

Knowledge of community members on the risk factors influencing maternal mortality in Ede South Local Government Area, Osun State, Nigeria

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Abstract

Maternal mortality remains a major public health challenge in Nigeria, with an estimated 40,000 women dying annually from pregnancy-related complications. Poor access to quality healthcare, poverty, and harmful sociocultural practices continue to contribute to this burden. This study assessed community members' knowledge and attitudes regarding maternal mortality risk factors in Ede South Local Government Area, Osun State, Nigeria.

A descriptive community-based cross-sectional study was conducted among 185 adults selected through systematic sampling. Data were collected using a semi-structured, self-administered questionnaire and analyzed using SPSS version 21.

The mean age of respondents was 27.3±8.3 years, and 64.9% were female. Overall, 91.4% were aware of maternal mortality. Most respondents correctly identified bleeding (88.1%) and unsafe abortion (88.6%) as major causes, while 92.4% recognized antenatal care as an important preventive measure. However, knowledge gaps persisted regarding hypertension, the role of skilled birth attendants, and awareness of the Sustainable Development Goal target for reducing maternal mortality.

Although awareness was generally high, targeted community health education and improved access to skilled maternal healthcare are needed to address persistent misconceptions and reduce preventable maternal deaths.

Key words: knowledge, community members, risk factors, maternal mortality.

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Introduction

Maternal mortality remains a critical public health concern globally, especially in developing countries. It refers to the death of a woman while pregnant or within 42 days of the termination of pregnancy, resulting from pregnancy-related causes.¹ Despite efforts to improve maternal health, maternal mortality remains disproportionately high in Sub-Saharan Africa, accounting for approximately 70% of global maternal deaths.² Maternal mortality is a significant contributor to poor health outcomes in Nigeria, where an estimated 40,000 women die annually due to pregnancy-related complications.³ Maternal mortality in Nigeria is driven by several socio-economic and healthcare-related factors, including poverty, lack of access to quality healthcare, and limited education. Studies have identified bleeding, unsafe abortions, infection, and hypertension as direct causes of maternal deaths.^{4,5} Additionally, indirect factors, such as pre-existing conditions exacerbated by pregnancy, contribute significantly to maternal deaths in developing countries.² While Nigeria has made some progress toward reducing maternal mortality, the country's maternal mortality ratio remains one of the highest globally, at 630 deaths per 100,000 live births.⁶⁻¹²

Maternal deaths can be direct or indirect. Direct maternal deaths

result from obstetric complications during pregnancy, labor, or puerperium, while indirect deaths stem from pre-existing diseases aggravated by pregnancy, such as anemia, HIV/AIDS, heart disease, and diabetes.¹ World Health Organization reported an alarming death rate of 144 women per day in Nigeria due to childbirth-related conditions.³ The lifetime risk of a woman dying during pregnancy in Nigeria is estimated at 1 in 18, significantly higher than in developed countries such as Sweden, where the risk is 1 in 4500.³ Previous studies have emphasized the importance of socio-demographic factors, including age, education, and income, in shaping knowledge, attitudes, and perceptions regarding maternal mortality. For instance, a study in Ghana found that women with secondary education were more likely to delay pregnancies and have fewer children, thereby reducing their risk of maternal mortality.¹³ Similarly, Chowdhury *et al.* highlighted the role of education in improving maternal health outcomes in Bangladesh.¹⁴

In Nigeria, factors such as early marriage, teenage pregnancies, and unsafe abortions further complicate efforts to reduce maternal mortality.^{7-12,15} Although substantial progress has been achieved in many developed countries, maternal mortality remains unacceptably high in developing nations. Timely postnatal care plays a pivotal role in preventing maternal deaths by facilitating early detection and management of post-delivery complications, with recommen-

dations advocating postnatal assessment within two days after delivery.¹⁶ Obstetric complications remain one of the leading causes of mortality among women of reproductive age, highlighting the need for sustained public health interventions.^{7-12,17}

Despite growing evidence on maternal mortality in Nigeria, most studies have focused on clinical determinants and health system challenges, with relatively limited attention given to community knowledge, attitudes, and perceptions that influence care-seeking behaviors, particularly at the local government level. Furthermore, there is limited evidence describing community understanding of maternal mortality risk factors in Ede South Local Government Area (LGA), despite its diverse urban and peri-urban population and continuing maternal health challenges. Generating context-specific evidence from this setting is essential for designing culturally appropriate interventions, strengthening community engagement, and informing local maternal health programs. Therefore, this study assessed community members' knowledge, attitudes, and perceptions regarding maternal mortality risk factors in Ede South LGA of Osun State, Nigeria, to provide evidence to support targeted interventions for reducing maternal mortality.

