

## **A Critical Assessment on the Need for Integrating Alternative Birth Attendant into Prevention of Mother to Child Transmission of HIV (PMTCT) Programme in Ekiti State, Nigeria**

Article by Charles Olusegun Doherty<sup>1</sup>, Remi Ajayi<sup>2</sup>, Yemi Ajumobi<sup>3</sup>

<sup>1</sup>Public Health, Texila American University

<sup>2</sup>Ekiti State AIDS Control Agency

<sup>3</sup>Ekiti State AIDS Control Agency

E-mail: dcolusegun@yahoo.com<sup>1</sup>

### **Abstract**

*Background: The 2014 National ANC Sero-prevalence Survey result for Ekiti State, Nigeria recorded HIV prevalence rate of 2.9% for the state, yet the uptake of PMTCT services was found to be low despite the availability of services even in the remotest local government area in the State. This survey investigated factors influencing the low patronage of government facilities and the possibility of integrating TBA/MBA into the PMTCT programme in the state.*

*Methods: Study conducted in the sixteen local Government area of Ekiti State. The sample size was 160 women of reproductive age (18-48) years of age, 35 ABH, and their clients (122), research period of 12 months. The instruments used were questionnaire, unstructured personal interviews and documentary reports. Data were collected and analysed by the use of Statistical Package for Social Sciences (SPSS 20) Software.*

*Results: Of the 16 LGAs in Ekiti State, 14 participated in the survey. Reasons for patronizing TBA/MBA are spiritual assistance 40%, Low bills 10%, Church influence 5.5%, availability 3.4%, personal relationship 7.6%, and other minor reasons. Less than 45%”, 32% of the respondents have very low knowledge of HIV; its mode of transmission and prevention, and 32% also score above 79% (Very good knowledge).*

*76% of the respondents have linkage system with the Government health facilities, while 24% respondents (24%) said NO.*

*Conclusions: This study showed that integrating TBA/MBA in health care service can be very effective in promoting PMTCT in Nigeria.*

**Keywords:** Alternative birth Attendants, HIV, PMTCT, TBA, MBA, Government facilities.

### **Introduction**

Every year, approximately 600,000 women die of pregnancy-related causes.<sup>1</sup> Ninety- eight percent of these deaths occur in developing countries, and for every woman who dies, at least 30 others suffer injuries and, often, permanent disability Donna, (2000). Since the adoption of the primary health care approach in Nigeria in 1979, the three tiers of government (federal, state and local government levels) have accepted the idea of the need to integrate TBAs into PHC system and have consequently initiated TBAs training programmes, (Fatusi and Abioye-Ketuyi 1997). A TBA has been defined by United Nations as a person who assists mothers during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs (WHO, 1992). TBAs presently deliver the majority of women in Nigeria as in other developing countries. (Fatusi and Abioye-Ketuyi 1997). It is estimated that between 60 and 80% of all deliveries in the developing countries occur outside modern health care facilities, with a significant proportion of this attended to by TBAs (WHO, 1992). Elimination of vertical transmission of HIV is a global priority, yet interventions still face diverse challenges in the country. It is estimated that 15% of eligible women only found to be enrolled into prevention of Mother to Child Transmission (PMTCT) of HIV program in Ekiti State, Nigeria. Household inequalities and access to resources remains a determinant factor for women choice for a place of birth.

## Rationale

The 2014 National ANC Sero-prevalence Survey result for Ekiti State, Nigeria recorded HIV prevalence rate of 2.9% for the state yet the uptake of Prevention of Mother to Child Transmission of HIV (PMTCT) services was found to be low despite the availability of services even in the remotest local government area in the State. Donor partners who activated and supported 34 of the PMTCT facilities threatened to discontinue support in terms of drug supply, sample collection etc. in about five (5) of them for a start due to low service uptake and decided to link the five facilities to other facilities in the urban and sub-urban areas where the few HIV positive mothers found would be linked for service uptake for cost effectiveness.

## General and specific objectives of the study

The purpose of this study is to ascertain the extent to which Alternative Birth Attendants (TBAs and MBAs) are patronized in Ekiti State, as well as factors responsible for such in one part and reasons for low patronage of pregnant women attending Antenatal Care to complete PMTCT programme in the State. The survey also intends to emphasize the need to integrate Alternative Birth Attendants into PMTCT in Ekiti State to achieve a zero level of vertical transmission.

The specific objectives of the study were to:

1. Conduct statistical Analysis of patronage of alternative birth places in Ekiti State.
2. Determine factors influencing the choice of birth place among women of reproductive age
3. Determine TBAs/MBAs Staff capacities and professional skills in maternal care.
4. Determine level of knowledge of TBA/MBA owners on HIV/AIDS
5. Identify and examine the extent of Linkage and partnership of TBAs/MBAs with Government Health Facilities in the referral process for the promotion of antenatal clinic and PMTCT services in Ekiti State.

## Literature review

### History of traditional attendants (TBAS)

Traditional Birth Attendants (TBAs) is as old as human race operating in an informal setting; TBA is also known as Traditional midwife, Community Midwife or lay midwife. The traditional birth attendants predate colonialism in Africa, they provide the majority of primary maternity care in many developing countries, and may function within specific communities in developed countries (Isichei, and Ammann, 2015).

Traditional birth attendant provide basic health care, support and advice during and after pregnancy and childbirth, based primarily on experience and knowledge acquired informally through the traditions and practices of the communities where they originated (Inegbenebor, 2014) They often learn their trade through apprenticeship or are self-taught in many developing countries of the world; one of the criteria for being accepted as TBAs by clients is experience as a mother (Harrison, 2011). They usually work in rural, remote and other medically underserved areas. TBAs may not receive formal education and training in health care provision and there are no specific professional requisites such as certification or licensure. In recent times,

### TBAs socio-demographic characteristics and focus of work

Traditional birth Attendants are often older women who are well respected in their communities with only a small percentage being males, in some communities in the South Western region of Nigeria, the men provided background support particularly in preparation and administration traditional medicine. Men TBAs are also herbalists or other traditional healers (Sareminetol *et al.*, 2016). They considered themselves as private health care practitioners whose service only required on requests. In the past, entry into traditional medical practice was through long period of apprenticeship or through inheritance or a hobby as a form of service to the community with low or no financial expectation from their clients (Bukar, and Jauro, 2013). Health services were administered by illiterate and old people could not document and therefore lost most of their medical knowledge.

