OPEN ACCESS

Middle East Research Journal of Humanities and Social Sciences
ISSN 2789-7761 (Print) | ISSN 2958-2040 (Online)
Frequency: Bi-Monthly
DOI: https://doi.org/10.36348/merjhss.2026.v06i03.003

KUWAIT SCHOLARS PUBLISHER
Website: http://www.kspublisher.com/
Email: office@kspublisher.com

Bridging Tradition and Modernity: A Socio-Historical Analysis of Traditional Birth Attendants and the Integration of Maternal Healthcare in North-Western Nigeria

Labbo Abdullahi, PhD[1*]
[1]Department of History and International Studies, Usmanu Danfodiyo University, Sokoto, Nigeria

Abstract: Despite the advancement of modern medical infrastructure, Traditional Birth Attendants (TBAs) remain the primary providers of maternal and child health (MCH) services for a significant proportion of the population in North-western Nigeria. This paper provides a socio-historical appraisal of the role of TBAs, tracing their evolution from an entrenched indigenous medical tradition through the resistance of the colonial era to contemporary post-colonial health initiatives. Utilising a qualitative, historical-analytical approach, the study identifies a myriad of structural and cultural barriers including historical mistrust of Western medicine, the *purdah* system, and systemic socioeconomic constraints that contribute to the suboptimal uptake of formalised MCH services. The findings reveal that while TBAs offer critical psychosocial support and cultural competence, certain traditional practices pose significant clinical risks, such as those contributing to vesico-vaginal fistula (VVF). The paper argues that the persistent reliance on TBAs, particularly in rural locales, necessitates a strategic shift from alienation to formalised integration. It concludes that by incorporating TBAs into the formal healthcare framework as pivotal stakeholders in referral and accompaniment, North-western Nigeria can better mitigate maternal morbidity and mortality, ultimately fostering a more inclusive and effective maternal healthcare system.

Keywords: Traditional Birth Attendants (TBAs), Maternal and Child Health (MCH), North-western Nigeria, Healthcare Integration, Maternal Mortality.

Review Paper

***Corresponding Author:**
Labbo Abdullahi
Department of History and International Studies, Usmanu Danfodiyo University, Sokoto, Nigeria

How to cite this paper:
Labbo Abdullahi (2026). Bridging Tradition and Modernity: A Socio-Historical Analysis of Traditional Birth Attendants and the Integration of Maternal Healthcare in North-Western Nigeria. *Middle East Res J. Humanities Soc. Sci, 6*(3): 84-90.

Article History:
| Submit: 08.05.2026 |
| Accepted: 11.06.2026 |
| Published: 25.06.2026 |

Background and Aim

According to an analysis of the 2013 Nigeria Demographic and Health Survey (NDHS), Nigeria accounts for approximately 10% of global maternal and under-five mortality. It is estimated that 52,900 Nigerian women succumb annually to pregnancy-related complications, with the lifetime risk of maternal death in the country cited as 1 in 13. [1] A Traditional Birth Attendant (TBA) is defined as an individual who assists women during parturition, having typically acquired their skills through personal experience or via an apprenticeship under established practitioners. TBAs are pivotal community members who provide a vital conduit for indigenous customs, traditions, and beliefs regarding childbirth and neonatal care; as such, they constitute an integral component of African medical systems. Despite advancements in modern healthcare, TBAs remain extensively utilised within Nigeria's rural communities. [2] The 2013 NDHS data indicates that only 39% of births nationwide are attended by skilled birth attendants (SBAs), such as medical doctors, nurses, or midwives. [3] Significant urban-rural disparities in maternal and child health (MCH) persist, notwithstanding the

[1]O.U. Joseph, Factors Associated with the Use of Traditional Birth Attendants in Nigeria: A Secondary Analysis of 2013 Nigeria National Demography and Health Survey', *The Nigerian Journal of General Practice*, Wolters Kluwer-Medknow, 2018, p. 46
[2]A. Ndidiamaka, 'Progresses and Challenges of Utilizing Traditional Birth Attendants in Maternal and Child Health in Nigeria', in *International Journal of MCH and AIDS*, 2017 Global Health and Education Projects, 2017, 6(2), p. 130
[3]O.U. Joseph, Factors Associated with the Use of Traditional Birth Attendants… p. 46

objectives of the United Nations Millennium Development Goals (MDGs) to reduce maternal mortality. [4]

