

Community social support roles of trained traditional birth attendants in Chongwe district, Zambia

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Traditional birth attendants (TBAs) play an important role in providing maternal and newborn care in Zambia, especially in rural areas where 60.5% of the Zambian population resides (Central Statistics Office (CSO), 2010). The World Health Organization (WHO) definition of the TBA is 'a person (normally a woman) who assists the mother during childbirth and who initially acquires skills by delivering babies herself or through an apprenticeship to other TBAs' (WHO, United Nations Population Fund, UNICEF, 1992:1–17). Sibley and Sipe (2003) quoted research by Fortney (1997) which noted that 'TBAs tend to be older women, respected in the community for their knowledge and experience. They are often illiterate and have learned their skills through older, more experienced TBAs. They may work independently, in collaboration with an individual provider or facility, or they may be integrated into the health system'. However, there is some doubt about how effective trained (t) TBAs are in terms of reducing maternal and infant morbidity and mortality rates. A large number (60.5%) of the population in Zambia resides in remote areas (CSO, 2010) and these people have limited access to health-care facilities. In addition, for those who can use health facilities, transportation to the facilities is a significant barrier. Subsequently, tTBAs fill this gap in services. According to Maimbowla (2004), tTBAs conduct up to 53% of the deliveries in rural Zambian villages. Sibley and Sipe (2003) reported findings from previous research that indicated that TBAs assisted in 1–66% of births in 44 developing countries. Swai (2005) reported that TBAs conduct 30–40% of deliveries in South Africa, 70% in Ghana and 60% in rural Tanzania. In the Chongwe district of Zambia (the site for the present study), the percentage of deliveries done by TBAs rose from 4% in 2002 to 10% in 2004. The percentage of deliveries by trained midwives in the Chongwe district was 21% in 2004. Thus, a total of 31% of women in this district were attended by either tTBAs or trained midwives, suggesting that 69% of women delivered without any trained birth attendant (Chongwe District Health Management Team, 2000). TBAs need to be trained as they are an indispensable part of the health-care delivery system.

TBAs are important for providing maternal and child health services in low resource countries, but disagreement exists about what their appropriate roles should be. The scope of practice of tTBAs includes direct care to mothers during the prenatal, intrapartum and postpartum periods, health education, and counselling at health centres and

Abstract

Although traditional birth attendants (TBAs) play key roles in providing maternal health care in many low-resource countries, there are few studies that describe the actual roles and practices of TBAs in their local communities. In addition, there remains controversy about the impact of TBAs on the reduction of maternal and infant morbidity and mortality. This paper presents the results of focus group discussions that were conducted in the Chongwe district in the Lusaka Province of Zambia. It describes the roles of trained (t)TBAs in the district.

Method: The researcher used an interview guide to conduct five focus group discussions with 28 tTBAs, four mothers, two midwives, two nurses, and one village leader. The study participants were recruited using a convenience sampling approach, from four district health facilities. The focus group discussions were conducted in English, tape-recorded and then transcribed. The data were analysed using the qualitative content analysis method. **R**esults: The main theme identified as describing the role of the tTBA was community social support. This theme was further divided into three categories: providing safe motherhood services, counselling, and health education. Each of these categories also included sub-categories. These findings do not present a view of the general population since it was conducted in only one out of 73 districts in Zambia. **C**onclusions: The findings from this study recommend the continued training, monitoring, evaluating and documenting of the impact of the TBAs' practices using the modified Ministry of Health TBA training curriculum and the monitoring tool during supervisions. The documentation of their impact would inform evidence-based policy formulation. The influential leaders should sustain their practice by using rural folks' wealth-ranking approach. Generally, tTBAs are likened to 'spare wheels of cars' which need to be ready for use in emergency situations when a tyre fails. Chongwe district should form an association to advocate for tTBAs' sustainability.

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in the home. Some researchers have suggested that TBAs can reduce maternal and neonatal mortality rates through providing direct care to mothers and infants (Sibley and Sipe, 2003), but others recommend that they assume roles only in health education (Ministry of Health (MoH), 2011). Currently, no studies have described the actual roles of TBAs in Zambia, thus justifying the need for the focus group discussions of this study.