## **The reality of indigenous alternate birth attendants within medical sub-system in nigeria**

TBASs may not have any formal training on how to attend to pregnant women or ailing women. Many are highly experienced in women care including how to recognize and respond appropriately to complications of pregnancy Zuluaga *et al.*, 2016. They sometimes serve as a bridge between the community and the formal health system as a panacea in the effect of poverty, non-availability of health services and weak institutional support experienced in most developing countries. TBAs are often thought of as the bridge between formal healthcare and cultural methods. Balogun, M.; and Odeyemi, K.; (2010); and Agbo, M.A.E. (2013) reported that TBAs provide a broad range of reproductive health services including antenatal care, labor and delivery, infertility treatment, and management of threatened abortion. Ofili and Orojie (2005) In a study conducted amongst the users of these services, 74.7 % were satisfied with their services. Ebuehi and Akintujoye, (2012) reported Reasons individuals prefer TBA services were due to greater accessibility, better relationships, lower cost, convenience, and freedom to use traditional birthing positions. Though no valid statistics available on the TBAs population in Nigeria, their age, sex distribution and years of experience yet they were found to be spatially distributed in communities of their residence most especially in the rural communities.

## **Dynamics of changing structure and emerging trends in traditional midwifery in nigeria**

Traditional midwifery in Nigeria has come a long way; most families believe and rely upon the services of the traditional midwifery for the delivery of their unborn babies and also for the relief of physical illness as well as psychological and spiritual comfort (Ekanem *et al.*, 2006). Over the years, their success is enhanced by their understanding of the personal, social, cultural, economic and political conditions of the individuals, families and communities (Roan, 1999). To many Nigerian, therefore, traditional birth delivery services are indispensable as it is more accessible, cheaper and more holistic than the modern health service (Nduka, and Nduka, (2014).

Traditional midwifery as an integral part of traditional medicine represents a natural form of health care which has been used through generations. According to the World Health Organization (WHO, 2015) traditional medicine is the sum total of all knowledge and practices whether explicable or not used in the diagnosis, prevention and elimination of physical mental imbalance but relying exclusively on practical experience and observation down from generation to generation whether verbally or in writing.

## **Methodology of study**

### **Study area**

This study was conducted in the sixteen local Government area of Ekiti State, Nigeria. Ekiti State, called the “Fountain of Knowledge” is one of the 36 states of the Federal Republic of Nigeria. Although Ekiti State is the smallest state in the country in terms of landmass, the National Population Commission (NPC) put the 2006 provisional census figure for the state as 2,300,000 out of the total national figure of 140 million. Ekiti state is an agrarian society and characterised by increased proliferation of low-income earners. The state is estimated entirely within the tropics with the coordinate 7°40'N 5°15'E / 7.667°N 5.250°E (NPC, 2016).

### **Study population**

The survey was carried out with mapping of Alternative Birth Places in the State. 160 women of Reproductive age (18-48) years of age and 35 Faith Based Birth Home or Mission Birth Place (MBH) owners and their clients (122) in four communities of each of the 16 Local Government in the State were targeted for the study.

### **Study duration**

The research study, which lasted for one year, began with Research design, Instrument test and validation in February 2018 and came to a close February 2019 with report presentation. The second part of the project is devoted to Monitoring, Evaluation and Sustainability of the programme.

### **Sampling method**

The purpose of this study was to access the various Alternative Birth Places and the level of patronage by Women of Reproductive age to underlying critical interventions such as strengthening linkages and

referral systems between traditional alternative birthplaces and health care facilities for increase in the uptake of PMTCT services.

In carrying out this study, the instruments used for research investigation are:

- Questionnaire, Unstructured Personal Interviews and Documentary Reports.

### Collection of data

In the process of gathering data, open and closed ended questionnaire which allow the respondents to write freely on the research topic were used. The questionnaire was for the women of Reproductive age (18-48 years of age). It focuses on general information on the choice of Birth place among women of Reproductive age:

- Social and Demographic information about the respondents
- Analysis of preferences of women of Reproductive age among Alternative Birth Places across the LGAs.
- Analysis of factors influencing the choice of birthplace among women of Reproductive age.

The second questionnaire was designed for TBAs and MBAs owners. This focuses on analyzing the capacities of the TBA and MBA owners in terms of this professional skills and competence. It also evaluates their knowledge level on the basic transmission mechanisms and prevention methods of HIV and the level of synergy existing between the TBAs/MBAs and the various government health facilities around them.

### Data analysis

Data collected was analyzed using the Statistical Package for Social Sciences (SPSS 20) and the Epi-Info 7 Software. All data collected were presented and analyzed under the following major ideas:

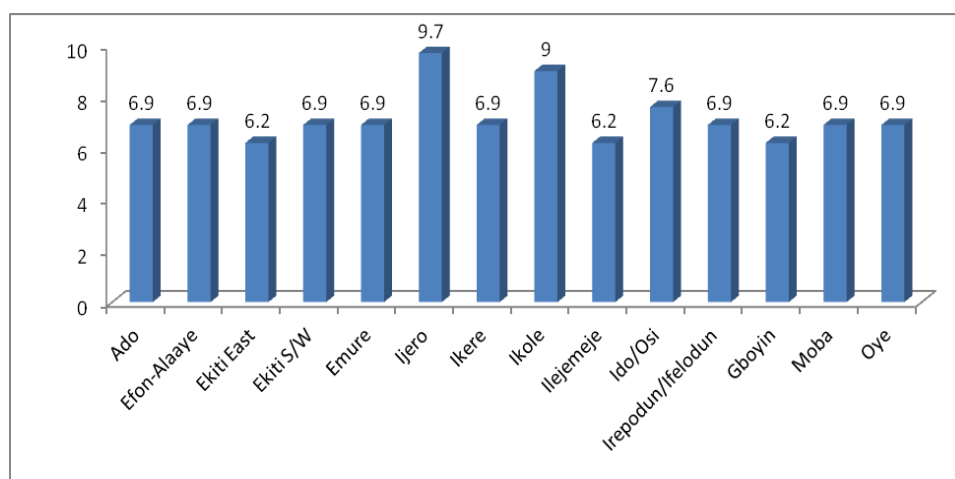
- Distribution of women of reproductive age by LGA/Regions
- Age distribution of women of reproductive age
- Respondent Birth Places
- Distribution of Birth Places by educational level
- Reasons for the preference of TBAs/MBAs above Government Health Facilities
- Distribution of TBAs/MBAs by LGA/Regions
- Distribution of TBAs/MBAs by age
- Average of deliveries and staff capacities of TBAs/MBAs
- Level of professional skills of TBAs/MBAs by region
- TBAs/MBAs owners' knowledge of HIV/AIDS
- Distribution of TBAs/MBAs partnership and linkage with Government Health Facilities.

