At the level of policies, TBAs are frequently not integrated into national health workforce frameworks which makes their integration invisible institutionally and complex operationally (UNFPA, 2012). Many countries maternal health approaches have focused on skilled birth attendance to the exclusion of traditional providers based on the concern that TBA participation will undermine institutional delivery objectives. This lack of formal recognition limits interaction with training, supervision and resources, which amounts to the marginalisation of TBAs in reform agendas. Professional resistance is another large obstacle. Midwives and other healthcare workers can see TBAs as competition or even amateurs who place a professional standard at risk with involvement. Such perceptions can lead to tension, prevent collaboration and destroy mutual trust (Gurara et al., 2020). Without deliberate attempts to both develop interprofessional respect and interprofessional role clarity, there is a risk that integration initiatives will tend to reinforce alchemical hierarchies that offend many TBAs and wash down adversarial relationships.

Inconsistent training and quality control make the integration even more difficult. Existing training authority of training (TBA) programmes are highly variable in terms of duration, content and effectiveness and lead to patchwork levels of competences and discredit the safety confidence. Even if TBAs are willing to work with patients, weak referral systems, a lack of transportation, and suboptimal facility readiness are barriers to effective linkages. Not only that, TBAs frequently receive no compensation by orthodox systems, curtailing motivation to refer the women away from income-generating home births. Legal and ethical ambiguities add to these difficulties, because in some places TBA-led deliveries are banned, making it legal to work informally. The lack of TBAs from routine health data systems further in the dark on their contributions and the evidence-based planning. Notwithstanding all these barriers, pathways to integration that are evidence based show great promise. One strategic approach is to set up structured training institutions to provide CBAs with basic midwifery competencies. In resource poor settings such trainings can make a huge difference in the reduction of maternal mortality by enabling TBAs to manage normal deliveries and recognise complications early. There is a notable example from the Nigerian state of Oyo which in 2013

established a School of Community Nursing and Midwifery under the college of Nursing and Midwifery with the approval of the Nursing and Midwifery Council of Nigeria. One hundred participants, including children of practising TBAs, were trained and registered and the twin objectives were to increase the number of skilled workforce and improve at the community level.

Mapping and formally recognising TBAs is also a way of strengthening integration. In Oyo State, accounts of TBAs have been mapped systematically in local government areas in the state, in an effort to create a functional database for engagement of TBAs in health promotion and disease prevention. This way, routine data collection and performance monitoring and structured collaboration can happen which embeds TBAs within the public health architecture. Modeled Supervised Collaboration Supervised collaboration models provide another peptide of integration. Allowing TBAs to stay with women during delivery at the facility is similar to the doula model in the United States, where non-clinical birth companions are used to give emotional, physical and informational support to the woman (Sobczak et al., 2023). Doula support is linked to lower rate of LBW, shorter labour, reduced rate of caesarean section deliveries and higher rate of breastfeeding initiation (Thurston et al., 2013; Aziato & Omenyo, 2018). Analogous tasks to TBAs in LMICs may have a similar effect on improving poor outcomes (Miller & Smith, 2017).

The integration is also facilitated by training the healthcare workers in interpersonal and cultural competence. In Guatemala, nutritional education of skilled providers about TBA practices resulted in a 2.8-fold increase of referrals. Similar programs involving better communication channels escaped by referral cards, radio systems, or mobile phones have been shown to improve TBA-facility linkages in Indonesia and Uganda, although, as evidenced in Bangladesh, contextual constraints, such as access to phones, point to the need for locally adapted approaches. Defining TBA roles are still important. In Malaysia, defining roles sprayed the contradiction between long-standing rivalry between TBAs and village midwives, bringing both groups together for efforts of identifying and referring high-risk pregnancies early. Encouraging TBAs to be primarily promoters of facility-based care, repugnant as this may be, may be the most pragmatic model in situations in which comprehensive training and monitoring are not feasible.

Socio-cultural and institutional barriers need to be dealt with, too. Traditional beliefs, gender norms, and household power relationships still influence maternal health-seeking behaviour and people often end up delaying accessing skilled care (Koblinsky et al., 2006). Restrictive policies that involve keeping TBAs out of formal frameworks further perpetuate these patterns (Campbell & Graham, 2006). Targeted funds, policy reform in general and community sensitisation in particular are therefore indispensable. Integration of TBAs is not a concession to tradition but a strategic match of community assets to public health goals. By busting the structural hurdles and institutionalising the collaborative pathways, health systems can move TBAs from being at the periphery to being integral in the quest towards an equitable and sustainable maternal health.