The practice of TBAs varies in different countries and even in communities within countries (Flemming, 1994; Kruske and Barclay, 2004). It is important to understand their practice for policy formulation. Therefore, the aim of this study was to describe the practice of TBAs as reported by TBAs themselves, by their district midwife supervisors and by their clients in Chongwe district. These TBAs are ordinary women who volunteer their services to their communities through their varied experiences.

Background

The literature reviewed focused on previous studies describing the roles assumed by TBAs. Several researchers have reported that TBAs tend to be illiterate and untrained, thus precluding their ability to conduct safe and clean deliveries (Lefebvre, 1994; Green, 1999; Kruske and Barclay, 2004; Swai, 2005). Goodburn et al (1995) reported that TBAs often engage in cultural practices and provide important social support to women after childbirth. These authors further noted that the workload of TBAs varies considerably, ranging from 2–20 deliveries per year.

Some researchers have advocated training TBAs to deliver women in geographically and medically isolated rural locations (Akutse, 2004; Day, 2004; Buttiëns et al, 2004). Others, however, have recommended that TBAs should only provide health education (MoH, 2011). Many authorities advocate integrating indigenous knowledge and western medicine as a primary health-care strategy through community participation (Onjoro, 2001; Baez and Manzana, 2002; Swai, 2005) due to the critical shortage of trained health-care personnel, and because women value their culture and traditional medicine. Poor infection prevention practices and cultural practices affect the practice of even tTBAs' safe and clean deliveries (Hazemba, 2003). However, many TBAs have adapted to their low-resource environments to prevent complications and enhance maternal and infant outcomes. For example, TBAs bathe newborn babies a day after delivery in order to prevent hypothermia, rather than bathe the infant immediately after birth (Bergström et al, 2005; Thatte et al, 2009).

The findings from studies reported in this literature review suggest that the main role of TBAs is to care for mothers during the prenatal, intrapartum and puerperal periods, and provide health education, counselling and social support.

Methods and materials

Focus group discussions were used to collect data from 28 tTBAs, four mothers, two midwives, two nurses and one village leader who participated in five focus group discussions using the qualitative content analysis method. Focus group discussions were chosen as the study design

because it allowed the study participants to exchange ideas, and discuss, agree or disagree on certain concepts, experiences and challenges that they encounter while volunteering their services (Kitzinger, 1994; Kevern and Webb, 2001; Curtis and Redmond, 2007; Parahoo, 2007; Shaha, 2011). The method facilitated validation of the actual roles of the TBAs (Morgan and Krueger, 1997; Barbour, 2005; Burns and Grove, 2005). This method helped the researcher to innovate ways of not stifling the voices of the quiet ones within the group (Morgan and Krueger, 1997; Kidd and Parshall, 2000; Owen, 2001). The researcher collected data during the group sessions by tape-recording the discussions which were conducted in English, the Zambian national language. Assistants also took some notes during the discussions. The recordings and notes were subsequently transcribed verbatim and analysed.

Five focus group discussions were held which involved the tTBAs, their supervising midwives from the health centres within the district, and women whose babies were delivered by tTBAs. These groups were selected according to their willingness and convenience to participate in the discussions. The discussions were part of a larger study that aimed to identify the impact of using the modified Ministry of Health TBA training curriculum on infection prevention knowledge, practice and attitude of TBAs in the Chongwe district of Zambia. The TBAs had participated in a 6-week training programme (2 weeks theory and 4 weeks practical in the various health centres in the district). The supervising midwives conducted the training in collaboration with the researcher. The focus groups were conducted 3–6 months after the end of the training.

Including the TBAs and their clients in the same focus groups allowed opportunities to clarify differences in perspectives about the tTBAs roles that were reported by both. The number of focus groups was determined by theoretical sampling, as groups were continued until no new themes emerged. Each interview took between 60 and 90 minutes. The original goal was to include six TBAs and six mothers in each group; however, the difficulty to recruit mothers became apparent as issues such as their childcare and household duties made it difficult to attend the group sessions. Therefore, it was decided to attempt to recruit at least six tTBAs, three mothers and one midwife-TBA supervisor for each group. It was recognised that having fewer mothers than TBAs in the groups may have made the mothers hesitant to share their feelings but all mothers participated actively in the groups. It was also acknowledged that having the midwife supervisors in the group sessions may have influenced the information shared by the TBAs, and this is subsequently acknowledged as a potential limitation of this study.