Conceptual framework

This study was guided by a conceptual framework that explains the relationship between socio-demographic characteristics, knowledge, attitudes, perceptions, and maternal health-related behaviors (Figure 1). The framework assumes that socio-demographic factors such as age, sex, educational attainment, occupation, and marital status influence community members' knowledge of maternal mortality risk factors. Adequate knowledge is expected to shape positive attitudes towards maternal healthcare services and foster accurate perceptions of pregnancy-related risks. These attitudes and perceptions are, in turn, expected to influence health-seeking behaviors, including timely antenatal care attendance, skilled birth attendance, prompt recognition of obstetric danger signs, and appropriate healthcare utilization, which collectively contribute to reducing maternal mortality. This framework informed the development of the study questionnaire by guiding the selection of variables included under socio-demographic characteristics, knowledge, attitudes, and perceptions, and also provided the basis for interpreting the relationships observed in the study.

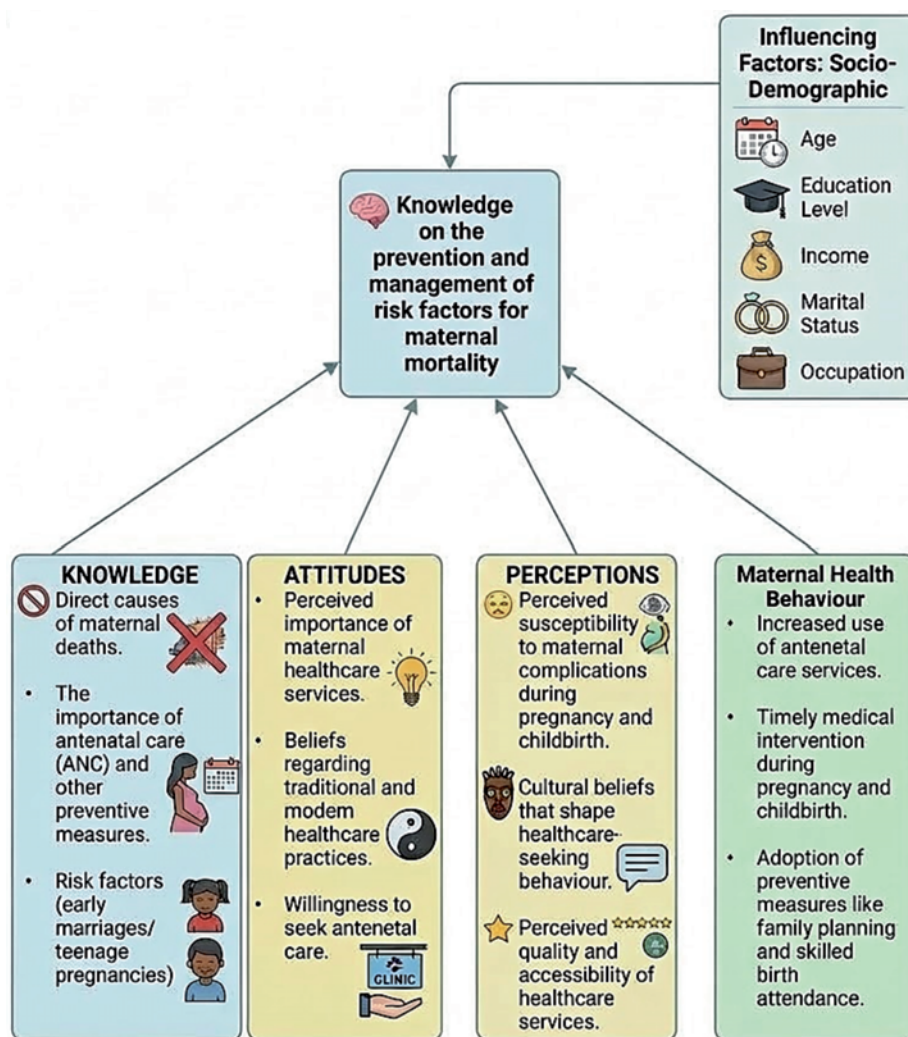


Figure 1. Conceptual framework.