North-western Nigeria, a region comprising seven states predominantly inhabited by the Hausa people and various minority groups, exhibits considerable diversity in customs regarding prenatal, perinatal, and postnatal practices. In this region, TBAs typically elder women, serve as essential sources of socio-cultural support. Due to entrenched cultural beliefs, prevailing misconceptions, and the inaccessibility or prohibitive cost of SBAs, a substantial proportion of rural women continue to deliver at home under the guidance of TBAs. This paper aims to review the contributions of TBAs to the pregnancy and birthing process in North-western Nigeria. The central thesis posits that the formal integration of TBAs into the healthcare system could significantly enhance MCH outcomes both within the region and across Nigeria more broadly.

The Study Area

The North-western region is one of the six geopolitical zones in Nigeria and constitutes the northernmost part of the country. Comprising the seven states of Kano, Kaduna, Sokoto, Katsina, Kebbi, Jigawa, and Zamfara, the zone is predominantly inhabited by Hausa-speaking Muslims. [5] It covers a total landmass of 220,571 square kilometres and had a projected population of 50,416,775 as of June 2018. [6] Although several minority groups exist within North-western Nigeria, the Hausa culture remains dominant; consequently, the Hausa medical tradition prevails as the region's primary medical culture. A 2008 study by Pathfinder International indicates that the region is among the most economically and educationally disadvantaged in the country, characterised by a significant disease burden and high rates of maternal and child mortality dating back to the colonial period. [7] The area is also associated with an elevated risk of maternal and neonatal mortality, as well as severe health complications. For example, childhood mortality is exceptionally high, with more than one in four children dying before their fifth birthday. [8] Regarding maternal health, unsupervised labour and delivery are common practices in North-western Nigeria. Evidence suggests that due to the inaccessibility and unaffordability of modern healthcare facilities, among other factors, only 10% to 17% of women deliver in such institutions. For instance, Gulumbe's study of Kebbi State a constituent state of the region found that over two-thirds (71%) of pregnant women had never attended antenatal care. [9] Furthermore, 91% of these women delivered at home, and fewer than 10% received skilled birth attendance during their most recent delivery. [10] This implies that between 83% and 90% of pregnant women in the region give birth at home, typically assisted by Traditional Birth Attendants (TBAs).

Structural and Cultural Barriers to the Uptake of Modern Maternal and Child Health Services: A Brief Longitudinal Perspective

From the colonial era to the contemporary period, a myriad of factors has precipitated the limited uptake of modern Maternal and Child Health (MCH) services in North-western Nigeria. During the colonial epoch, pervasive mistrust and suspicion, alongside the entrenched role of Traditional Birth Attendants (TBAs), served as the primary determinants of historical resistance to formalised MCH services. Broadly speaking, the African conceptualisation of modern medicine was fundamentally underpinned by a deep-seated distrust of European actors. The evolution of trade relations between the British and the inhabitants of North-western Nigeria which ultimately transitioned into colonial hegemony engendered a profound scepticism towards Western medicine. Furthermore, the continued prevalence of traditional medicine, which the local population believed could sufficiently address their health requirements as it had for preceding generations, contributed to the ambivalent reception of colonial medical practices. Specifically, these same elements of suspicion and the reliance on TBAs obfuscated the integration of modern MCH services upon their introduction. This scepticism was rooted in historical grievances, ranging from the perceived duplicity in the formulation of treaties to the eventual physical conquest of the region by British forces. [11] It is within this context that Fanon posited that Africans perceived

[4]A. Ndidiamaka, 'Progresses and Challenges of Utilizing Traditional Birth Attendants in Maternal and Child Health in Nigeria', in *International Journal of MCH and AIDS*, 2017 Global Health and Education Projects, 2017, 6(2), p. 130

[5]UNDP, *Human Development Report Nigeria 2008-2009*.The United Nations, 2009, p. 98-9.

[6]National Population Commission, Population Projection of Nigeria as at June, 2018 and Nigerian Bureau of Statistic, Nigerian Population Projection as at June, 2018.

