

Knowledge, Prevalence and Determinants of Traditional Home Delivery Among Women of Reproductive Age in Oluku Community, Benin City, Nigeria

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Abstract

Background: Traditional home delivery remains an important maternal-health issue in many Nigerian communities where cultural preferences, affordability, access to formal health services and trust in traditional birth attendants (TBAs) may influence place of childbirth. **Objective:** To assess knowledge and prevalence of traditional home delivery and identify factors associated with delivery choices among women of reproductive age in Oluku Community, Ovia North-East Local Government Area, Edo State, Nigeria. **Methods:** A descriptive cross-sectional survey was conducted among 110 women aged 15–49 years residing in Oluku Community. Participants were selected using simple random sampling and data were collected with a structured questionnaire. Data were analysed using SPSS version 20.0. Frequencies and percentages were used for descriptive analysis, while chi-square tests examined associations between selected sociodemographic characteristics and delivery-related variables. **Results:** Awareness of traditional home delivery was high (90.9%), and 85.5% identified TBAs as the common attendants at traditional home deliveries. Fifty participants (45.5%) reported delivering their last child at home, compared with 44 (40.0%) who delivered in a hospital or health centre; 16 (14.5%) reported other locations. TBAs were reported as the delivery attendant by 59.1% of respondents. Lack of access to healthcare facilities (27.3%), cultural or religious beliefs (22.7%), trust in TBAs (20.0%), fear of medical interventions (16.4%) and cost of hospital delivery (13.6%) were reported reasons for home delivery. Only 41.8% considered traditional home delivery to carry higher risks than hospital delivery, while 60.9% reported no access to a health facility within their community. Education level was significantly associated with location of last delivery ($\chi^2=14.090$, $p=0.029$); age and marital status were not significantly associated with location of last delivery. **Conclusion:** Traditional home delivery was common in Oluku Community despite high awareness of the practice. Access barriers, cost, sociocultural beliefs and trust in TBAs influenced delivery choices. Interventions should strengthen access to skilled childbirth care, reduce financial and transport barriers, improve respectful maternity care and establish effective referral linkages with community-based providers.

Keywords: Home delivery; traditional birth attendants; skilled birth attendance; maternal health; childbirth; Edo State; Nigeria.

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INTRODUCTION

Maternal deaths remain concentrated in low- and lower-middle-income countries, and access to skilled health professionals before, during and after childbirth is a key component of preventing avoidable maternal and newborn morbidity and mortality. [1]

Skilled health personnel providing childbirth care are trained and regulated maternal and newborn health professionals who can support normal labour, identify complications, provide appropriate management and arrange timely referral. Traditional birth attendants, whether trained or untrained, are not classified as skilled

birth attendants under the current international definition. [2]

Nigeria continues to have important gaps in skilled attendance and institutional delivery. The 2021 Nigeria Multiple Indicator Cluster Survey reported that 50.7% of births were attended by skilled health personnel and 49.0% occurred in health facilities nationally, demonstrating that a substantial proportion of childbirth still occurs outside formal facilities. [3]

Home delivery is influenced by interacting individual, household, community and health-system factors. National Nigerian analyses have associated home childbirth with rural residence, lower educational attainment, poverty, low antenatal-care attendance, distance from health facilities and regional differences. [4,5]

Traditional birth attendants remain important community maternity-care providers in parts of Nigeria. In Edo State, earlier research found that availability, accessibility, lower cost and community confidence contributed to preference for TBA services, while studies from other Nigerian settings have similarly documented positive perceptions of TBAs and continued utilisation of their services. [6,7]

More recent qualitative and quantitative evidence from Nigeria shows that women may choose TBAs because of interpersonal treatment, familiarity, perceived spiritual support, proximity, affordability, fear of caesarean delivery and dissatisfaction or mistrust of formal services. [8,9]

These patterns indicate that improving skilled birth attendance requires more than health education alone. Financial access, transport, quality and respectful care, community trust, referral pathways and culturally responsive services are also important. [5,8,10]

This study therefore assessed knowledge and prevalence of traditional home delivery among women of reproductive age in Oluku Community, Edo State, and examined attitudes, barriers and selected sociodemographic factors associated with delivery choices.