The person product moment coefficient of correction would be used. In expressing the adequacy or inadequacy of every facilities material, percentage would be used.

### Observations and findings

#### Part A: TBA/MBA patronage by the Women of Reproductive age

##### Section 1: Social and Demographic information



**Figure1.** Distribution of Respondents by LGA

Figure 1 above shows the distribution of respondents by LGA. Out of the 16 LGAs in Ekiti State, 14 participated in the survey. It could be deduced that Ijero has the highest representation in the survey with about 9.7% respondent, followed by Ikole (9%) and Ido/Osi (7.6%). Others were about 6% representations.

**Table 1.** Distribution of respondents by region

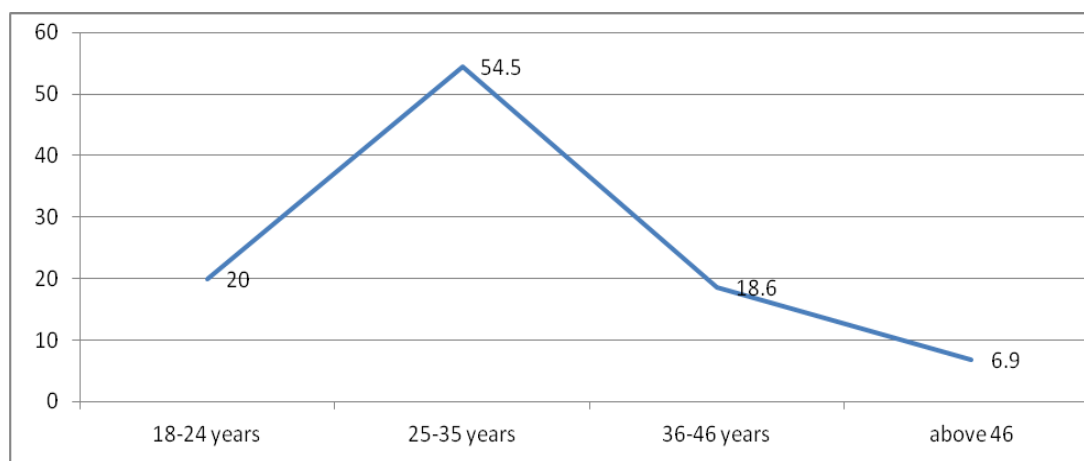
Regions	Urban	Sub-Urban	Rural
Percentage	27.6	24.8	47.6

It could be seen from the table1 above that majority of the respondents reside in the rural communities in Oye, Moba, Ilejemeje, and Emure. About 27 percent of the respondents reside in communities in Ado, Ikere, efon-Alaaye, Ekiti East and Ekiti West. Others (about 25 percent) are located in the sub-urban centres of Ido/Osi, Gboyin and Ikole LGAs among others.

**Table 2.** Descriptive Statistics of number of births by respondent and deliveries in TBA/MBA

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
Number of children born by respondent	144	8.00	.00	8.00	2.6181	1.77392	.611	.202
Number of children born in either TBA or MBA	145	7.00	.00	7.00	1.1172	1.70987	1.590	.201
Valid N (list wise)	144							

It is seen from the table that the respondents had an average of two (2) children each. This suggests that each of the respondents must have at least given birth twice irrespective of the birth place. Similarly, it could be deduced that at least a child was delivered at TBA/MBA.



**Figure 2.** Age distribution of Respondent

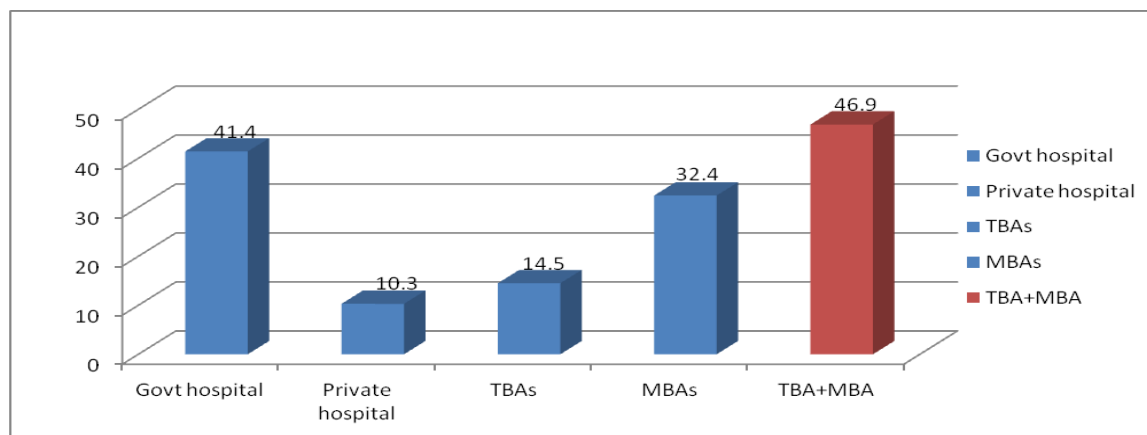
Considering the distribution of respondents according to their age brackets across the LGAs, it was observed that majority (about 54 percent) of the women fall within the age bracket of 25-35 years, and about 7 percent are above 46 years.