[7]Pathfinder International. *Reproductive Health Knowledge and Practices in Northern Nigeria: Challenging Misconceptions: The Reproductive Health/Family Planning Service Delivery Project in Northern Nigeria*. Watertown, MA: Pathfinder International, 2008, p. 6

[8]Pathfinder International. *Reproductive Health Knowledge,* p. 6

[9]U Gulumbe *et'al, '*Maternal Mortality ratio in Selected Rural Communities in Kebbi State, Northwest Nigeria', *BMC Pregnancy and Childbirth*, 2018, 18:503, pp. 1-2

[10]U Gulumbe *et'al, '*Maternal Mortality ratio, p. 2

[11]Ibrahim Musa Argungu, Former Zonal Health Co-ordinator, Birnin-Kebbi Zonal Office, 75 years, *Interview* at his Residence Argungu town, 29th May, 2019

Europeans as possessing ulterior motives, suggesting that colonial injections and pharmaceuticals were instruments employed to manipulate the African conscience and ensure compliance with colonial agendas. [12]

In the contemporary era, conversely, a combination of cultural conservatism, pervasive misconceptions, and limited awareness compounded by systemic poverty and the inaccessibility of modern infrastructure accounts for the suboptimal uptake of modern antenatal and postnatal services. With respect to conservative attitudes and misconceptions, many husbands, particularly within rural locales, restrict their wives' access to modern healthcare facilities in adherence to the *purdah* system. This Islamic tradition, which entails the seclusion of married women from unrelated males, often serves as a significant socio-cultural barrier to the utilisation of formal medical services. [13] "In certain instances, husbands preclude their wives' access to modern healthcare facilities primarily due to the associated financial implications. This phenomenon is not unique to North-western Nigeria; as Inyang and Anucha observe, financial constraints represent a significant impediment that hinders access to, and the utilisation of, skilled birth attendants and institutional deliveries across various African nations. Furthermore, suboptimal attendance at antenatal and postnatal clinics is often attributable to a limited appreciation of the clinical advantages offered by modern healthcare facilities in comparison to the traditional services provided by TBAs. [14]

The Evolution of Traditional Birth Attendants in North-western Nigeria:
A Socio-Historical Analysis of Resistance, Integration, and Maternal Health Outcomes

Historically, Traditional Birth Attendants (TBAs) have served as the primary human resource for women during parturition. Their role is undeniably significant, particularly regarding cultural competence, emotional consolation, empathy, and psychosocial support during childbirth factors that yield substantial benefits for both maternal and neonatal well-being. [15]

The provenance of TBAs in Africa is intrinsically linked to the continent's earliest history; as indigenous populations adapted to their environment, they developed holistic and dynamic healing traditions. Like many other African societies, the people of North-western Nigeria established sophisticated systems for the identification, treatment, and prevention of maternal and child health (MCH) complications. [16]

Central to these systems were traditional ontologies regarding the causation of illness, which were often attributed to supernatural, mystical, hereditary, or genetic factors. [17] These belief systems provided the diagnostic framework for identifying maternal and paediatric ailments and dictated the protocols for therapeutic intervention. Within the North-western Nigerian context, conditions such as miscarriage, stillbirth, poliomyelitis, smallpox, and leprosy were frequently associated with spiritual influences. [18] Over centuries, TBAs refined a repertoire of preventive and curative methodologies, often involving the administration of medicinal preparations through ingestion, ablution, or topical application. [19] Following delivery, the TBA typically attends to the mother twice daily for a minimum of seven days, assuming responsibility for essential postnatal tasks such as neonatal umbilical cord care and the ritual bathing of both the mother and the infant. [20] Specifically, the scope of TBA practice in North-western Nigeria encompasses, but is not limited to, the following interventions:

i. Preparation of concoctions against infertility and or for fertility enhancement.
ii. Preparation of inductive concoctions for easy and safe deliveries.
iii. Preparation of concoctions to be taken by pregnant women to guard themselves and their unborn babies against miscarriage, still-birth, poliomyelitis, smallpox and leprosy.
iv. *Tsagar gishiri* or *yankan gishiri* (vaginal incision) this is done to pregnant women during child birth. It is a traditional episiotomy done by TBAs using a razor blade. It is performed