Opportunities for Improvement at the Policy and Community Levels

The crucial role of Traditional Birth Attendants in maternal and newborn care shows a huge scope for reinforcing the health systems through participatory and localised reforms. Governments and health institutions must recognise that TBAs form an indispensable component of community-based care and especially in rural and not easily accessible settings where skilled birth attendants are still scarce. Integrative policy, where TBAs are formally included in national and subnational policy and healthcare frameworks, may bring about a paradigm shift from TBAs being seen as periphery actors to that of strategic partners in maternal health delivery. Central to this process is the setting up of structured and

continuous training programmes with the aim of equipping TBAs with the basic obstetric knowledge, strengthen safe birthing practices and improve their abilities to identify and refer high-risk pregnancies in time (WHO, 2021). Such training is not aimed to replace traditional knowledge but to supplement it with models of life-saving knowledge and skills that are acceptable to modern standards of maternal and neonatal care.

Equally important is formalising the TBAs as providers of complementary healthcare services instead of informal or unregulated practitioners. This recognition can reduce institutional margin leads and promote knowledge sharing and collaborative work relationships between TBAs and Skilled Birth Attendants (SBAs), creating the right maternal healthcare ecosystem that caters to the preferences, but is primarily focused on safety, any form of marginalisation (WHO 2021). When TBAs are recognized under policy frameworks, they are more likely to interact positively with the health facilities and take part in referral networks and follow agreed protocol. This approach reframes TBAs not as barriers against progress, but as culturally situated media through which the formal health systems can increase their reach into the communities that they still do not routinely reach with their biomedical services.

Community engagement forms a parallel and vital impossible pathway to improve the outcome of maternal health. In many rural settings, TBAs are the basic health care providers during pregnancy and delivery, and their power over health-seeking behaviour is considerable. Community-based interventions on the numerous advantages of skilled birth attendance could possibly gradually flow cultural attitudes toward institutional deliveries without debilitating the cultural legitimacy of TBAs (Rudrum, 2016; MacDonald, 2022). Such interventions are best done in a participatory manner, culturally sensitive and through trusted local actors; including TBAs themselves. By reframing the role of TBAs as an advocate for safe motherhood, and their role as one of support and cooperation, rather than competition to formal NHS care, communities can be mobilised to work for a variety of things: to adopt more healthful practices while retaining valued traditions.

The proactive development of relationships between TBAs and SBAs that digs into this integrative model. Joint training programmes, common referral routes and regular interactivity between the two groups can help to build mutual respect and professional trust. These types of collaborative arrangements help bridge the traditional and biomedical paradigms for a more seamless continuum of care for women across antenatal, delivery and postnatal stages (Rudrum, 2016; MacDonald, 2022). Through such partnerships, TBAs can serve as successful middlemen who encourage early antenatal attendance; accompany women to facilities once problems arise and strengthen postnatal follow-up. In turn, SBAs receive culturally-informed allies to support community entry, improve communication and contribute to improved adherence to health advice.

Harnessing these opportunities means political commitment, institutional flexibility and sustained dialogue with communities. Policy reform and community engagement need to go hand in hand, and integration must not have symbolic meaning, but be substantive. By engaging TBAs in formal systems through training, recognition and collaboration, health authorities can leverage on their social capital and proximity to women and extend the reach of maternal health services as a result. Such an approach is in line with the global imperatives for inclusive and people-centred care, and provides a viable and pragmatic pathway for improving the outcomes of mothers and newborns in resource-constrained settings.

Conclusion

Despite worldwide efforts, many low and middle-income countries (LMICs) are still lagging behind in realising universal health coverage towards achieving the eventuality of their Sustainable Development Goal 3. Persistently high maternal mortality rates aggravated by weak health systems, poor access to skilled birth attendants, and extensive socioeconomic inequities highlight the urgent need for suitable and sustainable solutions. One promising

way forward is through creating strategic linkages between the formal health systems and trusted individuals from the community - such as the Traditional Birth Attendants (TBAs). TBAs who are embedded in their communities with inestimable cultural knowledge, provide care that is affordable and command the trust of women in the most marginalised of settings. Rather than seeing them as relic models of heath humans, however, findings of evidence are mounting that their incorporation into community-based heath systems as a supplement as opposed to downlevel to heath humans skilled care is advisable.