Materials and Methods

Study area

The study was conducted in Ede South LGA, Osun State, southwestern Nigeria. Ede South is part of the larger Ede community and comprises a mixture of urban and peri-urban settlements. The area is predominantly inhabited by the Yoruba ethnic group, with Yoruba and English being the major languages spoken. The major occupations include farming, petty trading, artisan work, and civil service.

Maternal healthcare services in the LGA are provided through several primary healthcare centers and a general hospital. However, access to quality maternal healthcare remains suboptimal for some residents because of socio-economic and health system challenges. Ede South was selected for this study because it represents a typical Nigerian community where maternal mortality remains a public health concern, and there is limited community-level evidence on community knowledge, attitudes, and perceptions regarding maternal mortality risk factors. Generating context-specific evidence from the LGA is expected to support the development of locally relevant maternal health interventions and policies.

Study population

The study population comprised community members aged 18 years and above who were permanent residents of Ede South LGA, Osun State, Nigeria.

Study design

A descriptive community-based cross-sectional study was conducted to assess community members' knowledge, attitudes, and perceptions regarding maternal mortality risk factors.

Sample size determination

The minimum sample size was determined using the Leslie Kish formula for a single population proportion: $n = Z^2pq/d^2$; where n is the minimum sample size, Z is the standard normal deviate corresponding to a 95% confidence level (1.96), p is the estimated proportion of the population possessing the characteristic of interest, q is $(1-p)$, and margin of error set at 5% (0.05). A 10% allowance was added to compensate for possible non-response, resulting in a final sample size of 185 respondents.

Sampling technique

A systematic sampling technique was employed to recruit study participants. Eligible households within the selected communities were identified, and the first household was selected using a random starting point. Thereafter, households were approached systematically following the predetermined sampling sequence until the required sample size of 185 respondents was obtained. Within each selected household, all eligible adults aged 18 years and above were identified. Where more than one eligible respondent was available, one participant was selected using the systematic sampling approach to ensure equal opportunity for participation and to minimize clustering of responses within households. Households without eligible respondents or those declining participation were skipped, and the next eligible household in the sampling sequence was approached. This systematic approach enhanced the representativeness of the study sample while reducing selection bias.

Data collection instrument

Data were collected using a researcher-developed semi-structured, self-administered questionnaire based on an extensive review of relevant literature on maternal mortality and its associated risk factors. The questionnaire consisted of three sections that assessed respondents' socio-demographic characteristics, knowledge of maternal mortality and its causes, attitudes and perceptions regarding maternal mortality risk factors, and preventive measures. The questionnaire was reviewed by experts in public health and maternal health to establish content validity and was pretested among a population with characteristics similar to those of the study participants. Feedback from the pretest informed minor revisions to improve clarity and comprehension before the main data collection.

Data collection procedure

Eligible participants were informed about the objectives and procedures of the study before enrolment. Written informed consent was obtained from all participants before questionnaire administration. Participants completed the questionnaire independently, while trained research assistants provided clarification where necessary without influencing responses.

Data analysis

Completed questionnaires were checked for completeness and consistency before data entry. Data were entered and analyzed using the Statistical Package for the Social Sciences (SPSS) version 21 (IBM, Armonk, NY, USA). Descriptive statistics, including frequencies, percentages, means, and standard deviations where appropriate, were used to summarize the study variables.

Inclusion and exclusion criteria

Inclusion criteria

Participants were included in this study if they were community members aged 18 years and above; permanent residents of Ede South LGA; and individuals who provided written informed consent to participate in the study.

Exclusion criteria

Participants were excluded from participating in this study if they were community members younger than 18 years; individuals who declined to provide informed consent; and individuals who were unavailable during the period of data collection.