[12]F. Fanon, *A Dying Colonialism,* trans. by Haakon Chevalier (New York Grove), 1965, pp. 121-135
[13]Pathfinder International, 'Reproductive Health Knowledge and Practices in Northern Nigeria … p. 12
[14]Pathfinder International, 'Reproductive Health Knowledge and Practices in Northern Nigeria … p. 12
[15]H. Polly, *Rural Hausa: A Village and a Setting,* Cambridge University Press, 1972, p. 300
[16]Malam Na'Allah Bui, Colonial Medical Staff, 91 years, *Interview* at his Residence, Argungu, 14th May, 2019
[17]J. Amzat, O. Razum, "Health, Disease, and Illness as Conceptual Tools".*Medical Sociology in Africa,* Switzerland: Springer International Publishing, 2014: 34-36
[18]Ibrahim Musa Argungu... *Interview*
[19]M.U. Bunza "The Contribution of Sultan Muhammadu Bello to the Development of Medicinal Services in the 19th Century Hausaland", *M.A. History,* UDU Sokoto, 1995, pp. 48-53
[20]H. Polly, *Rural Hausa: A Village and a Setting,* Cambridge University Press, 1972, p. 300 and U.K Asabe and M.U. Aisha, 'Myth or Reality: The Portrayal of Women Characters In *Kukan Zaki* (The Roar of the Lion' in *Ahmed Y. and Saeedat A. (eds.), Gender Politics: Women's Writings and Film in Northern Nigeria,* Proceedings of the 6th Conference on Northern Nigerian Literature held at the Kwara State University from the 29th of November to the 2nd of December, 2011, p. 125

during obstructed labour, especially in premature births.

v. *Yankan cibi* (cutting the umbilical cord). On the event birth TBAs cut the navel string of the new born baby.
vi. *Wankan jariri* (bathing of the baby). The new born baby is given bath twice a day.
vii. *Wankan jego*" (bathing of the nursing mother). The nursing mother is given a hot bath using leaves of the neem tree twice a day for about 40 days following delivery. The leaves are usually dipped into boiled water and splashed on the body until the water runs out. Although the hot water massages the body and many women say the bath makes them feel good, if overdone, it can raise the woman's blood pressure.[21]
viii. Preparation of the special gruel (*kunun kanwa*) which is believed to be medicinal and the nursing mother is expected to take for at least forty days after birth.[22]
ix. TBA advises nursing mother not give the new born baby ordinary milk because there is danger in giving the milk to a child when the baby is sucking the breast… So the best thing a nursing mother will do is to give breast milk to the baby.
x. Preparation of concoction for the purification and increase of breast milk of the nursing mother.
xi. Preparation of herbal concoctions for post-natal and neonatal care.[23]

Despite undergoing various transformations and facing numerous challenges over time, as detailed in the subsequent sections, these practices continue to support the health and well-being of mothers and children in the region to the present day.

The Colonial Period

Modern healthcare services, encompassing maternal and child health (MCH) such as antenatal and postnatal care, were introduced to North-western Nigeria during the colonial era. At the time of their introduction, these services encountered an established indigenous framework where mothers and mothers-in-law assisted in deliveries, supported by the expertise of Traditional Birth Attendants (TBAs). [24] Consequently, the nascent colonial services intersected with an entrenched tradition of antenatal, postnatal, and neonatal care. In conjunction with the aforementioned factors, it proved exceedingly difficult for both TBAs and their clientele to relinquish practices inherited from their ancestors. This cultural continuity explains the reluctance of many TBAs to adopt modern MCH techniques; a significant majority remained steadfast in their opposition to what they perceived as a competing medical tradition. [25] Furthermore, women in the region maintained a profound belief in the efficacy of TBAs, a trust rooted in the perceived success of these practitioners in serving previous generations. As a result, much of the population, mirroring trends observed in other African societies, exhibited ambivalent or resistant attitudes towards modern MCH services throughout the colonial period.