However, successful integration requires more than the unstructured collaboration of people. It requires well-defined roles, training structures, referral pathways, and even more constant supervision placed within a larger framework of respectful partnership and health system strengthening. When appropriately supported and strategically included, regional TBAs can make a meaningful contribution to the development of a better maternal and neonatal health outcome, especially in rural and underserved areas. As LMICs work towards equitable and inclusive healthcare systems, working across the divide between traditional and formal care providers provide a path not only to expand access, but to ensure that maternal health services are trusted, culturally sensitive and that they truly are community-centered.

The future of TBAs in healthcare lies in finding a middle ground between traditional medical practice and formal medical practice. Stakeholders to be aware of their role and offer training and Stakeholders to be integrated in healthcare systems with a view to improve the health outcomes of mothers and babies.

References

Akute, Y. I., Poblete, R., Elusoji, C. I., & Borode, S. B. (2023). Synergy between skilled and traditional birth attendants on quality of maternal and newborn care in Nigeria. *International Journal of Public Health Pharmacy and Pharmacology, 8*(4), 15–25. https://doi.org/10.37745/ijphpp.15/vol8n41525

Aziato, L., & Omenyo, C. N. (2018). Initiation of traditional birth attendants and their traditional and spiritual practices during pregnancy and childbirth in Ghana. *BMC Pregnancy and Childbirth, 18*, 1–10.

Byrne, A., & Morgan, A. (2011). How the integration of traditional birth attendants with formal health systems can increase skilled birth attendance. *International Journal of Gynecology & Obstetrics, 115*(2), 127–134.

Campbell, O. M., & Graham, W. J. (2006). Strategies for reducing maternal mortality: Getting on with what works. *The Lancet, 368*(9543), 1284–1299. https://doi.org/10.1016/S0140-6736(06)69381-1

Ekwuazi, E. K., Chigbu, C. O., & Ngene, N. C. (2023). Reducing maternal mortality in low- and middle-income countries. *Case Reports in Women's Health, 39*, e00542.

Esan, D. T., Ayenioye, O. H., Ajayi, P. O., & Sokan-Adeaga, A. A. (2023). Traditional birth attendants' knowledge, preventive and management practices for postpartum haemorrhage in Osun State, Southwestern Nigeria. *Scientific Reports, 13*(1), 12314.

Fleming, J. R. (1994). What in the world is being done about TBAs? An overview of international and national attitudes to traditional birth attendants. *Midwifery, 10*(3), 142–147.

Kassie, A., Wale, A., Girma, D., Amsalu, H., & Yechale, M. (2022). The role of traditional birth attendants and problem of integration with health facilities in remote rural community of West Omo Zone 2021: An exploratory qualitative study. *BMC Pregnancy and Childbirth, 22*(1), 425.

Koblinsky, M., Matthews, Z., Hussein, J., et al. (2006). Going to scale with professional skilled care. *The Lancet, 368*(9544), 1377–1386. https://doi.org/10.1016/S0140-6736(06)69382-3