The supervising midwives recruited the trained TBAs and the mothers for each group. On two occasions it was not possible to recruit mothers to participate, and on one occasion only two mothers were recruited. One group also included a village leader who requested permission to sit in on the meetings, and two groups also included two nurses who were interested in participating.

The request of the village leader in the focus group discussions may have influenced the results because they got information which they used to improve and sustain the services provided by the community volunteers. Also, having the nurses and the midwives who supervise the tTBAs' work in the groups gave them the opportunity to obtain free information which they could use in improving their supportive supervisory activities in order to improve the tTBAs' service provision in rural settings.

Ethical approval

The researcher obtained permission to conduct the study from the Biomedical Research and Ethics Committee of the School of Medicine, University of Zambia. The participants consented verbally to participation. The investigator ensured a noiseless, conducive environment with thorough ventilation for the discussions. The principal investigator welcomed the discussants and encouraged them to feel free to speak and not to feel intimidated. All discussants were assured that all information would be kept in strict confidence.

Qualitative content analysis

In this study, the process of analysis of the focus group discussions necessitated the researcher going through

the texts from the interviews over and over again for familiarisation. The data were analysed using the qualitative content analysis method. The study used the process of conducting content analysis recommended by Graneheim and Lundman (2004). The unit of analysis in this study was the interview text on what the tTBAs do in their rural settings. These focus group discussions centred on the interpretation from the 'manifest content', which described the visible and obvious aspects of the texts from the discussions (Downe-Wamboldt, 1992; Graneheim and Lundman, 2004).

Table 1a. Focus group participants by role

Group	tTBAs	Mothers	Midwife supervisor	Village leaders	Nurses	Total
1	6	1	0	1	0	8
2	6	1	0	0	1	8
3	6	0	0	0	1	7
4	4	2	1	0	0	7
5	6	0	1	0	0	7
Total	28	4	2	1	2	37

Table 1b. Demographic characteristics of participants

Characteristic	TBAs (n=28)	Mothers (n=4)	Midwife supervisor (n=2)	Village leader (n=1)	Nurse (n=2)
Age					
22–31	3 (10.7%)	2 (50%)	0	0	0
32–41	4 (14.2%)	2 (50%)	2 (100%)	0	2 (100%)
42–51	13 (46.4%)	0	0	0	0
52–61	7 (25%)	0	0	1 (100%)	0
62 years	1 (3.6%)	0	0	0	0
Marital status					
Married	28 (100%)	4 (100%)	2 (100%)	1 (100%)	2 (100%)
Single	0	0	0	0	0
Education level					
Illiterate	2 (7.1%)	0	0	0	0
Primary education	14 (50%)	4 (100%)	0	1 (100%)	0
Lower secondary education	12 (42.9%)	0	0	0	0
Upper secondary education	0	0	2 (100%)	0	2 (100%)
Able to read and write in both English and local language					
Yes	26 (92.9%)	4 (100%)	2 (100%)	1 (100%)	2 (100%)
No	2 (5.4%)	0	0	0	0
Number of children					
1–5	12 (42.9%)	2 (50%)	2 (100%)	0	2 (100%)
6–10	15 (53.6%)	2 (50%)	0	1 (100%)	0
11 or more	1 (3.6%)	0	0	0	0
Occupation					
Housewife	28 (100%)	4 (100%)	0	0	0
Nursing	0	0	0	0	2 (100%)
Midwifery supervisor	0	0	2 (100%)	0	0
Subsistence farmer	0	0		1 (100%)	0

The principal investigator identified and noted the underlying meanings from the manifest content. The researcher then teased out and extracted the experiences that relate to the TBAs' actual roles during which they applied disease and infection prevention measures.

The researcher derived concepts from the characteristics of the responses in the interview texts, which were then grouped into meaning units that linked to each other, and compared the discussions which were similar in nature in each meaning unit. These meaning units were condensed and coded. The codes were later grouped together according to their differences and

similarities. The main themes were identified and grouped into categories, sub-categories and codes. *Table 1a* illustrates the constituents of the people who attended as well as those who actually participated in the focus group discussions.

Table 1b demonstrates that less than a quarter (13.5%) of the study participants were aged between 22 and 31 years old. All were married. The professionals (the midwife-supervisors and the nurses) had attained upper secondary level of education, whereas 14 (50%) and 12 (42.9%) of the tTBAs had primary and lower secondary level of education respectively. All of the mothers and the village leader had only completed primary education. *Table 1b* also showed that a little less than half of the tTBAs (46.4%) were aged between 42 and 51.