**Table 3.** Respondents educational attainment

Educational level	No Education	Primary	Secondary	Tertiary	Others
Percentage	5.5	15.2	42.1	33.8	2.1

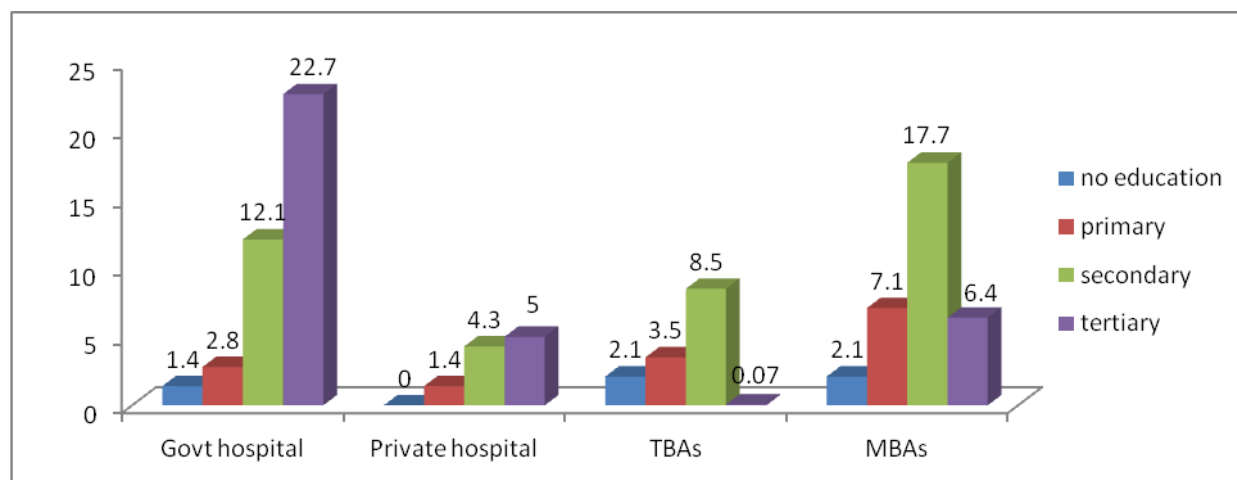
The table 3 above shows the distribution of educational qualifications of the women of reproductive age who participated in the survey. It reveals that about 5 percent of the respondents did not have any form of formal education, 15 percent for Primary school, while majority (42.1%) of them stopped at secondary school. This is followed by those who had tertiary education (33.8%).

## Section 2: Analysis of preferences of women of reproductive among alternative birth places across the LGAs



**Figure 3.** Respondents' Birth Places

Considering the various alternative birth places and the level of patronage by the women of reproductive age, it was discovered from the survey that, put together, about 47 percent of the women preferred to give birth at either TBA or MBA, compared to about 41 percent of who patronized the government hospitals for delivery.



**Figure 4.** Distribution of birth places by educational level

Cross tabulating respondents' choices of birth places with their respective educational attainment, the data show that women with higher educational qualifications (about 23 percent) preferred Government hospital to other health facilities. However, those with secondary and primary schools' qualifications (about 18 percent for MBAs and 8 percent for TBAs; secondary schools; and 7 percent in MBA and 3 percent; primary school) opt for non-government health facilities.

**Table 4.** Percentage of women patronizing TBAs/MBAs disaggregated by regions and level of education

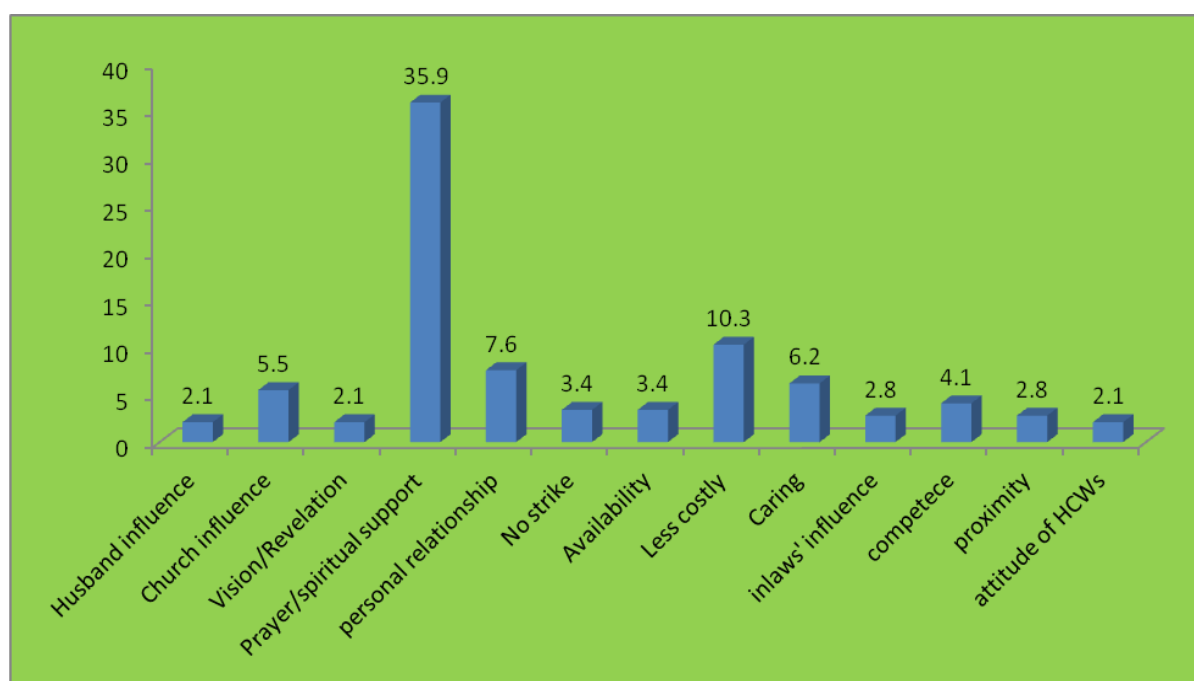
TBA/MBA patronage by regions in percentage of total respondent	Urban (N=18)	Sub-urban (N=20)	Rural (N=38)	Total (N=76)
	12.4	13.8	26.2	52.4
TBA/MBA patronage by level of education attainment in percentage of total respondent	No education (N=6)	Primary (N=17)	Secondary (N=40)	Tertiary (N=49)
	4.2	11.9	28	9.1

Discussing the percentage of women disaggregate by their respective regions, who patronize TBAs/MBAs for delivery, it shows that about 26 percent of women of reproductive age in the rural areas preferred delivery at TBAs/MBAs. Comparing to other areas, Women in the rural areas showed more preference for TBA/MBA than others in urban and sub-urban areas.

Disaggregating them by their levels of education, it is deduced that 28 percent of the respondents had their deliveries at the Mission home have only secondary education. Similarly, among those with primary education, about 12 percent had their deliveries at the TBAs/MBAs, and among those with tertiary education, about 9 percent still patronized them.

The survey further identified some of the reason as pointed out by the respondents, why they patronize TBAs/MBAs. These are presented in the figure below.