Kruske, S., & Barclay, L. (2004). Effect of shifting policies on traditional birth attendant training. *Journal of Midwifery & Women's Health, 49*(4), 306–311.
Lassi, Z. S., Kumar, R., & Bhutta, Z. A. (2016). Community-based care to improve maternal, newborn, and child health. *Disease Control Priorities, 2*, 263–284.
MacDonald, M. E. (2022). The place of traditional birth attendants in global maternal health: Policy retreat, ambivalence and return (pp. 95–115). https://doi.org/10.1007/978-3-030-84514-8_6
Macrotrends. (2025). *Nigeria fertility rate 1950–2025*. https://www.macrotrends.net/global-metrics/countries/nga/nigeria/fertility-rate
Mahada, T., Tshitangano, T. G., & Mudau, A. G. (2023). Strategies to reduce maternal death rate and improve the provision of quality healthcare services in selected hospitals of Vhembe District, Limpopo Province. *Nursing Reports, 13*(3), 1251–1270. https://doi.org/10.3390/nursrep13030107
Ministry of Foreign Affairs of Denmark in Nigeria. (2025). *About Nigeria*. https://nigeria.um.dk/en/about-nigeria
Mullany, B. C., Becker, S., & Hindin, M. J. (2007). The impact of including husbands in antenatal health education services on maternal health practices in urban Nepal: Results from a randomized controlled trial. *Health Education Research, 22*(2), 166–176.
Nasir, S., Zerihun Kea, A., Steege, R., Limato, R., Tumbelaka, P., Datiko, D. G., Syafruddin, Kok, M., Ahmed, R., & Taegtmeyer, M. (2020). Cultural norms create a preference for traditional birth attendants and hinder health facility-based childbirth in Indonesia and Ethiopia: A qualitative inter-country study. *International Journal of Health Promotion and Education, 58*(3), 109–123.
National Bureau of Statistics. (2024). *Statistical report*. https://www.nigerianstat.gov.ng/elibrary/read/1241549
National Population Commission (NPC) [Nigeria] & ICF. (2019). *Nigeria demographic and health survey 2018*. NPC and ICF.
Ngunyulu, R. N., Mulaudzi, F. M., & Peu, M. D. (2020). Traditional birth attendants' experiences during the provision of post-natal care in Mopani District, Limpopo Province of South Africa. *Health SA Gesondheid, 25*.
National Primary Health Care Development Agency. (2012). *Nigeria midwives service scheme*. http://www.who.int/workforcealliance/forum/2011/hrhawardscs26/en/index.html
Raina, N., Khanna, R., Gupta, S., Jayathilaka, C. A., Mehta, R., & Behera, S. (2023). Progress in achieving SDG targets for mortality reduction among mothers, newborns, and children in the WHO South-East Asia Region. *The Lancet Regional Health – Southeast Asia, 18*.
Rawe, K. (2011). *Missing midwives*. Save the Children.
Ribeiro Sarmento, D. (2014). Traditional birth attendance (TBA) in a health system: What are the roles, benefits and challenges? A case study of incorporated TBA in Timor-Leste. *Asia Pacific Family Medicine, 13*, 1–9.
Rowen, T., Prata, N., & Passano, P. (2011). Evaluation of a traditional birth attendant training programme in Bangladesh. *Midwifery, 27*(2), 229–236. https://doi.org/10.1016/J.MIDW.2009.06.003
Rudrum, S. (2016). Traditional birth attendants in rural Northern Uganda: Policy, practice, and ethics. *Health Care for Women International, 37*(2), 250–269. https://doi.org/10.1080/07399332.2015.1020539
Smith, L. J. (2016). *Training traditional birth attendants in Sub-Saharan Africa*.
Turinawe, E. B., Rwemisisi, J. T., Musinguzi, L. K., de Groot, M., Muhangi, D., de Vries, D. H., Mafigiri, D. K., Katamba, A., Parker, N., & Pool, R. (2016). Traditional birth attendants

as potential agents in promoting male involvement in maternity preparedness: Insights from a rural community in Uganda. *Reproductive Health, 13*, 1–11.

Vieira, C., Portela, A., Miller, T., Coast, E., Leone, T., & Marston, C. (2012). Increasing the use of skilled health personnel where traditional birth attendants were providers of childbirth care: A systematic review. *PLoS ONE, 7*(10), e47946.

Wilson, A., Gallos, I. D., Plana, N., et al. (2011). Effectiveness of strategies incorporating training and support of traditional birth attendants on perinatal and maternal mortality: Meta-analysis. *BMJ, 343*, d7102. https://doi.org/10.1136/bmj.d7102

World Health Organization. (2012). *Trends in maternal mortality: 1990 to 2010*. WHO.

World Health Organization. (2012). *WHO recommendations for the prevention and treatment of postpartum haemorrhage*. WHO.

World Health Organization. (2021). *Improving maternal and newborn health through collaboration with traditional birth attendants*. WHO.

World Health Organization. (2023). *Maternal mortality*. https://data.who.int/indicators/i/C071DCB/AC597B1

World Health Organization. (2023). *Trends in maternal mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division*. WHO.

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