

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING

UTILIZATION OF TRADITIONAL BIRTH ATTENDANTS IN LUSAKA
URBAN

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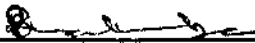
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DECLARATION

I hereby declare that the work presented in this study for the degree of Bachelor of Science in Nursing has not been presented either wholly or in part for any other degree and is not being currently submitted for any other degree.

SIGNED BY: 
(CANDIDATE)


APPROVED BY: 
(SUPERVISING LECTURER)

DEDICATION

Dedicated to my husband, all my family members and my children,
Lulu, Nsonganya and Chisha.

STATEMENT

I hereby Certify that this study is entirely the result of my own independent investigation. The various persons and sources to which I am indebted are clearly indicated in the reference.

Signed: 

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to the following people without whom this study could not have been conducted: Ms D. Gentles, Course Co-ordinator for the assistance she offered in the study. I wish to thank all my lecturers and course mates too, from whom I learnt much.

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I would also like to thank all the Traditional Birth Attendants who participated in the study and also the staff for their help rendered in locating the subjects for the study, without whom it could not have been possible for me to collect data.

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ABSTRACT

This descriptive research study was undertaken in the following areas: George, Kanyama, Chawama, Chilenje, Mtendere, Kaunda Square and Chelstone Health Centres. These health Centres are located in the respective compounds in Lusaka urban. The main aim of the study was to determine the extent to which the TBAs were being utilised in Lusaka Urban, and also to determine the influence of the incentives and remuneration on the performance of the TBA's which in turn would reinforce their utilisation by the community.

Literature review was based on the factors related to prevention of maternal and child mortality through the services being offered by the Traditional Birth Attendants, in areas where medical facilities are inadequate. It was from this basis that the objectives and hypothesis were formulated for the study. Data were collected from 20 trained Traditional Birth Attendants of the already stated compounds, through the interviewing method. The results of the study revealed that the majority of the TBA's practising fulfil the criteria for acceptance as traditional midwives in the community and also that most of the TBA's practising were given incentives by the Government in the form of either a TBA UNICEF kit or were issued with a certificate. There was very little collaboration between the health Centre staff and the practising trained Traditional Birth Attendants as evidenced by the fact that most of the health staff never came into contact with them. The study also revealed that despite the fact that the community was appreciating the work being done by the TBA's there was very little support from them in form of remuneration.

The communities are advised to make use of the existing facilities of the TBA's and also to support or give remuneration to the TBA's

..(x)

whenever they have helped a woman deliver, some token should be given to show appreciation as according to tradition when a token cannot be afforded in form of a gift, appreciation can be shown by offering some service to the TBA by doing work such as helping cultivating the land or anything of such a kind. The communities have to be made to understand the role of the TBA in the community. The Government should also be praised for the good work that they do of giving incentives to the TBAs in form of either a UNILU TBA kit or a certificate that is issued at the end of the training. Appreciation of the TBA's services by the community will make her feel confident and motivate her to work even harder and therefore offer services required of her.

CHAPTER I

INTRODUCTION, STATEMENT OF PROBLEM

AND DEFINITION OF TERMS

1. "The traditional Birth Attendant has been defined as a person (usually a woman) who assists the mother at child birth, and who initially acquired her skill delivering babies by herself or by working with other Traditional Birth Attendants", (WHO 1979). She is known by other names in different areas of the world and she is a familiar figure in almost every community. In developing countries, the TBA has gained great recognition. National Administrators are becoming increasingly aware that health cannot be achieved without development, and that development is dependent on a healthy and productive population. In the light of this perception and of the imbalance that exists between health needs and available resources, alternative approaches to meeting the basic health needs of the people were introduced in the developing countries. (WHO 1979).

It is in this regard, that greater attention is being focused on ways and means of involving people in their own health care. This is done by recruiting people from their communities and training them to provide health care. This approach is basic to the concept of primary health care.

The problem of rural-urban migration has led to over crowding of peri urban areas, which has resulted in the inadequate provision of complete maternity care. Therefore, the above factors have led to the re-examination of the role and practices of TBA's and also how these practices could be improved. Consideration has also been given with regard to additional tasks which TBAs might be able to perform, including

the linking of these tasks with those of the organised or formal health system.

It is in regard to the above mentioned statement that the introduction of the training of TBAs was introduced in Zambia. The main aim of the programme however is to improve knowledge of the TBAs. The TBAs undergo a course of about six weeks duration, during which period both practical and theory courses are covered. The contents of the course are such that they will help the TBA at the end to understand her work. At the end of the course the TBA is awarded a UNICEF kit containing the instruments that she will be using and also a certificate is issued. These help as some form of incentive to the TBA and will make her feel more confident than before.