METHODS

Study Design and Setting

This was a descriptive cross-sectional study conducted in Oluku Community, Ovia North-East Local Government Area, Edo State, Nigeria. Oluku is a semi-

urban community close to Benin City. The source project reported a community population of 24,523.

Study Population and Eligibility

The study population comprised women of reproductive age (15–49 years) residing in Oluku Community. Eligible participants were residents who could provide informed consent and communicate their knowledge or experience regarding traditional home delivery. Women outside the reproductive-age range, non-residents, women without childbirth experience and those unwilling to participate were excluded according to the source protocol.

Sample Size and Sampling

The source study calculated a minimum sample size of 100 using Cochran's formula with an assumed prevalence of 93%, 5% precision and a 95% confidence level. A 10% allowance for non-response increased the target sample to 110. The study reported use of simple random sampling.

Data Collection

Data were collected using a structured, self-administered questionnaire. Items covered sociodemographic characteristics, awareness and knowledge of traditional home delivery, previous place of delivery and birth attendant, antenatal-care use, attitudes and perceived risks, education and income-related influences, barriers to facility delivery, access to health facilities and preventive measures.

Data Analysis

Data were analysed using SPSS version 20.0. Categorical variables were summarised using frequencies and percentages. Associations between age, marital status and education level and delivery-related variables were assessed using chi-square tests. Statistical significance was set at $p < 0.05$.

Ethical Considerations

The source project states that informed consent, confidentiality and voluntary participation were observed and that language assistance was provided for respondents who could not read or write. The exact name of the approving ethics committee and approval/reference number were not stated in the source document and should be inserted from the original ethics approval before journal submission.

RESULTS

A total of 110 respondents were included. The largest age group was 25–34 years (36.4%), 40.0% were married, 33.6% had secondary education and trading was the most common occupation (38.2%).

Table 1: Sociodemographic characteristics of respondents (N=110)

Characteristic	Category	n	%
Age (years)	15–24	38	34.5
	25–34	40	36.4
	35–49	32	29.1
Marital status	Single	29	26.4
	Married	44	40.0
	Divorced	19	17.3
	Widowed	18	16.4
Education	No formal education	10	9.1
	Primary	30	27.3
	Secondary	37	33.6
	Tertiary	33	30.0
Occupation	Housewife	26	23.6
	Trader	42	38.2
	Farmer	24	21.8
	Civil servant	17	15.5
	Traditional birth attendant	1	0.9

Awareness of traditional home delivery was reported by 100 respondents (90.9%). Most respondents (85.5%) identified TBAs as the common attendants. The leading reported reason why women chose home

delivery was lack of access to healthcare facilities (27.3%), followed by cultural or religious beliefs (22.7%) and trust in TBAs (20.0%).

Table 2: Knowledge and reported reasons for traditional home delivery (N=110)

Variable	Response	n	%
Aware of traditional home delivery	Yes	100	90.9
	No	10	9.1
Common attendant	Traditional birth attendant	94	85.5
	Family member	16	14.5
Reason for home delivery	Lack of access to healthcare facilities	30	27.3
	Cultural/religious beliefs	25	22.7
	Trust in traditional birth attendants	22	20.0
	Fear of medical interventions	18	16.4
	Cost of hospital delivery	15	13.6

Regarding previous childbirth, 50 respondents (45.5%) reported that their last child was delivered at home, 44 (40.0%) in a hospital or health centre and 16 (14.5%) elsewhere. TBAs were reported as the delivery

attendant by 65 respondents (59.1%). Antenatal care during the last pregnancy was reported by 68 respondents (61.8%).

Table 3: Delivery history and antenatal-care use (N=110)

Variable	Response	n	%
Number of children	0	29	26.4
	1–4	33	30.0
	≥5	48	43.6
Place of last delivery	Hospital/health centre	44	40.0
	Home	50	45.5
	Other	16	14.5
Delivery attendant	Doctor	7	6.4
	Nurse/midwife	13	11.8
	Traditional birth attendant	65	59.1
	Family member	14	12.7
	No one	11	10.0
Antenatal care in last pregnancy	Yes	68	61.8
	No	42	38.2

Note: The source questionnaire excluded women without childbirth experience, yet 29 respondents were recorded as having no children while delivery-history responses were reported for all 110 participants. This inconsistency should be checked against the original dataset before submission.