### Section 3: Analysis of factors influencing the choice of birth place among women of reproductive age



**Figure 5.** Reason for the preference of TBAs/MBAs above Government health Facilities

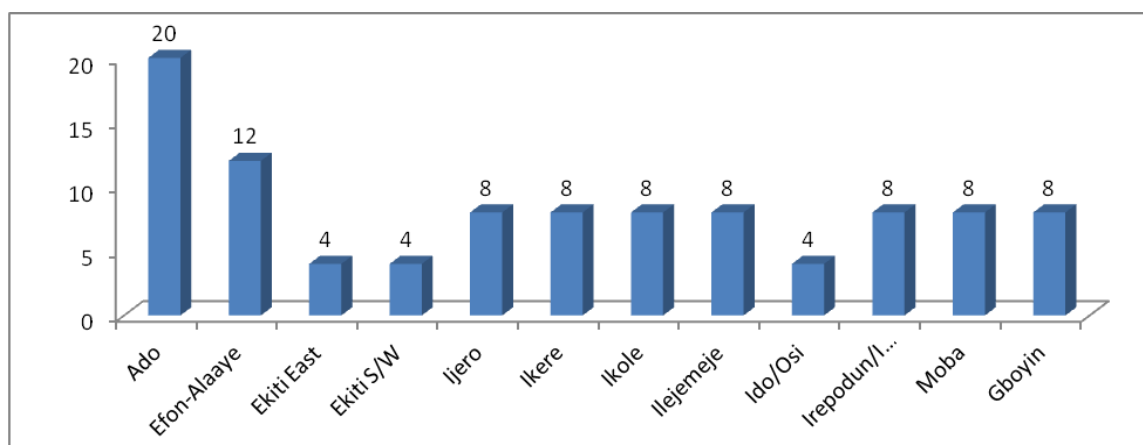
Among the reasons the women gave for patronizing TBA/MBAs, about 40 percent of the reported that their quest for spiritual assistance, prayer and miracles during delivery (which they always receive at the mission homes) was why they prefer TBAs/MBAs to Government health facilities. According to them, MBAs pray very well, prophecy and even see visions for them. Hence believe in the intervention of the supernatural power in their delivery is the strongest drive for visiting MBAs.

It was also discovered from the study that about 10 percent of the women patronized MBAs and TBAs because their bills are lesser compared with that of the conventional Government hospitals. Some posits that they do not pay for delivery at some places because it is a mission facility. The study also showed that the church has significant influence over their members' choices of delivery points. About 5 percent of the women opined that they deliver at the Mission homes because the facility belongs to their church, and their pastor had made it compulsory for them to deliver there.



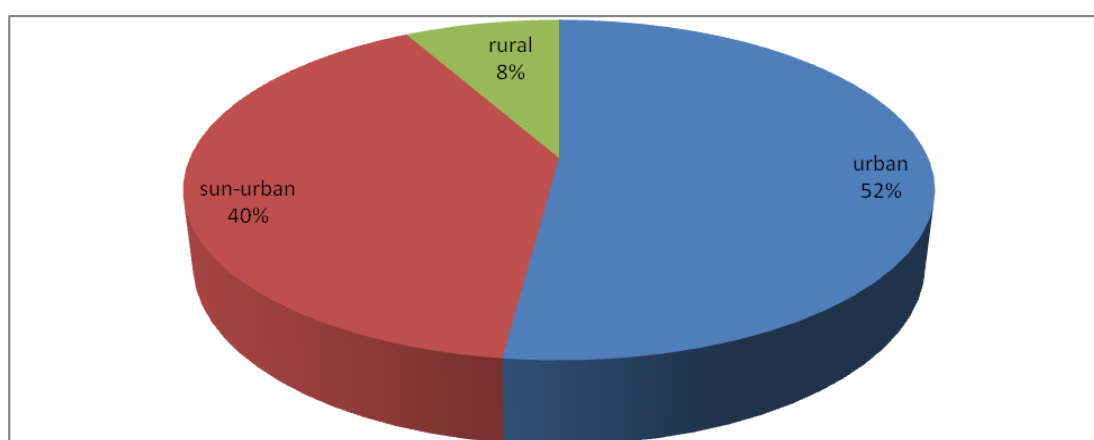
**Part B: Analysis of TBA/MBAs****Section 1: Demographic information of TBA/MBA Owners**

This section focuses on analyzing the capacities of the TBA and MBA owners in terms of their professional skills and competence. It also evaluates their knowledge level on the basic transmission mechanisms and prevention methods of HIV, and the level of synergy existing between the TBAs/MBAs and the various government health facilities around them.



**Figure 6.** Figure Distribution of Respondents by LGA

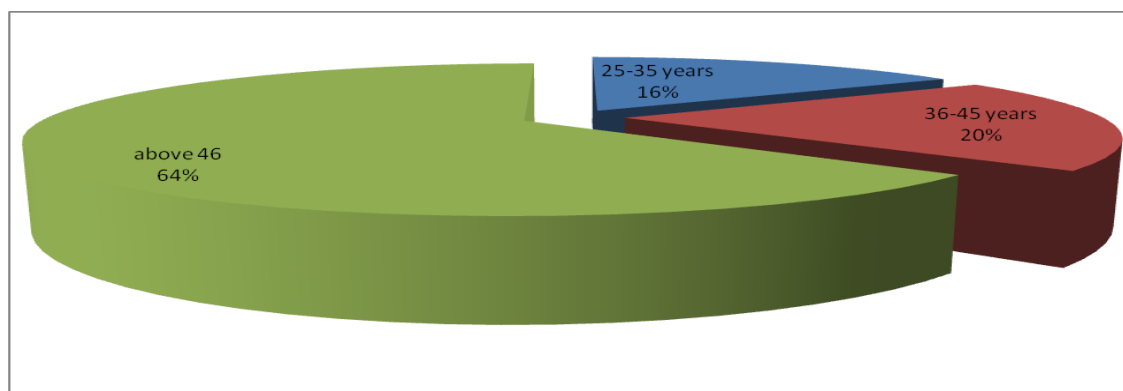
The chart above shows the distribution of respondents by LGA. Out of the 16 LGAs in Ekiti State, TBA/MBA owners in 12 participated in the survey. While Ado had the highest representation of response (20 percent), Ekiti East, Ekiti South/West and Ido/Osi shared equal representation of 4% each and others 8 percent.