Ethical approval

Ethical clearance and approval to conduct this research were sought from the Faculty of Basic Medical Sciences Research and Ethics Committee, Adeleke University, Ede. Approval to conduct the research in the community was also sought and approved by Ede North Local Government Authority.

Results

Table 1 presents the socio-demographic characteristics of the respondents. A total of 185 respondents participated in the study, with a mean age of 27.3 ± 8.3 years. The majority were aged 18-23 years (44.3%), female (64.9%), single (60.5%), and students (46.6%). More than half had a BSc qualification (55.7%), while most were Yoruba (64.9%) and Christian (61.1%).

Table 2 presents respondents' awareness and knowledge of maternal mortality, its causes, and prevention. Most respondents had heard of maternal mortality (91.4%) and knew that death could occur from pregnancy-related problems (90.8%). However, less than half correctly identified the SDG target of 70 maternal deaths per 100,000 live births by 2030 (48.6%) and the reported maternal mortality ratio in Nigeria (45.9%). Most respondents identified a nurse/midwife (97.8%) and doctor (95.1%) as skilled birth attendants. Bleeding (88.1%) and unsafe abortion (88.6%) were the most frequently identified causes of maternal mortality. Regarding prevention, public health education (96.2%), supervised delivery care (93.0%), antenatal care (92.4%), family planning (88.1%), and

women's empowerment (88.1%) were commonly recognized preventive measures.

Table 3 presents respondents' knowledge of the risk factors for maternal mortality. The majority strongly agreed or agreed that lack of education (99.0%), poor healthcare services (94.0%), misinformation about available health services (91.9%), care-seeking behavior during pregnancy (91.9%), distance to health facilities (91.4%), and poverty were risk factors for maternal mortality. Other commonly recognized factors included alcohol consumption (87.6%), socio-economic status (80.5%), poor transportation (78.4%), unemployment (77.3%), and smoking (75.7%).

Table 1. Socio-demographic characteristics of the respondents (n=185).

Variables	Frequency	Percentage (%)
Age (years)		
18-23 years	82	44.3
24-28 years	32	17.3
29-33 years	32	17.3
34-38 years	19	10.3
39 and above	20	10.8
Total	185	100
Mean age $\pm$ standard deviation = 27.3 $\pm$ 8.3		
Sex		
Females	120	64.9
Males	65	35.1
Total	185	100
Marital status		
Single	112	60.5
Married	67	36.2
Widowed	4	2.2
Divorced	2	1.1
Total	185	100
Occupation		
Trading	24	13.0
Health worker	31	16.8
Civil servant	31	16.8
Unemployed	5	2.7
Student	86	46.6
Others	8	4.3
Total	185	100
Qualifications		
OND	21	11.4
HND	26	14.1
BSC	103	55.7
MSC	14	7.6
PHD	3	1.6
Others	18	9.7
Total	185	100
Ethnicity		
Yoruba	120	64.9
Igbo	47	25.4
Hausa	8	9.7
Total	185	100
Religion		
Christianity	113	61.1
Islam	68	36.8
Traditional	4	2.2
Total	185	100

OND, Ordinary National Diploma; HND, Higher National Diploma; BSc, Bachelor of Science/Bachelor's Degree; MSc, Master of Science/Master's Degree; PHD, Doctor of Philosophy/Doctorate Degree.

Table 2. Awareness, knowledge, causes, and prevention of maternal mortality (n=185).