Recognising that colonial MCH initiatives could not achieve significant patient recruitment without the cooperation of TBAs, colonial medical authorities shifted their focus towards the training and integration of these practitioners into formal antenatal and postnatal services. Integration schemes were established in major urban centres, including Kano, Kaduna, Sokoto, and Katsina. Nevertheless, enrolment remained minimal, and those who did participate often did so with profound suspicion. Moreover, TBAs were perceived to have fostered a climate of scepticism and resistance among women regarding the delivery of these new services. Efforts to secure the cooperation of TBAs and to encourage the adoption of formal clinical skills and hygienic standards yielded negligible results. [26] Colonial officials grew increasingly concerned by this lack of engagement, as maternal and infant health were deemed critical for both administrative and socio-economic objectives. Maintaining the belief that local conservatism could be mitigated through patience and persistence, officials reconfigured the training programmes to include official recognition and financial incentives. Despite these modifications, recruitment remained stagnant until the end of the colonial regime; ultimately, over 98% of women in the region continued to bypass colonial MCH services in favour of traditional alternatives. [27]

The Post-colonial Period

In the post-colonial era, the training and integration of Traditional Birth Attendants (TBAs) into modern Maternal and Child Health (MCH) service

[21]Pathfinder International, 'Reproductive Health Knowledge and Practices in Northern Nigeria … p. 12
[22]U.K Asabe and M.U. Aisha, 'Myth or Reality: The Portrayal of Women Characters In *Kukan Zaki* (The Roar of the Lion' in *Ahmed Y. and Saeedat A. (eds.), Gender Politics: Women's Writings and Film in Northern Nigeria,* Proceedings of the 6th Conference on Northern Nigerian Literature held at the Kwara State University from the 29th of November to the 2nd of December, 2011, p. 125
[23]Pathfinder International, 'Reproductive Health Knowledge and Practices in Northern Nigeria … p. 13
[24]A. Ndidiamaka, 'Progresses and Challenges of Utilizing Traditional Birth… p. 131
[25]NAK/SOKPROF/3108/Training of Female Health Visitors/Nurses/Midwives/Community Attendants/Sanitary Inspectors
[26]NAK/SOKPROF/3108
[27]NAK/SOKPROF/3108/Training of Female Health Visitors/Nurses/Midwives/Community Attendants/Sanitary Inspectors

delivery in North-western Nigeria is best situated within the broader continental context. Following independence, many African nations continued to grapple with high maternal morbidity and mortality, necessitating a continued reliance on the services of TBAs. However, since the World Health Organisation (WHO) began advocating for TBA training in the 1970s, a movement reinforced by the 1987 Safe Motherhood Conference in Nairobi—there has been a concerted international effort to address maternal mortality in high-burden countries. Subsequent global fora, such as the 1994 International Conference on Population and Development (ICPD) in Cairo, further solidified commitments to reducing maternal and neonatal mortality. Central to these efforts was the adoption of an International Development Target (IDT) to reduce maternal mortality by 75% by 2015. Identifying and implementing effective, affordable interventions remained a critical challenge; among these, the strategic engagement of TBAs emerged as a pivotal, though contested, intervention. [28]

In alignment with the WHO's strategic focus on training TBAs to mitigate mortality during home deliveries, the Basic Health Service Scheme was launched across all states in North-western Nigeria in 1976. This initiative prioritised MCH services through the establishment of Basic Health Clinics, to which trained TBAs were subsequently attached. [29] In Sokoto State, for example, a TBA training programme was inaugurated in 1980, sponsored by the State Ministry of Health with support from the WHO and the United Nations Development Programme (UNDP). By September 1981, the number of trained TBAs in Sokoto State alone had reached approximately 612. [30] Although these practitioners were not fully integrated as skilled birth attendants, they were deployed within rural communities to support pregnant women and supervise deliveries. Following their engagement, these trained TBAs recorded 10,791 deliveries in 1980, [31] and by 1982, their reports included 11,720 live births, 250 stillbirths, 217 abortions, and 50 neonatal deaths. [32]

Nevertheless, over the three decades following the initial WHO advocacy, systematic reviews regarding the impact of TBA training failed to produce compelling evidence of significant mortality reduction. Consequently, by the late 1990s, a consensus emerged that training alone was insufficient; instead, TBAs were re-conceptualised as promoters of facility-based care who should work alongside skilled birth attendants. [33] This shift was further reinforced by Millennium Development Goal 5 (MDG 5), which sought to improve maternal health by 2015. [34] Building upon the momentum of the MDGs, Nigeria and other nations have since committed to the Sustainable Development Goals (SDGs), targeting a maternal mortality ratio of less than 70 per 100,000 live births by 2030. [35] Within the MDG/SDG framework, TBAs have also been integrated into programmes for the prevention of mother-to-child transmission (PMTCT) of HIV. However, their role remains primarily limited to patient referral and accompaniment during labour, rather than serving as facility-based care providers. [36] There is, therefore, a demonstrable need for a more comprehensive and formalised integration of TBAs within modern healthcare facilities in North-western Nigeria. This necessity is underscored by the enduring belief among rural populations in the efficacy of traditional medicinal preparations over formalised antenatal, postnatal, and neonatal services.