The decision to train TBAs, and to link their services to the organised health care system had been met with mixed feelings. The idea of integrating the TBAs into the organised Health System might lead to conflict between them and the communities they would be expected to serve. It has also been thought that this idea of integrating the TBA into the health system may make her loose her identity as perceived in the real traditional sense. However, this integration does not aim at making the TBA loose her identity but rather to ensure that she continues to observe concepts and modes of practice that are clearly shown to be harmless.

In the second National Development Plan (1972-1976), the Government of the Republic of Zambia stated that priority should be given to infants, pre-school and school children, expectant and nursing mothers. Special emphasis will be placed on the nutrition of these groups. Highest priority will be given to all training programmes, as personnel care is vital for the

maintenance and expansion of the Health Services and to ensure that mothers are under health care, and increase the trained assistance at child birth from 30% to 50%.

Also in the Third National Development Plan (1976-1983) it was further stated that the training of TBAs will be intensified. After training they will go to work in the communities to which they belong. The remuneration will be left to the community to decide.

This stresses the importance or the vital role the Traditional Birth Attendants have to play and still play in the field of Midwifery. This led the Zambian Government to support the training of TBA's programme with the financial support from UNICEF.

Evidence has shown that in Zambia most babies are delivered by TBAs, especially in the rural areas where about 75% of the population live and also in the peri urban settings.

The overall objective of the TBA training programme was to improve the collaboration between the TBAs and the centrally organised system of maternal and child care and to develop the TBAs as a multi disciplinary group within the integrated health team.

2. THE PURPOSE OF THE STUDY

In view of the above observations, the researcher thought it necessary to find out through scientific study the extent to which the TBA's were being utilised in Lusaka Urban, despite the existence of the delivery health centres. Further more to find out if the community was supporting the TBAs through remuneration and also to find if incentives were usually being given by the

Government to the TBAs to boost their morale. The incentives are usually given in form of a UNICEF TBA kit and a certificate issued at the end of training.

The researcher's intentions depended on the outcome of the study. If the findings will be favourable, the researcher would recommend that the programme of the training of the TBAs should continue in Lusaka Urban, in order to lessen the number of mothers in the delivery health Centres, and also to provide safe delivery in the home.

Furthermore, the favourable findings would contribute towards more collaboration between the health centre staff and TBAs. Another factor is that: if the communities were supporting their TBAs the spirit should be encouraged to continue since this motivates the TBA to become even more dedicated to her duties, and therefore, continue providing the necessary care to the woman during child birth. If the findings would not be favourable, the results would be a highlight to whether the training of TBAs programme should continue in Lusaka urban or should not, since its continuity will only lead to a waste of funds and manpower and ^{yet} less beneficial to the community and the society as a whole. If the community were not supporting the TBAs through remuneration, it would be the duty of the health centre staff to make the members of the community understand the role of the TBAs and also to make the community be aware of their role or obligation towards maintenance of the TBAs. They should be made to understand their commitment towards supporting of the TBAs. If incentives were not being given by the Government then strong recommendations would be made for incentives to be given in form of a UNICEF TBA kit and certificate. These would make the TBA feel confident and motivated in her work.

THE RESEARCH PROBLEM

The research problem was stated in an interrogative form, and the study was designed to answer the following questions:-

1. Does the availability of health delivery Services affect the utilization of TBAs in Lusaka Urban?
2. To what extent does the contribution of the community towards maintenance of the TBA satisfy the TBA?
3. Does the Government quite often motivate the TBA by giving incentives such as the UNICEF TBA kit and certificate?

HYPOTHESIS

This was the tentative answer to the questions posed in the research problem above.

"There is a relationship between utilisation of TBAs in Lusaka Urban, availability of health Services, remuneration from the community, and incentives from the Government."

*THE OBJECTIVES OF THE STUDY

At the end of the study the Researcher should be able to identify

1. Factors that influence the utilisation of TBAs in Lusaka Urban.
2. Apply knowledge gained from this study to improve the services of the TBAs in the community by motivating them through incentives.
3. To make the community understand their role in supporting the TBAs.