	Yes, n (%)	No, n (%)	Don't know, n (%)
Awareness of maternal mortality			
Have you heard about maternal mortality?	169 (91.4)	13 (7.0)	3 (1.6)
Knowledge of maternal mortality			
Do maternal deaths occur mainly in women of reproductive age?	138 (74.6)	30 (16.2)	17 (9.2)
Does ANC attendance affect the outcome of pregnancy	117 (63.2)	27 (14.6)	41 (22.2)
Can early marriage cause maternal mortality?	131 (70.8)	33 (17.8)	21 (11.4)
Can death occur from pregnancy-related problems	168 (90.8)	10 (5.4)	7 (3.8)
One of the SDGs calls for reduction in MMR to 70 deaths per 100,000 live births by 2030	90 (48.6)	10 (5.4)	85 (45.9)
The current maternal mortality ratio in Nigeria is 814 deaths per live births	85 (45.9)	11 (5.9)	89 (48.1)
Women are at the risk of death when they have malaria during pregnancy	129 (69.7)	27 (14.6)	29 (15.7)
A “skilled birth attendant” at birth may include all of the following			
a) a nurse/midwife	181 (97.8)	2 (1.1)	2 (1.1)
b) a doctor	176 (95.1)	9 (4.9)	0 (0.0)
c) a trained traditional birth attendant	86 (46.5)	93 (50.3)	6 (3.2)
d) herbalist	23 (12.4)	153 (82.7)	9 (4.9)
e) auxiliary nurse	53 (28.6)	114 (61.6)	18 (9.7)
Causes of maternal mortality			
Most maternal death occur during			
a) antenatal period	65 (34.1)	95 (51.4)	27 (14.6)
b) labor	169 (91.4)	10 (5.4)	6 (3.2)
c) birth	166 (89.7)	11 (5.9)	8 (4.3)
d) breast feeding	35 (18.9)	117 (63.2)	33 (17.8)
Direct causes of pregnancy-related death:			
a) bleeding	163 (88.1)	18 (9.7)	4 (2.2)
b) unsafe abortion	164 (88.6)	14 (7.6)	7 (3.8)
c) headache	29 (15.7)	145 (78.4)	11 (5.9)
d) infection	91 (49.2)	55 (29.7)	39 (21.1)
e) cancer	67 (36.2)	78 (42.2)	40 (21.6)
f) hypertension	120 (64.9)	41 (22.2)	24 (13.0)
Prevention of maternal mortality			
Prevention of MM include			
a) antenatal care	171 (92.4)	5 (2.7)	9 (9.7)
b) tuberculosis services	62 (33.5)	94 (50.8)	29 (15.7)
c) family planning	163 (88.1)	16 (8.6)	6 (3.2)
d) post-abortion care	143 (77.3)	25 (13.5)	17 (9.2)
e) cancer screening	71 (38.4)	89 (48.1)	25 (13.5)
f) HIV counselling and testing	76 (41.1)	90 (48.6)	19 (10.3)
g) well-supervised delivery care	172 (93.0)	11 (5.9)	2 (1.1)
h) breastfeeding	63 (34.1)	108 (58.4)	14 (7.6)
i) public health education	178 (96.2)	4 (2.2)	3 (1.6)
j) women empowerment	163 (88.1)	15 (8.1)	7 (3.8)

SDGs, Sustainable Development Goals; MMR, maternal mortality rate; MM, maternal mortality.

Table 3. Knowledge about the risk factors of maternal mortality (n=185).

Variables	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly disagree (%)
Lack of education	132 (71.4)	51 (27.6)	1 (0.5)	1 (0.5)
Unemployment	56 (30.3)	87 (47.0)	34 (18.4)	8 (4.3)
Poor transportation	82 (44.3)	63 (34.1)	35 (18.9)	5 (2.7)
Misinformation of available services in health facilities	93 (50.3)	77 (41.6)	12 (6.5)	3 (1.6)
Alcohol consumption	95 (51.4)	67 (36.2)	19 (10.3)	4 (2.4)
Poverty	157 (74.1)	38 (30.8)	9 (4.9)	1 (0.5)
Socio-economic status	79 (42.7)	70 (37.8)	34 (18.4)	2 (1.1)
Types of care seeking behavior during pregnancy	108 (58.4)	62 (33.5)	13 (7.0)	2 (1.1)
Distance to health facilities	106 (57.3)	63 (34.1)	13 (7.0)	3 (1.6)
Poor healthcare services rendered in health facilities	122 (65.9)	52 (28.1)	8 (4.3)	3 (1.6)
Access to quality maternal care	106 (57.3)	54 (29.2)	15 (8.1)	10 (5.4)
Smoking	84 (45.4)	56 (30.3)	34 (18.4)	11 (5.9)