Views on safety were divided: 36.4% considered traditional home delivery safe, 35.5% considered it unsafe and 28.2% were unsure. Seventy-nine per cent believed the practice could be improved.

Only 41.8% considered traditional home delivery to have higher risks than hospital delivery, while 60.9% reported no health facility within their community.

Table 4: Attitudes, perceived risks, access and preventive measures

Variable	Response	n	%
Traditional home delivery is safe	Yes	40	36.4
	No	39	35.5
	Not sure	31	28.2
Main perceived risk	Lack of medical intervention for complications	29	26.4
	Infection	29	26.4
	Delay in seeking help	29	26.4
	Lack of postnatal care	23	20.9
Traditional home delivery can be improved	Yes	87	79.1
	No	23	20.9
Aware of risks of traditional home delivery	Yes	65	59.1
	No	45	40.9
Home delivery has higher risk than hospital delivery	Yes	46	41.8
	No	30	27.3
	Not sure	34	30.9
Access to health facility within community	Yes	43	39.1
	No	67	60.9
Aware of safer-delivery programme	Yes	53	48.2
	No	57	51.8
Received antenatal-care education	Yes	62	56.4
	No	48	43.6
More likely to use facility if given financial/material incentive	Yes	62	56.4
	No	48	43.6
TBAs should receive more training	Yes	64	58.2
	No	46	41.8

Education and economic considerations were frequently reported. Fifty-seven per cent believed their education influenced delivery location, 40.0% believed income affected where they delivered and 56.4% would

prefer hospital delivery if cost or income were not factors. Cost of hospital delivery (30.0%) and lack of trust in healthcare providers (21.8%) were the most frequently reported barriers to facility delivery.

Table 5: Education, income and barriers to facility delivery (N=110)

Variable	Response	n	%
Education influenced delivery location	Yes	63	57.3
	No	47	42.7
Would prefer hospital if cost/income were not factors	Yes	62	56.4
	No	48	43.6
Income affects place of delivery	Yes	44	40.0
	No	32	29.1
	Not sure	34	30.9
Main barrier to facility delivery	Cost of hospital delivery	33	30.0
	Lack of trust in healthcare providers	24	21.8
	Cultural beliefs/tradition	19	17.3
	Preference for home delivery	19	17.3
	Distance to health facility	15	13.6

Age was not significantly associated with location of last delivery ($\chi^2=2.291$, $p=0.682$), delivery attendant ($\chi^2=9.262$, $p=0.321$) or antenatal-care receipt ($\chi^2=3.936$, $p=0.140$). Marital status was also not significantly associated with location of last delivery ($\chi^2=5.514$, $p=0.480$), delivery attendant ($\chi^2=7.277$,

$p=0.839$) or antenatal-care receipt ($\chi^2=3.684$, $p=0.298$). Education level was significantly associated with location of last delivery ($\chi^2=14.090$, $p=0.029$), but not with delivery attendant ($\chi^2=9.438$, $p=0.665$) or antenatal-care receipt ($\chi^2=3.001$, $p=0.391$).

Table 6: Association of selected sociodemographic characteristics with delivery-related outcomes

Characteristic	Outcome	χ^2	p-value
Age	Place of last delivery	2.291	0.682
	Delivery attendant	9.262	0.321
	Antenatal-care receipt	3.936	0.140
Marital status	Place of last delivery	5.514	0.480
	Delivery attendant	7.277	0.839
	Antenatal-care receipt	3.684	0.298
Education level	Place of last delivery	14.090	0.029*
	Delivery attendant	9.438	0.665
	Antenatal-care receipt	3.001	0.391

*Statistically significant at $p < 0.05$. The source study also tested number of children against age, marital status and education; these are not presented here because number of children is not itself a measure of traditional home delivery prevalence.