Table 1b showed that 92.9% ($n=26$) of the TBAs were literate. They could read and write in local and English languages. Only 7.1% ($n=2$) were illiterate.

Table 2 showed that, on average, the tTBA respondents conducted an average of six deliveries weekly, 23 deliveries monthly and 70 deliveries each year. The 62-year-old TBA conducted only one delivery in the year.

The researcher used the verbatim reports from the study respondents to support the narratives for clarity. The researcher identified similar categories during the analysis, from which sub categories were derived. Similar categories

Table 2. Deliveries conducted per week, month and year by tTBAs, organised by age

Age group	Frequency	Weekly	Monthly	Yearly
22–31 years old	3 (10.7%)	0	1	12
32–41 years old	4 (14.2%)	6	30	74
42–51 years old	13 (46.4%)	15	64	195
52–61 years old	7 (25%)	10	21	66
62 or over	1 (2.7%)	0	0	1
Total	28 (100%)	31	116	348
Average deliveries		6.2	23.2	69.6

Table 3: Themes, categories and sub-categories for the focus group discussions

Main theme	Sub-themes	Categories
Providing community social support	Providing safe motherhood initiatives	Care during prenatal period <ul style="list-style-type: none"> • Health education on early booking at antenatal clinics • Good nutrition • Infection prevention during pregnancy • Infection prevention practice • Personal hygiene practices • Maintenance of environmental sanitation • Avoiding harmful traditional practices during pregnancy, labour delivery and the postpartum period Observing infection prevention measure during the intrapartum period <ul style="list-style-type: none"> • Care during labour and intrapartum period by conducting the deliveries and caring for the women during the birthing process • Avoiding harmful traditional practices during labour Postpartum care <ul style="list-style-type: none"> • Integrating traditional practice with modern medicine in the disposal of the placenta after delivery and avoiding harmful traditional practices during the postpartum period • Care of vaginal and perineal wounds • Baby bathing after delivery • Care of the cord • Handling of complications such as bleeding from the cord • Infant feeding practices • Prevention of mother-to-child transmission of HIV virus • Family planning • Postnatal health education messages on clean environment Male involvement/support for the family <ul style="list-style-type: none"> • Counselling to prevent infections due to abortions, saving lives and improving parent-daughter relationships • Couple counselling for HIV testing • Teamwork
	Psycho-social counselling	

were then pooled together in a theme, which then provided the underlying meaning of the data. *Table 3* illustrates the main theme, the sub-themes and the categories following Graneheim and Lundman's (2004) process of qualitative content analysis. The key theme that emerged from the analysis was 'providing community social support'. The two sub-themes were 'providing safe motherhood initiatives' and 'psychosocial counselling'.

Community social support

A theme explains the underlying meaning of the data (Graneheim and Lundman, 2004). The researcher came up with the main theme of 'community social support' which has two sub-themes and two categories. The first category has three components while the second category has four components (*Table 3*). During the discussions, the TBAs showed that they visit and interact with their clients and thus provide them with the much-appreciated social support they need.

The sub-themes of 'providing safe motherhood initiatives' and 'psychosocial counselling' indicate that tTBAs give targeted health education messages and counselling to their clients.

Providing safe motherhood initiatives Care during the prenatal period

Health education on early booking at antenatal clinics: This category demonstrates that tTBAs provide health education to mothers on early antenatal booking. For example, one tTBA in group 5 stated:

'I teach women to attend the antenatal clinic as early as 2 months.'

Meanwhile, tTBA Edith further explained that:

'We advise them [women] in the case of any illnesses to come to the clinic.'

Good nutrition: Health education on good nutrition is also given because the tTBAs, being locals, know the seasonally available vegetables. For example, another tTBA in group 5 explained:

'We have to tell them what kinds of local vegetables to take when pregnant.'

Infection prevention during pregnancy in preparation for labour: As pregnancy progresses, the tTBAs provide health education to their clients advising them to buy the gloves in preparation for labour and delivery. For example, the tTBA in group 1 in Kasisi stated:

'We advise mothers to buy gloves or clean delivery kits. We don't have clean delivery kits (CDKs) so we tell mothers to buy these things.'