Conclusion and the Need for Integration

This paper has demonstrated that Traditional Birth Attendants (TBAs) provide a comprehensive spectrum of reproductive health services, encompassing antenatal care, labour and delivery support, postnatal and neonatal care, infertility treatment, and the management of threatened abortions. It is contended that a complex interplay of factors ranging from historical mistrust of colonial medical regimes and the enduring presence of traditional medical systems to contemporary cultural conservatism, limited awareness, and systemic issues of accessibility and affordability, collectively accounts for the prevailing preference for home births and the suboptimal uptake of formal Maternal and Child Health (MCH) services. From a clinical perspective, home deliveries conducted by TBAs are associated with a higher incidence of complications compared to those overseen by skilled birth attendants in institutional settings. Notably, home deliveries without adequate postnatal supervision may lead to genital sepsis, wound

[28]S. Bergstrom and E. Goodburn, 'The Role of Traditional Birth Attendants … p. 3

[29]*Interview* with Ibrahim Musa Argungu who championed the take-off of the scheme in Sokoto State, Age 75, Venue his residence in Argungu town, Kebbi State, 23rd June, 2019

[30]Sokoto State Health Project, Feasibility Report, February 1983, MOCO Nigeria Limited, Lagos Nigeria, Chap. 2, p. 27

[31]Sokoto State Health Statistics of 1981, Statistic Division, Economic Planning Department; Ministry of Finance and Economic Planning, Sokoto State, Sokoto, 1981, p. 51

[32]Sokoto State Health Statistics of 1982, Statistic Division; Ministry of Economic Planning, Sokoto, Nigeria, January, 1984, pp. 47-8

[33]O.U. Joseph, Factors Associated with the Use of Traditional Birth Attendants… p. 46

[34]WHO: Partnership for Maternal, Newborn, and Child Health

[35]O.U. Joseph, Factors Associated with the Use of Traditional Birth… p. 45

[36]O.U. Joseph, Factors Associated with the Use of Traditional Birth Attendants… p. 46

infections, or peritonitis, thereby endangering maternal lives. [37] Furthermore, the traditional practice of *tsagar gishiri* remains a primary aetiological factor in the development of vesico-vaginal fistula (VVF). [38]

Nevertheless, despite these documented clinical risks, the tradition of TBA-assisted delivery has historically played a vital role in sustaining maternal and neonatal well-being from the pre-modern era to the present day. In North-western Nigeria, a significant majority of pregnant women continue to exhibit a marked preference for TBAs over formalised medical practitioners. For instance, data from 2015 indicates that only 32.9% of pregnant women in the region utilised formal antenatal care. [39] This cultural preference is further evidenced by the common practice of relatives 'smuggling' traditional medicinal preparations to patients admitted to formal hospitals. Consequently, given the historical significance and continued influence of TBAs, it is imperative to integrate rather than alienate these practitioners if the utilisation of formalised MCH services is to be improved.

This study posits that, through targeted training, TBAs can become highly effective partners in addressing maternal and neonatal health challenges. Formalised training would enable TBAs to identify critical danger signs during pregnancy and labour, facilitating timely interventions that could significantly reduce maternal mortality. It is therefore recommended that TBA training be prioritised alongside efforts to increase institutional births, with a focus on encouraging TBAs to refer clients to modern facilities when complications arise. Providing high-quality maternal health training will empower TBAs to recognise the limits of their clinical scope, thereby facilitating referrals for essential services such as immunisation, family planning, and emergency obstetric care.

Ultimately, such training would position TBAs as pivotal agents in mitigating the challenges associated with poor maternal and child health outcomes. It is essential for policymakers to recognise the value of TBAs in community mobilisation and their potential to improve the uptake of formalised health services. By involving these culturally and socially sanctioned practitioners in MCH programmes and interventions, North-western Nigeria can better address the barriers to formal healthcare. TBAs should not be alienated from the search for solutions to maternal health challenges; rather, they must be viewed as indispensable stakeholders in the delivery of safe and culturally competent maternal and child health services.