**Figure 7.** Distribution of respondents by their regions

Considering the distribution of the respondents by region, it could be seen from the figure above that 52 percent of the respondents have their facilities in the urban areas such as Ado and Ikere LGA, 40 percent are in the sub-urban towns and the remaining in the rural communities.





**Figure 8.** Distribution of Respondents by age

The distribution of respondents according to their age brackets across the LGAs show that majority (about 64 percent) of the women are above 46 years of age, and 16 percent fall within the age bracket of 25-35 years

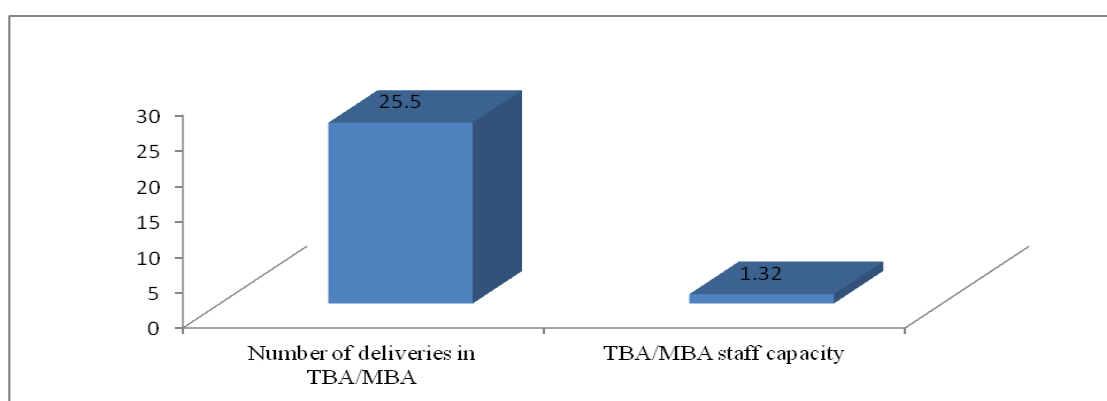
**Table 5.** Percentage distribution of TBA/MBA owners by educational qualification, religion and ethnicity

Percentage distribution of TBA/MBA owners' educational qualification	No education	Primary	Secondary	Tertiary
	4	56	36	4
Percentage distribution of TBA/MBA religion	Christianity	Muslim	Traditionalist	Others
	92	4	4	-
Percentage distribution of TBA/MBA by ethnicity	Yoruba	Igbo	Hausa	Others
	92	0	8	-

The table above summarized the distribution of the respondent by their educational status, religion and ethnicity. It can be observed that majority (56 percent) of the TBA/MBA owners possess primary school certificates, while those that attended Secondary school are 36 percent of the total respondent. Among the TBA/MBA owners, only 4 percent had higher educational certificate.

Considering their religious backgrounds, the study shows that over 92 percent of respondents are Christians. Similarly, the sample comprised 92 percent Yoruba and 8 percent Hausa across the state.

## Section 2: TBAs/MBAs Staff capacities and professional skills



**Figure 9.** Averages of deliveries and staff capacities of TBA/MBA

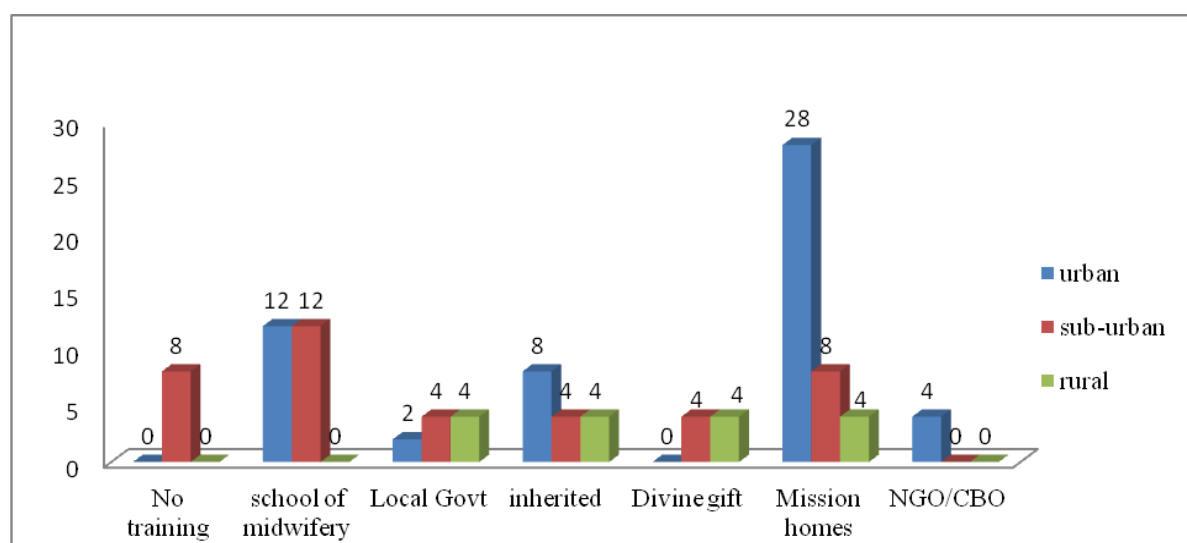
Considering the average number of deliveries handled by the TBAs/MBAs, the static shows that they have handle an average of 25 deliveries in recent times. On their staff strength, the TBAs have an average of one staff per facility.