Personal hygiene practices and maintenance of environmental sanitation: The tTBAs also teach their clients about personal hygiene practices and proper maintenance of environmental sanitation. Another tTBA in group 1 reported:

'I am a member of the neighbourhood health committee (NHC). I work with Kasisi Home Based Care and Christian Children's Fund. We all come together at Kasisi Health Center when they call us. I teach my friends about hygiene, and cleanliness to the community also.'

Avoiding harmful traditional practices during pregnancy, labour delivery and the postpartum period: The tTBAs also teach their clients to avoid negative traditional practices such as drinking herbs during the last trimester to initiate and hasten labour, as this practice may lead to a ruptured uterus. For example, one tTBA in group 3 noted:

'We don't allow them to drink any African medicine.'

Roleplays on dangerous traditional birthing practices to avoid while conducting deliveries were demonstrated by another tTBA in group 4 who stated:

'The untrained TBA sits the woman in labour down with her legs wide apart. She ties a cloth round her back and pushes her foot onto the perineum as the client pushes. This is expected to help push out the baby quickly.'



The tTBAs teach pregnant women about good hygiene practices

Observing infection prevention measures during the intrapartum period

This category also shows how the tTBAs prepare the environment for delivery and all that they do during the birthing process as the verbatim descriptions from the tTBAs in group 5 in Chongwe below depicts.

'We inspect the room, clean it, spread a clean plastic if we have any.'

'We clean the floor for the delivery if there are no family members to help them. But even before you wash your hands, you must analyse the warmth of the environment. If it is cold, you must make a fire. You dry your hands in the air. Then you put everything in order. When the baby is coming out, you take a napkin and spread and be ready to receive the child. Once the baby has shown its head, you wipe its nose and mouth. You then put the baby on the mother's chest. Now you must tie the umbilical cord and cut it. Then you must clean the baby and leave it on the mother's chest. Now you must be ready for the placenta to come. You need to put something between the anus and vagina so that the placenta falls into that container. Now you must clean the mother on both sides. When you finish, you take out the dirty clothes and replace them with clean ones.'

The focus group discussions showed that the tTBAs apply theory to practice thus proving evidence-based hand washing practices among the tTBAs. A tTBA in group 5 explained:

'I wash my hands, put on my gloves before I start receiving the baby. I know there are germs on my hands from the test during the training.'

Ministry of Health Reproductive Health Policy—no vaginal examinations during delivery: The Ministry of Health Reproductive Health Policy bars the TBAs from conducting vaginal examinations. One of the comments from a tTBA in group 3 indicated that she abides by this policy, which was stressed during training, in order to avoid infecting clients.

Care during the postpartum period

Integrating traditional practices with modern medicine in the disposal of the placenta after delivery and avoiding harmful traditional practices during the postpartum period: The verbatim report below aptly illustrates this integration which shows that the tTBAs examine the placenta for completion before disposal. A tTBA in group 3 stated:

'I checked to see that the placenta has no spaces between them. Then I knew it was complete. I put it into a plastic bag. We went together and threw it down the pit latrine, the razor blade I used to cut the cord and the plastic mat and the cotton wool with blood, I threw them into pit latrine. You must find a close relative to go with.'

The focus group discussion findings confirmed that traditional beliefs promote the proper disposal of placenta after delivery in rural settings. For example, another tTBA in the same group 3 noted:

'Because we want to make sure it was thrown down the pit latrine ... some people practice witchcraft with blood.'

Care of the vaginal and perineal wounds during the postnatal period: The verbatim quotes in this category illustrate the application of infection prevention measures by the tTBAs in their practice for the prevention of puerperal sepsis.

A mother whose child was delivered by a tTBA in Kanakantapa (group 2) stated:

'My mother-in-law prepares the leaves from the mukuyu tree. She adds it in cold water and tells me to sit in the cold water every day until my wounds heal. According to tradition we use traditional herbs on the perineum till the wound heals. The tTBA advised me against this practice as it may cause infections. She said we must wash our female parts with cooled boiled water with no salt three times a day.'

Baby bathing after delivery: Different cultures have different methods and beliefs on baby bathing after delivery. Some cultures believe the baby should not be bathed till the cord drops off. Both the clients and the tTBAs reported that babies are bathed a day after delivery and are protected from hypothermia, avoiding harmful traditional practices as the discussions illustrate. The mother who had been delivered by a tTBA in group 2 in Kanakantapa reported:

'She came the following day and assisted me in bathing the baby. Then after, she used to come daily to visit me for some 4 days examining and bathing the baby each time she comes and showing me how to bathe the baby.'