4. THE SIGNIFICANCE OF THE STUDY

This is an important study, because it has tried to probe into problems that affect the utilisation of the TBAs in the community. To find out whether the TBAs are being utilised to the maximum by the community or there is minimal use of them by the community, whether the TBAs are fully supported by the community and the Government so that they are recognised by the communities

For many women in many parts of the world assistance at child birth is provided only by the Traditional Birth Attendant. These people may not be able to read and write but are able to perform deliveries in their own way, and are therefore, relied on very much by members of their communities. It is therefore, with this view of the contribution that TBAs are making to the community that programmes were developed for incorporating the TBA in the health care system (WHO 1966).

In many areas of the world, Zambia included and with the Cooperation of WHO and UNICEF, training programmes have been established for improving the knowledge and performance of the TBA. At the completion of her training, the TBA is given supplies and equipment to make her able to carry out deliveries in a manner that will provide safety to both mother and child. Her duties are not limited to the carrying out of deliveries only but her work also included the provision of basic care to women throughout the normal maternal cycle, the provision of care to the normal new born, participation in other primary Health Care activities including the identification and referral of high risk patients.

6. OPERATIONAL DEFINITIONS OF VARIABLES AND KEY TERMS

1. **Traditional Birth Attendant:** in this study refers to a woman who assists the mother at child birth and who has achieved her skill delivering babies by herself or by working with other Traditional Birth Attendants. (WHO, 1979).
2. **Community:** in this study refers to persons living together and sharing common practices.
3. **Health Care:** in this study refers to services directed at improving or sustaining health.
4. **Community support:** in this study refers to payment by the woman who has been assisted by a TBA. The payment is made to the TBA.
5. **Incentives:** in this study refers to the UNICEF TBA kit and the Certificate issued to the TBA on completion of her training.
6. **Remuneration:** in this study refers to the payment given to the TBA for the work she does in the community.
7. **Adult literacy:** in this study refers to a programme for teaching adults who have had no chance of going to school how to read and write.
8. **Maternity Care:** in this study refers to services directed at ensuring safe motherhood.
9. **Integration:** in this study refers to combination of different

10. Primary Health Care: in this study refers to the basic care given by individuals in the community.

11. Maternal Mortality Rate: in this study refers to the number of deaths reported as due to pregnancy in a Calendar year per 100,000 live birth reported in the same year. (Fromer, Joan Margot 1983).

12. Infant Mortality Rate: in this study refers to the number of deaths during a year of children less than 1 year of age per 1,000 live births (Fromer and Margot 1983).

CHAPTER 2

LITERATURE REVIEW

Research has been done on various aspects of maternal and child health care but less studies have been done on the utilization of TBAs in the community.

Literature on the activities of TBA's in Zambia is limited. The literature done is based on the factors related to prevention of neonatal deaths.

Mahler (1985) states that the prevention of neonatal deaths and infection can be achieved through the increased training of Traditional Birth Attendants and immunization of pregnant women, an improvement of mothers conditions. He further states that each adult should consider the children of the world as his/her own, strengthening our community awareness and involvement in the care of mothers and children is essential. This stresses the importance of the role of the TBA in midwifery. In Zambia, like any other developing countries, most of the babies are delivered by the TBAs. This is as a result of inadequate trained midwives which is sometimes caused by the trained personnel to shun working in the rural areas. Poor communication, inadequate health facilities and the rural urban migration have caused great concern to health authorities and the communities at large.

Sikota (1983) in her report, "Evaluation of TBA programme in Zambia", has expressed the same view that limited health care caused by inadequate health facilities in the rural areas where 75% of the total population lives, makes it difficult for the health services to reach every village in the communities. She further states that the problem is compounded by

poor communication due to lack of transport on all weather roads, and she points out the people in those areas rely on the Services of the TBA's.

In Zambia the problem of inadequate health facilities is not only limited to the rural areas but the problem has spread to the peri urban and urban areas. This is as a result of rural urban migration which has resulted in many people coming to the cities, therefore, causing an increase in the population, and as a result, inadequate health facilities.

Ampofo (1975) in his paper entitled "ROLE OF TRADITIONAL MIDWIFERY IN MATERNAL AND CHILD HEALTH CARE", indicates that in many developing countries, the health Services including Maternal and Child health do not provide adequate coverage for the population. He goes on to say that in many countries, serious attempts have been made to provide maternity care for the population. He further states that inspite of large sums of money spent, coverage of scientific midwifery is confined to the cities and a few urban areas but the rural areas and the Village environment have remained untouched by modern midwifery. Lusaka is one of the Urban areas where urbanization has its effects on the health facilities. Population in Lusaka is on the increase and is evidenced by the mushrooming of shanty compounds near the city.