**Table 6.** Percentage Distribution of TBAs/MBAs acquisition of professional skills and training schools attended as expressed by the respondents

<b>Does the owner have professional Health Care training</b>		
	Frequency	Percentage
No	6	24
Yes	19	76
<b>Where did you train as health care provider</b>		
No training	2	8
School of midwifery	6	24
Local Government Authority	1	4
Inherited it the skill from my forefather(s)	4	16
Call from God	1	4
Mission homes and TBAs	10	40
NGO/CBO	1	4

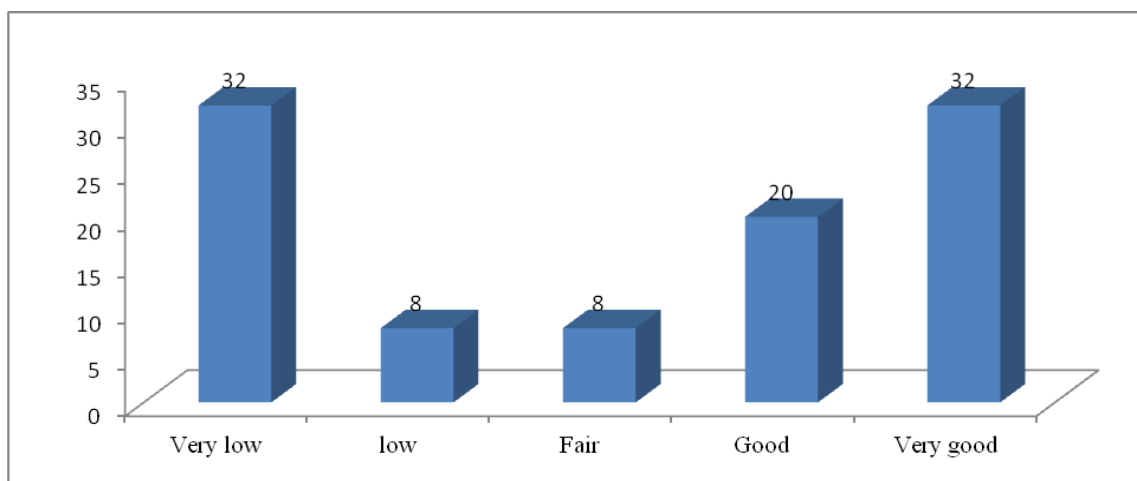
On whether the TBA/MBA owner had received any form of professional training before starting the business and/or after, 76 percent of the respondent confirmed that they had received professional health care training in relation to their field of operation.

Among those who had received professional trainings, 40 percent were trained by a Mission. A regular mission home referred to by them is the Christ Apostolic Church (CAC) mission home at Ede, Osun State. About 24 percent attended a school of midwifery while 16 percent suggest that they inherited the skills from their father. However, 8 percent of the respondents had not received any professional skills on midwifery across the sample.

**Figure 10.** Level of profession skills of TBAs/MBAs by region

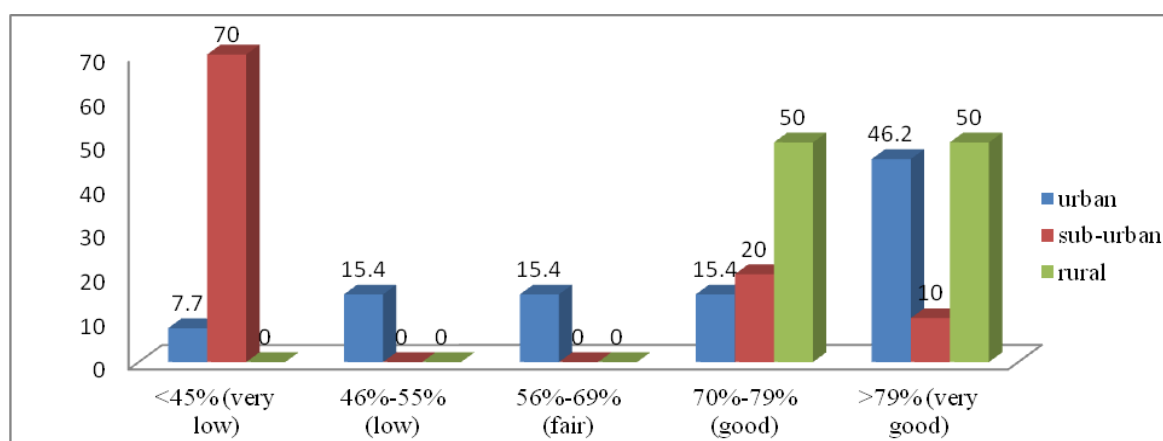
Cross tabulating the level of professional skills by the TBA/MBAs by the various regions, it was found that the 8 percent that has not any professional skills are in the sub-urban communities. None of the traditional birth attendants in the rural areas attended a school of midwifery. It is also seen that 28 percent of the TBAs/MBAs that were trained in a mission home are located in the urban areas while 8 percent and 4 percent are in the sub-urban and rural areas respectively. It is also found that NGOs contribution in training of TBAs only benefited 4 percent of the respondents in the urban areas while the sub-urban and rural communities are left out. Similarly, effort of the Local Government Authorities in training the target group also reached 4 percent of the TBA/MBA owners in sub-urban and rural areas

### Section 3: TBA/MBA owners' knowledge of HIV/AIDS



**Figure 11.** TBAs/MBAs owners' Knowledge of HIV/AIDS

On the knowledge of Traditional and Mission homes birth attendants on the basic HIV infection and prevention methods, the result shows that on a scale of “less than 45%”, 32 percent of the respondents have very low knowledge of HIV; its mode of transmission and prevention, and 32 percent also score above 79 percent (Very good knowledge).



**Figure 12.** TBA/MBA knowledge of HIV across regions

Relating the above figure to TBA/MBA knowledge of HIV, 70 percent of respondents in the sub-urban showed very low knowledge of HIV/AIDS; the basic mode of transmission and prevention, and about 46 percent of those in the urban areas have very good knowledge of the virus.

### Section4: Partnership and linkage of TBAs/MBAs with government health facilities in the state

**Table 7.** Distribution of TBA/MBA partnership/linkage with government health facilities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	6	24.0	24.0	24.0
	Yes	19	76.0	76.0	100.0
	Total	25	100.0	100.0	

The table shows that 76 percent of the sample has linkage system with the Government health facilities in the State. Disaggregating the linkage by the type of facilities, 32 percent of the respondents do not refer clients to Government health care facilities. While 24 percent refer to the Basic Health Centres in the communities, 20 percent to Comprehensive Health Centres, 4 percents refer to either State specialist hospital or General hospital nearest to them.

Disaggregating the data by regions, about 23 percent of the TBA/MBA owners in urban areas do not have linkage with Government health facilities. Similarly, 40 percent and 50 percent of those in sub-urban and rural communities are also involved in the same attitude. While about 31 percent in urban areas and 23 percent refer to Basic health centres and Comprehensive Health Centres respectively, 20 percent in sub-urbans refer to any of the General Hospitals, Comprehensive Health Centres and the Basic Health Centers nearest to them. However, none in the rural areas made referral to either the Basic or Comprehensive health centers nearest to them.