A tTBA in group 2 in Kanakantapa went on to illustrate what she does to prevent hypothermia in the newborn:

'I dry baby with clean cloth, I put a hat and socks on the baby and put on clean clothes, then wrap baby in a shawl if there is any. This is done so that the baby does not catch cold.'

Care of the cord after delivery: Cords can bleed or even become infected after delivery if mothers apply cow dung and herbs on them hence the necessity for tTBAs to educate their clients, confirmed by this text narrated by a mother whose baby was delivered by a tTBA in group 1 at Kasisi:

'She advised me not to put herbs on the baby's umbilicus. I cleaned the cord with boiled cooled water until it dropped after 6 days.'

Handling of complications such as bleeding from the cord: A mother who had been delivered by a tTBA in group 4 in Chongwe reported:

'She advised me to check and see if baby bleeds from the cord or has any sores in the mouth and that I should take baby to the clinic.'

Another mother in group 4 delivered by a tTBA in Chongwe reported:

'She advised me not to cover the cord with cloth.'

Infant feeding practices—breastfeeding practices: The tTBAs provide health education to clients on the importance of breastfeeding as confirmed below. A tTBA in group 5 in Chongwe noted:

'We explain that the breast is like a tank for the milk and full of nutrition.'

A mother in group 2 in Kanakantapa whose baby had been delivered by a tTBA noted:

'The TBA said we breastfeed all our babies after delivery pantu (because) the first milk (colostrum) is very good for the baby. It protects baby against diseases. Breastfeeding is also cheaper than buying tinned milk.'

Prevention of mother-to-child transmission of HIV virus: A tTBA in group 1 at Kasisi said:

'We promote exclusive breastfeeding, even on how to attach the baby to the breast, and the advantages of breastfeeding, especially for HIV positive mothers.'

A mother delivered by a tTBA in group 1 in Kasisi said:

'I was told to breastfeed exclusively for 6 months—no feeding baby with anything else, not even water.'

A tTBA from group 1 in Kasisi continued:

'If you are HIV positive, you should breastfeed exclusively for 6 months and then visit the clinic after 6 months. You can heat the breast milk and feed it to the baby with cup and spoon.'

Family planning: Several tTBAs reported that they provide family planning services to women. For example, one of the tTBAs in group 3 in Chinyunyu reported:

'As we go around the village, if we see that there are mothers that are having a lot of children we talk to the mothers about the benefits of family planning and the disadvantages of having many children in a short period of time.'

Psychosocial counselling

Male involvement/support for the family

The discussion showed that the tTBAs counsel the men in the community on helping out with housework during the puerperal period. Their involvement in housework helps their wives to concentrate on looking after the babies. This is very essential for mothers to adhere to exclusive breastfeeding if that is their chosen infant feeding option. The tTBAs noted that male involvement promotes harmony and communication in the family and lessens the workload on the wife during pregnancy and the puerperal period.

A tTBA in group 1 in Kasisi, who is also a member of a Safe Motherhood Action Group (SMAG) had this to say:

'They are able to talk to their husbands freely about having time to breastfeed the baby. The community is co-operating with each other in this way and I am very happy about it.'

A male SMAG member in group 1 at Kasisi made this observation during the focus group:

'I am very happy with what the women (TBAs) in the SMAG are doing in the community. They teach us to help our wives when they are pregnant. Also when I look at my wife, I know it is me who has this pregnancy so I should help in sweeping, bathing the children and fetching firewood for cooking. People in the community now come to me to discuss their diseases very openly as a community health worker (CHW) in a SMAG.'

Counselling to prevent infections due to abortions, save lives and improve parent-daughter relationships

During the discussions, it surfaced that the tTBAs carry out their culturally assigned roles for elderly people in rural communities by advising youth against conduct that may lead to teenage pregnancies, abortions and poor parent-daughter relationships as the following statements confirm:

A tTBA in group 4 in Chongwe stated:

'Sometimes, when initiating young generations, it is very difficult. You can educate them right there but when they go outside they have bad friends. Whatever you teach them can be a waste of time because they want to experience what they hear. After that, they get pregnant without even knowing what they were doing. You can find that the mother and the father are good people, but their child, they are in a miserable state because of friends' influence.'