DISCUSSION

This community-based study found that traditional home delivery remained common in Oluku: 45.5% of respondents reported home as the place of their last delivery, while only 40.0% reported a hospital or health centre. Although direct comparison with national surveys should be made cautiously because of differences in sampling and population, the finding is consistent with continuing gaps in institutional and skilled delivery in Nigeria. The 2021 MICS reported institutional delivery of 49.0% nationally. [3]

The prominent role of TBAs was particularly striking, with 59.1% of respondents reporting a TBA as the attendant at their delivery and 85.5% identifying TBAs as the common attendants at traditional home births. This is consistent with longstanding evidence from Edo State that TBAs remain accessible, affordable and trusted providers of maternity care, and with studies in other Nigerian settings documenting substantial utilisation and positive perceptions of TBA services. [6,7]

The reasons reported for home delivery in Oluku, limited access to healthcare facilities, cultural or religious beliefs, trust in TBAs, fear of medical interventions and cost are consistent with Nigerian evidence showing that place of delivery is shaped by a combination of socioeconomic, geographic, cultural and health-system factors rather than by knowledge alone. [4,5,8,9]

Lack of access was an important finding. More than three-fifths of respondents reported no health facility within their community, and distance was identified as a barrier to facility delivery. National analyses have similarly shown that difficulty with distance to health facilities is associated with increased likelihood of home childbirth, while transportation support is associated with facility delivery among young Nigerian mothers. [4,11]

Cost was the most frequently reported barrier to facility delivery, and more than half of respondents

stated that they would prefer hospital delivery if cost or income were not factors. Previous Nigerian research has consistently identified affordability and household socioeconomic position as important determinants of maternity-service utilisation and place of delivery. [4,5,12]

Trust and quality of interpersonal care also appear important. About one-fifth of respondents identified lack of trust in healthcare providers as the main barrier to facility delivery. Recent Nigerian studies of TBA users describe welcoming treatment, familiarity, positive recommendations, perceived spiritual support and fear of caesarean delivery as reasons women may prefer informal maternity providers. [8,9]

Education level was significantly associated with location of last delivery in this study, whereas age and marital status were not. National studies have also identified maternal education as an important determinant of facility use and home delivery. However, the pattern within the present cross-tabulation was not monotonic, and the small sample means the association should not be interpreted as a simple dose-response effect of education. [4,5,11]

A notable knowledge gap remained despite high general awareness of traditional home delivery. Only 41.8% believed home delivery carried higher risk than hospital delivery, and 40.9% had not heard of risks associated with traditional home delivery. Skilled health personnel are specifically trained to identify, manage and refer maternal and newborn complications; TBAs are not included in the international definition of skilled childbirth personnel. [2]

Most respondents believed traditional home delivery practices could be improved, and 58.2% supported additional training for TBAs. Evidence from a meta-analysis suggests that strategies incorporating TBA training, support and linkage with health services can improve perinatal and neonatal outcomes, but such strategies should not be interpreted as a substitute for skilled birth attendance. Their value lies particularly in

community engagement, recognition of danger signs, referral and linkage to formal maternity services. [10]

The findings therefore support a combined strategy for Oluku: improve affordable access to skilled childbirth services; strengthen transport and referral arrangements; provide respectful and culturally responsive facility care; use antenatal and community contacts for risk communication; and engage TBAs and community leaders as referral and health-promotion partners rather than as replacements for skilled maternal and newborn health professionals. [2,8,10]

STRENGTHS AND LIMITATIONS

This study provides useful community-level information on awareness, delivery location, birth attendants, attitudes, perceived barriers, and access to maternal healthcare in Oluku Community. Its main limitations are the cross-sectional design, reliance on self-reported information, relatively small sample size, and restriction to a single community, which may limit the generalisability of the findings.

CONCLUSION

Traditional home delivery was common among respondents in Oluku Community, with TBAs playing a major role in childbirth. Although awareness of traditional home delivery was high, important gaps remained in perception of risk and access to formal maternity services. Limited healthcare access, cost, cultural and religious beliefs, trust in TBAs, fear of medical interventions and mistrust of healthcare providers influenced delivery choices. Improving skilled birth attendance in the community will require affordable and accessible maternity services, reliable referral and transport pathways, respectful care and culturally responsive community engagement.

RECOMMENDATIONS

Community and primary healthcare programmes should strengthen education on childbirth danger signs and the benefits of skilled birth attendance while addressing misconceptions and fear of facility-based care. Financial and transport barriers to facility delivery should be reduced, particularly for lower-income women. Health facilities should prioritise respectful, patient-centred maternity care to improve community trust. TBAs and community leaders may be engaged in health promotion, birth preparedness, early recognition of complications and prompt referral to skilled providers. Local maternal-health programmes should monitor place of delivery, skilled attendance, referral delays and barriers to care to guide future interventions.

DECLARATIONS

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