Discussion

This study demonstrated a high level of community awareness of maternal mortality, with 91.4% of respondents reporting awareness of the concept. Nevertheless, the proportion of respondents who lacked awareness (8.6%) indicates that important knowledge gaps still exist within the community and highlights the need for sustained public health education. These findings are comparable to those of Lawoyin *et al.*,¹⁸ who reported that many community members had personal experience with maternal deaths through relatives or acquaintances. However, despite the generally high awareness observed in this study, approximately half of the respondents were unaware of Nigeria's current maternal mortality ratio, consistent with findings reported by Suleiman *et al.*,¹⁹ Omoge and Kayode, and Omoge *et al.*,⁷⁻¹² suggesting that awareness of maternal mortality does not necessarily translate into adequate knowledge of its magnitude or public health implications. Although respondents correctly identified several major causes of maternal mortality, important misconceptions persisted. Nearly one-third believed that malaria during pregnancy does not increase maternal mortality risk, while only 64.9% recognized hypertension as a major cause of maternal death. These findings indicate persistent gaps in knowledge regarding indirect and preventable causes of maternal mortality, underscoring the need for comprehensive maternal health education beyond general awareness campaigns.

One notable finding was that more than half of the respondents regarded traditional birth attendants (TBAs) as skilled birth attendants. Similar observations were reported by Lawoyin *et al.*,¹⁸ who attributed this perception to financial constraints, limited availability of skilled healthcare providers, and poor accessibility of health facilities. In the context of Ede South, this finding may also reflect longstanding cultural trust in TBAs, their perceived affordability, proximity to communities, and the personalized care they often provide. While TBAs remain influential within many communities, their limited capacity to manage obstetric emergencies reinforces the importance of strengthening collaboration between TBAs and formal healthcare services through appropriate referral mechanisms and community education.

Respondents demonstrated good knowledge of several preventive measures, particularly antenatal care, supervised delivery, family planning, public health education, and women's empowerment. These findings support previous evidence emphasizing the importance of preventive maternal healthcare interventions.^{19,20} Nevertheless, the persistence of misconceptions regarding malaria, infection, and skilled birth attendance suggests that knowledge remains selective rather than comprehensive, highlighting opportunities for targeted health promotion. The study further identified several socio-economic determinants of maternal mortality, including low educational attainment, poverty, distance to health facilities, and place of delivery. These findings are consistent with previous studies by Karlsen,²¹ Adeyemi, and Omoge *et al.*,⁷⁻¹² Samuel and Haptamu,¹⁹ Ramos *et al.*,²² Asamoah,¹³ Suleiman *et al.*,¹⁹ Chowdhury *et al.*,¹⁴ Fillipi *et al.*,²³ and Harding *et al.*,²⁴ which demonstrated that educational attainment improves health literacy and healthcare utilization, while poverty and geographical barriers reduce timely access to skilled obstetric care. Collectively, these findings reinforce the multidimensional nature of maternal mortality and the need for interventions that address both health system and social determinants.

This study has several important implications for maternal health programming in Ede South. Although community awareness

of maternal mortality was relatively high, important knowledge gaps regarding specific risk factors, the national maternal mortality burden, and global maternal health targets remain. These deficiencies may reduce timely recognition of obstetric danger signs and delay appropriate healthcare-seeking. Strengthening community-based health education through primary healthcare facilities, community health workers, religious institutions, women's groups, schools, and local media could improve public understanding of maternal health risks and available services. The widespread perception that TBAs are skilled birth attendants also has important programmatic implications. Rather than excluding TBAs from maternal health programs, policymakers should consider structured engagement through training on danger sign recognition, prompt referral of obstetric emergencies, and collaboration with skilled birth attendants. Such culturally sensitive approaches are more likely to improve community acceptance while promoting safer maternal healthcare practices.

Despite recognition of preventive measures such as antenatal care and supervised delivery, financial constraints, transportation difficulties, healthcare accessibility, and cultural beliefs continue to influence healthcare utilization. Addressing these barriers requires integrated interventions that combine community education with improved availability, affordability, and quality of maternal healthcare services.

Implications of the study

The findings of this study have important implications for maternal health policy, practice, and research in Ede South LGA and similar settings. Although community awareness of maternal mortality was generally high, persistent misconceptions regarding important risk factors and the role of TBAs indicate that awareness alone is insufficient to promote appropriate maternal health-seeking behaviors. Community-based health education programs should therefore focus on improving knowledge of obstetric danger signs, the benefits of skilled birth attendance, timely antenatal and postnatal care, and the risks associated with delayed healthcare-seeking.