A tTBA in group 1 who is also a SMAG member in Kasisi made this contribution:

'ZINGO is an organisation which educates youth on sex and HIV through the churches such as the New Apostolic, Roman Catholic and Christian Unity. ZINGO organises materials they use for sensitising the youth in communities. We get permission from the headman to address the youths at school.'

‘The tTBAs also emphasised good nutrition, birth preparedness, and avoiding harmful traditional birthing practices during pregnancy, labour and delivery’

A tTBA in group 1 who is also in a SMAG continued:

I intervene to stop young girls from aborting but some die in the process. Because of the work Centre for Infectious Disease Research in Zambia (CIDRZ) is doing going to talk to the girl not to abort.’

A tTBA in group 2 in Kanakantapa shared that:

‘So far, I have saved the lives of two young girls who got pregnant when they were 15 years old. I also talk to her mother to try and understand the daughter. I have to be very careful when I talk to both of them.’

Promoting couple counselling for HIV testing

The ideal situation in counselling focuses on couple counselling. It promotes acceptance of HIV status, treatment, adherence and understanding, and prevents physical and emotional abuse of spouses in families. During the discussions, emphasis on all the above was shown by statements such as this made by a tTBA in group 1 in Kasisi:

If women test on their own, it’s usually a problem. They fail to disclose to their husbands because they fear being divorced, being beaten, being accused of unfaithfulness ... so most of the time women are advised to go and tell the husbands that at the clinic they want to see you. That way they get tested together, they get told together. That’s what we advise them. Because of the tTBAs in SMAG when wives test rapid plasma reagent (RPR) positive, they quietly go and bring their husbands for treatment so both get treated without fighting each other.’

Promoting teamwork

A tTBA in group 3 in Chinyunyu commented on the importance of teamwork which facilitates referrals in rural settings:

‘Women are being brought to the clinic—they are able to go to the clinic through the help of the villagers. The distance is too far to the clinics. During the day if the mother can manage to walk, we go to the road and beg for a taxi to help us. We have no money. During night we beg neighbours with bicycles to help us. If not we use ox-carts. The farmers who have ox-carts help us out a lot.’

Discussion

The results of the focus group discussions showed that the roles of tTBAs in Chongwe district emphasise providing community social support by supporting safe motherhood practices in the prenatal, intrapartum and postpartum period, and by providing counselling services. This blends well with the culturally sensitive care they render to their clients, the majority who opt to be cared

for by the tTBAs (Maimbolwa, 1998; Yousuf et al, 2010).

Findings from this study related to the health education provided by tTBAs are consistent with findings previously reported. For example, several authors have reported that TBAs advise clients about the importance of early antenatal booking (Menown et al, 1993; Jimoh, 2003). In Zambia, tTBAs educate their clients against the cultural belief that pregnancies should not be told to anyone (resulting in late antenatal booking) for fear that it may disappear because of witchcraft and this promotes utilisation of antenatal care services.

The tTBAs also emphasised good nutrition, birth preparedness, and avoiding harmful traditional birthing practices during pregnancy, labour and delivery. These messages help the mothers to abstain from inserting herbs into their birth canal or drinking them to hasten labour towards the end of their pregnancies as they cause infections and uterine rupture. After delivery, the focus group discussion respondents follow the cultural practice for placental disposal where a family member accompanies them to ensure the placenta is disposed in the pit latrine to avoid suspicions of witchcraft.

The focus group discussion findings also showed that the tTBAs emphasised safe delivery environments and practise clean delivery practices such as hand washing, clean cord care and delivering on clean surfaces, similar to the findings reported by others (Goodburn et al, 1995; Hill et al, 2010).

The tTBAs who participated in these focus group discussions also described strategies to promote healing of vaginal and perineal wounds after delivery, educating their clients to sit in boiled cooled water with no added salt. They also taught clients about cleaning the cord with boiled cooled water in the absence of methylated spirit or gentian violet. They also advise against applying local herbs that are unhygienically prepared or cow dung that can cause tetanus neonatorum. The tTBAs ensure that the umbilical stumps remain uninjected and heal within the first week.