REFERENCES

1. Joseph, O.U., 'Factors Associated with the Use of Traditional Birth Attendants in Nigeria: A Secondary Analysis of 2013 Nigeria National Demography and Health Survey', *The Nigerian Journal of General Practice*, Wolters Kluwer-Medknow, 2018
2. Ndidiamaka, A., 'Progresses and Challenges of Utilizing Traditional Birth Attendants in Maternal and Child Health in Nigeria', in *International Journal of MCH and AIDS*, 2017 Global Health and Education Projects, 2017, 6(2)
3. UNDP, *Human Development Report Nigeria 2008-2009*.The United Nations, 2009
4. National Population Commission, Population Projection of Nigeria as at June, 2018 and Nigerian Bureau of Statistic, Nigerian Population Projection as at June, 2018
5. Arewa House Archives Kaduna/19/23/A.395
6. Pathfinder International, 'Reproductive Health Knowledge and Practices in Northern Nigeria: Challenging Misconceptions', The Reproductive Health/Family Planning Service Delivery Project in Northern Nigeria, (nd.)
7. Gulumbe, U. *et'al,* 'Maternal Mortality ratio in Selected Rural Communities in Kebbi State, Northwest Nigeria', *BMC Pregnancy and Childbirth*, 2018, 18:503
8. Ibrahim Musa Argungu, Former Zonal Health Co-ordinator, Birnin-Kebbi Zonal Office, 75 years, *Interview* at his Residence Argungu town, 29th May, 2019
9. Fanon, F., *A Dying Colonialism,* trans. by Haakon Chevalier (New York Grove), 1965
10. Inyang and M.P. and Anucha, O.U., 'Traditional Birth Attendants and Maternal Mortality', in *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS),* 14(2), 2015, p. 21
11. Polly, H., *Rural Hausa: A Village and a Setting,* Cambridge University Press, 1972
12. Malam Na'Allah Bui, Colonial Medical Staff, 91 years, *Interview* at his Residence, Argungu, 14th May, 2019
13. Amzat, J. and Razum, O., "Health, Disease, and Illness as Conceptual Tools".*Medical Sociology in Africa,* Switzerland: Springer International Publishing, 2014
14. Bunza, M.U., "The Contribution of Sultan Muhammadu Bello to the Development of Medicinal Services in the 19th Century Hausaland", *M.A. History,* UDU Sokoto, 1995
15. Asabe, U.K and Aisha, M.U., 'Myth or Reality: The Portrayal of Women Characters in *Kukan Zaki* (The Roar of the Lion' in *Ahmed Y. and Saeedat A. (eds.), Gender Politics: Women's Writings and Film in*

[37]A. Ndidiamaka, 'Progresses and Challenges of Utilizing Traditional Birth… p. 132-133

[38]Pathfinder International, 'Reproductive Health Knowledge and Practices in Northern Nigeria … p. 12

[39]Statistical Report on Women and Men in Nigeria; 2015, National Bureau of Statistics, November, 2016, p. vi

Northern Nigeria, Proceedings of the 6th Conference on Northern Nigerian Literature held at the Kwara State University from the 29th of November to the 2nd of December, 2011
16. NAK/SOKPROF/3108/Training of Female Health Visitors/Nurses/Midwives/Community Attendants/Sanitary Inspectors
17. NAK/SOKPROF/3108
18. NAK/SOKPROF/3108/Training of Female Health Visitors/Nurses/Midwives/Community Attendants/Sanitary Inspectors
19. *Interview* with Ibrahim Musa Argungu who championed the take-off of the scheme in Sokoto State, Age 75, Venue his residence in Argungu town, Kebbi State, 23rd June, 2019
20. Sokoto State Health Project, Feasibility Report, February 1983, MOCO Nigeria Limited, Lagos Nigeria, Chap. 2
21. Sokoto State Health Statistics of 1981, Statistic Division, Economic Planning Department; Ministry of Finance and Economic Planning, Sokoto State, Sokoto, 1981, p. 51
22. Sokoto State Health Statistics of 1982, Statistic Division; Ministry of Economic Planning, Sokoto, Nigeria, January, 1984
23. WHO: Partnership for Maternal, Newborn, and Child Health
24. Statistical Report on Women and Men in Nigeria; 2015, National Bureau of Statistics, November, 2016