**Table 8.** Percentage distribution of TBAs/MBAs regular referral points

No linkage	FUTH, Ido	SSH	GH	CHC	BHC	Others	
32.0	4	4	12	20	24	4	
Percentage distribution of TBAs/MBAs regular referral points by Region							
	No linkage	FUTH, Ido	SSH	GH	CHC	BHC	Others
Urban	23.1	7.7	7.7	0	23.1	30.8	7.7
sub-urban	40	0	0	20	20	20	0
rural	50	0	0	50	0	0	0

## Discussion

The patronage of TBAs and MBAs in Ekiti State is still very high despite Government effort to encourage pregnant women to access services at public health facilities. Basically, the rate is highest among the rural settlers compared to their counterparts in the urban areas.

Hamela *et al.*, (2014) reported that TBAs continue to play a significant role in the delivery of maternal health services in developing countries

Relating the above to their level of education, it appears that more women who either had no formal education or stopped at primary or secondary schools have greater preference for TBAs/MBAs. Contrarily, those with higher education showed more preference for government facilities. It suggests that one's level of education may be a factor influencing her choice of where to give birth.

Decision to give birth at TBA, MBA or Government hospital is a function of many variables. These variables include the availability of health care officers in the government hospitals, their attitude to clients, cost/bills charged at the facility, poverty level, quest for spiritual support, miracle and prayers, ability of health worker to see vision and revelation for the clients, proximity of the health facility to the client, church and pastors' influence on their members, husband's influence and the influence of parent in-laws. However, among these many variables, desire for prayers by the pregnant women stood out as the major force. Similarly, influence of the religious bodies and family institution are also prominent in deciding where a woman gives birth. Alison, (2009) reported that Most health facilities are far from the communities, making it difficult to utilize facilities at the time of labor and delivery. Distance, money, and being sick were some of the common reasons for not delivering in the hospital in Malawi (Abubakar *et al.*, 2011). Negative attitudes of health workers were mentioned by the TBAs as a reason woman did not report to the health facility. This finding concurs with findings in Kenya, in which women continued to prefer TBAs due to disrespectful attitudes of health care workers at the health facilities (Kruske, S.; and Barclay, L, 2004). In most rural areas of the study locations, women preferred TBAs because TBAs were more respectful (Harrison, 2011). While we did not discuss health care worker attitudes with the women seeking TBA services, understaffing at primary health centers in Ekiti State is common, suggesting the potential for overworked and stressed health workers. Until staffing deficiencies and a provision for inclusive antenatal care are addressed, strategies that incorporate and empower TBAs within National Health Scheme may be a feasible and realistic (Iyaniwura, C.A.; and Yusuf, Q.; 2009).

It was found that majority of the TBA/MBA owners only have either Primary or secondary education and very few have tertiary education. In the same line, many of them did not train as midwife in a government institution. They were majorly trained in mission homes. While such institutions might train them, it is not a substitute for quality training in government institutions. There is need to evaluate the quality of the training, the training curricular, and possibly provide the training under the supervision of the government so as to ensure global best practices in the field of midwifery. The type of training they received should reflect in their knowledge about basic prevention methods of HIV. However, this was found to be low. This is in agreement with the submission of Ekiti State AIDS Control Agency

publication on Community Based PMTCT, the paper asserted that TBAs lack adequate knowledge on issues relating to reproductive health, STIs and HIV/AIDS. It therefore becomes pertinent to train the informal cadre of community health resource persons to ensure a HIV/AIDS-free future generation. Alison, (2009) also posited that many TBAs have low levels of literacy and some may not be interested in further training, attention must be given to making instructions relevant to the local culture in which TBAs practice. He further suggested that Training and the provision of birth kits resulted in a reported increase in safe deliveries with improved infection control practices. Consistent with our finding, another TBA programme in Malawi concluded that empowering TBAs through supervision and provision of supplies helped them to comply with the requirement of ensuring infection free deliveries.

The study showed that the level of synergy between the TBAs/MBAs is not encouraging. Strong referral and linkage system between TBAs/MBAs and government facilities contribute to providing quality health services to the pregnant women and proper management of complications. Alison Ray and Salihu (2009) reported that Programmes with the greatest impact utilized TBAs and village midwives within multisectoral interventions, and suggested that TBAs and village midwives contribute to positive programme outcomes. However, further investigation is needed to determine the nature of their contribution within larger programmes. Oyeledun *et al.*, (2014) reported that the uptake of PMTCT services in Nigeria remains notably low despite significant advances in HIV/AIDS treatment and care. Community collaborative work aims at improving referral practices between TBAs and PHCs and induces self-referrals to skilled healthcare providers. Where this is lacking in some of the communities and TBAs, it could have a detriment on the clients (Sibley, .L.M.; and Sipe, T.A.; 2006).

## Conclusions

The lessons from situation analysis give information on the need for further interventions beyond PMTCT service provision at health facilities. It speaks largely to factors responsible for service uptake and the need to map out strategies and plans for other interventions to address these factors in order to record immense success in PMTCT programme. Such interventions beyond behavioral could include structural interventions such as strengthening linkages and referral systems between these alternative birthplaces and health care facilities/providers, training of the attendants of alternative birthplaces on HCT and referral of positives for PMTCT uptake.

The study also highlighted reasons why decision to give birth at TBA and MBA is a function of many variables. These variables include the unavailability of health care officers in the government hospitals especially in the rural areas, unfriendly attitude of health officers, cost/bills charged at the health care facility, poverty level, quest for spiritual support, miracle and prayers, ability of traditional birth attendants to see vision and revelation for their clients, proximity of TBA/MBA, Religious leaders' influence on their members, husband's influence and the influence of parent in-laws. However, among these many variables, desire for prayers by the pregnant women stood out as the major force. Similarly, influence of the religious bodies and family institution are also prominent in deciding where a woman gives birth and these found to be significantly impede progress in the PMTCT programme in the state as very insignificant population of pregnant women registered in antenatal give birth in the hospital and complete PMTCT in the state.

This study showed that integrating TBA/MBA in health care service can be very effective in promoting PMTCT in Nigeria. Although TBAs are not recognized as part of the formal healthcare system; this experience showed that they could be very useful in promoting maternal and child health services as well as PMTCT. It is imperative for policy makers to acknowledge the importance of TBAs in community mobilization to enhance the success of PMTCT and other maternal and child health programs. Such an important profession in our society should not be alienated from the process of scaling up PMTCT coverage as it that affect the public health.

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