The tTBAs also promoted postpartum practices to prevent hypothermia similar to those reported by Bergström et al (2005) and Thatte et al (2009) who studied tTBA practices in Uganda and rural Nepal, respectively, and found that tTBAs prevented hypothermia by dressing the baby with locally woven clothing such as hand-knitted hats, socks and clean clothes, and bath the neonates a day after the delivery.

The tTBAs also encouraged mothers to adopt good breastfeeding practices such as putting the baby on the breast within 1 hour of delivery because ‘the breast is like a tank for the milk and full of nutrition’.

Finally, results from the focus group discussions noted that the tTBAs worked as a team within the SMAGs. They also provided education on male involvement to facilitate referrals to the next level of care by using traditional modes of transport including the ox-cart to ferry pregnant women should any complications arise during pregnancy, labour and delivery. The Chongwe tTBAs also integrated indigenous and western medical practices as advocated by Pigg (1973), Ademuwagun (1978) and Asghar (1999).

Study strengths and limitations

A major strength of this study was the use of the focus group discussions which allowed the TBAs and the women they serve to provide their own perspectives and share their views on the

activities and roles of the TBAs within their scope of practice. The views expressed by the women whose babies were delivered by the tTBAs encouraged the tTBAs and so became a source of strength and confidence as they carry out their roles.

The participation of the village leaders also provided an important perspective about the roles of the TBAs in the Chongwe community. The participation of the midwives who supervised the tTBAs provided another perspective and opportunity to corroborate the information provided by the tTBAs and their clients. A limitation of this study was that findings cannot be generalised about the whole country as it was done in only one district out of 73 districts in Zambia and the recruitment of the focus group discussion participants was not always easy. In addition, having a smaller number of women than midwives in each group may have inhibited some of the women, and the presence of the supervising midwives in the groups may have inhibited some tTBAs from reporting all their activities honestly since they are their supervisors.

Implications for practice

The themes that emerged in *Table 3* are related to the categories of direct practice of the TBAs when providing care to clients during the pregnancy, labour, delivery and postpartum periods. The care of mother and baby suggest that the tTBAs are applying infection prevention theoretical knowledge to their practices. It is acknowledged that it is not possible from a focus group design to determine whether these practices were influenced by the training. However, the findings suggest that TBAs can learn to use infection control procedures and apply them in practice.

The findings also indicate that the TBAs are being incorporated into teams such as SMAGs and that their contributions are valued and accepted by the women in medically and geographically disadvantaged rural communities that they serve.

Findings show that tTBAs teach women against the use of some harmful traditional practices during pregnancy, labour, and delivery and during the postpartum period when they provide direct care to both mother and baby. The findings also indicate that the tTBAs do a lot of counselling in schools in an effort to prevent teenage pregnancies and subsequent abortions. The findings suggest many positive roles of TBAs such as also contributing to health education, counselling and direct care. These implications show that there is need to improve the capacity of these rural women (Asghar, 1999) to serve their communities. Their services help to integrate positive indigenous knowledge with modern medicine for better health service utilisation and better health outcomes (Onjoro, 2001).

Implications for future research

There is a need for ongoing research to continue to examine the roles of tTBAs, and also to assess their impact on maternal and child health outcomes. It will be good to replicate these focus group discussions using separate groups for TBAs, women and midwives. It would also be valuable to include other stakeholders in separate groups such as men, traditional healers and other community members. In addition, further research is needed using observational methods to confirm the reported activities of the TBAs that emerged from the focus group discussions (eg. observing their infection control practices, counselling and health education provided). Finally, there is a

Key Points

- Trained traditional birth attendants (tTBAs) provide community social support
- The tTBAs apply infection prevention theory into practice as illustrated in their handwashing practices, neonatal cord care and perineal care during the postpartum period
- They counsel in schools in an effort to prevent teenage pregnancies and subsequent abortions during the teenage turbulent years, and provide HIV and AIDS counselling, as well as advising on breastfeeding options for HIV positive mothers
- They give targeted health education messages to families against harmful sociocultural and traditional practices, as well as advising on the improvement of personal hygiene practices, maintenance of environmental sanitation and male involvement
- The tTBAs are incorporated into teams that facilitate referrals at community levels
- There is need to increase the capacity of these rural women to serve their communities

need for ongoing research to document the outcomes of TBA practices and of educational interventions designed to improve TBA knowledge, skills and practice.

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