The study also highlights the need for culturally appropriate interventions that actively engage community leaders, religious leaders, women's groups, healthcare professionals, and TBAs in promoting evidence-based maternal healthcare practices. Strengthening collaboration between TBAs and formal healthcare providers through referral linkages and community outreach may improve early identification and referral of obstetric complications.

From a policy perspective, the findings underscore the importance of strengthening primary healthcare services, improving access to skilled maternal healthcare, and addressing socio-economic barriers such as poverty, inadequate transportation, and low educational attainment that continue to influence maternal health outcomes. Routine community awareness campaigns and continuous monitoring of maternal health indicators should be integrated into existing maternal and child health programs to improve service utilization and contribute to reducing preventable maternal deaths.

Study strengths

This study has several strengths. It provides community-level evidence on knowledge, attitudes, and perceptions regarding maternal mortality risk factors in Ede South LGA, a setting where such data are limited. By assessing awareness alongside perceived risk factors and preventive measures, the study offers context-specific findings that can inform maternal health education programs, com-

munity-based interventions, and policy decisions aimed at reducing maternal mortality. The use of a systematic sampling technique also enhanced the representativeness of the study population and minimized selection bias.

Study limitations

This study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design limits the ability to establish causal relationships between respondents' characteristics and their knowledge, attitudes, and perceptions regarding maternal mortality. Second, the use of self-reported questionnaire data may have introduced social desirability and recall bias, as respondents may have over-reported socially acceptable knowledge or behaviors. Third, although systematic sampling was employed, the findings are limited to Ede South LGA and may not be generalizable to other communities with different socio-cultural or healthcare contexts. Finally, community knowledge was used as a proxy for potential health behavior; however, knowledge alone may not necessarily translate into appropriate maternal healthcare practices.

Conclusions

The findings demonstrate that community members in Ede South possess substantial awareness of maternal mortality and recognize many of its major causes and preventive measures. However, important knowledge gaps remain regarding indirect risk factors, national maternal mortality statistics, Sustainable Development Goal targets, and the role of skilled birth attendance. Persistent misconceptions regarding TBAs and continuing socio-economic barriers may further hinder appropriate maternal healthcare utilization. Addressing these gaps through culturally appropriate health education, strengthened primary healthcare services, improved referral systems, and community engagement will be essential for improving maternal health outcomes and reducing preventable maternal deaths in Ede South and similar settings.

Recommendations

Based on the findings of this study, the following recommendations are proposed.

1. Community-based maternal health education programs should be implemented through primary healthcare centers, community health workers, religious organizations, women's associations, and local media to improve knowledge of maternal mortality risk factors and danger signs.
2. The Local Government and Osun State Ministry of Health should strengthen access to quality antenatal, delivery, emergency obstetric, and postnatal care by improving healthcare infrastructure, staffing, transportation, and referral systems, particularly in underserved communities.
3. TBAs should be integrated into community maternal health programs through structured training on pregnancy danger signs, early referral of obstetric complications, and collaboration with skilled birth attendants.
4. Family planning services and women's empowerment initiatives should be expanded to improve reproductive health decision-making, reduce unintended pregnancies, and promote timely utilization of maternal healthcare services.
5. Routine monitoring and evaluation of community maternal health education programs should be conducted using measur-

able indicators, including antenatal care attendance, skilled birth attendance, timely referral of obstetric emergencies, and changes in community knowledge and perceptions, to assess program effectiveness and guide continuous improvement.

Future directions

Future research should employ longitudinal or mixed-methods designs to better understand how community knowledge, attitudes, and perceptions influence maternal healthcare-seeking behaviors and maternal health outcomes over time. Qualitative studies involving community members, TBAs, healthcare providers, and policymakers would provide deeper insights into the socio-cultural beliefs and health system factors that shape maternal health practices in Ede South and similar settings. In addition, future studies should examine the effectiveness of community-based maternal health education programs, TBA-health facility collaboration, and other context-specific interventions using robust monitoring and evaluation frameworks. Multicenter studies across different regions of Nigeria are also recommended to enhance the generalizability of findings and support the development of evidence-based maternal health policies and programs.

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