Mwambazi and Keller (1983) have speculated that nearly half of Zambia's population will be urban dwellers and will live in high residential areas, mainly squatter compounds. They further state that as a result, these problems call for an organised health System that will be able to provide adequate health facilities.

The training of TBA programme was introduced in Lusaka to meet the increased demand for health services.

Sikote (1983) in her report of the evaluation of TBA programme in Zambia states that the programme was introduced in Zambia in order to improve the knowledge and proficiency of maternity care Services offered to the community as well as to encourage and reinforce positive and beneficial cultural beliefs and practices whilst discouraging and eliminating the influence of the harmful practice about pregnancy and maternity. She further indicates that the programme aims at improving the collaboration between the TBA and the centrally organised system of maternal and child care as well as to develop TBAs as a multi disciplinary group within the integrated health team. The emphasis, of the programme is on inculcating basic health practices related to personal cleanliness. WHO Technical Report 1966 states that most of the TBAs are illiterate and mostly have no training at all in midwifery but they are usually capable of carrying out duties relating to maternal and infant care, and are likely to be the most highly respected members of the communities. Imoague (1975) in his paper entitled "Current Information on the Practice, training and Supervision of TBA," shares the same view that the main aim of the training of TBAs is to teach them simple ante-natal care and also the importance of cleanliness in practising midwifery so as to reduce maternal and infant mortality. TBAs are trained therefore to offer Services to people who are not ^{have} priviledged to the health facilities for one reason or another.

Different countries have different opinions concerning the incorporation of the TBA in the health Care System. WHO 1979 states that allusion has been made at times to the notion of integrating the TBA into the organised health system. The paper

further points out that the idea of integrating the TBA in the health system would lead to the TBA losing her identity as perceived in the traditional sense. It is indicated that if/so intimately connected to the organised health system, it might lead to a conflict between the TBAs and other categories of health personnel, as well as between the TBAs and the communities that they would be expected to serve. To ensure that the identity of the TBAs is not lost, only informal and flexible links should be developed between her and the organised health system. In Zambia the informal links between the TBA and the health system have been maintained as is evidenced by the fact that after completion of her training, the TBA visits the health centre only for supplies or when she refers the cases which she feels she cannot manage. She rarely operates from the health institutions. Neither does she get paid by the Government. She works on humanitarian grounds and it is for the person assisted to look into the matter of remuneration.

Angara (1977) indicates that the general attitude has been to discourage hilot (TBA) practice and to promote their replacement by trained licenced midwives. It was only after revision of the prevailing status of Midwifery Service that it was found that a large population of births were attended by TBAs. In Zambia the government attaches great importance to health programmes, and therefore, has great support for them.

Sikota (1983) indicates that in the second National Development Plan, the government of the Republic of Zambia has committed itself to give priority to all training programmes because of the importance of trained personnel to the expansion of health Services as well as to ensure that mothers are under health care and also to increase the trained assistance at deliveries. It

is further stated that the training of TBAs would be intensified, after training they would be expected to go back and serve in the community to which they belong.

LHO Technical Report (1973) states that at peripheral level, it is desirable to take the prevention of certain minimum service areas as primary objective.

Kao (1986) indicated that primary health care in the sense in which it was introduced depends mainly on new kinds of first line health workers, non-professionals chosen and trained for rural communities where there are no health professional workers.

The TBA is often the first health care worker with whom pregnant women in poor countries have contact.

In Zambia primary health care is well integrated with the rest of the health Services, as it is throughout many developing countries. Participation by the people in primary health care is well established, as they are involved in its planning and management, through the local leadership and the Ministry of health authorities.

Karakushar (1983) indicates that in the Alma-Ata declaration, special emphasis is laid on the fact that ^{an} Primary health Care must be integral part of the country's health system and on the fact that health status is dependent on overall Social and economic development of the community Primary health care is the first level of contact between the individual and the national health system, and its aim is to focus as closely as possible on where people are living and working.

Most of the provisions of the Alma Ata Declaration concur with the principles of the health Services in Zambia where a decree for free medical services was declared with the view that everyone should be able to receive health care without hinderance, resulting from her/his social status in the community. This has ensured that there is an improvement in the expansion of the health Services to both the rural and urban population.

The primary health Care approach is nothing new in Zambia. Each and every Community has committees composed of community leaders such as party leaders and church leaders and their Chairmen. The community leaders conduct all social and health activities at the community level, in cooperation with health workers whether in the rural or urban areas. They work hand in hand with health workers such as public Health Nurse or Health Assistant.

Community participation in Zambia is a reality as is demonstrated by the fact in some places health centres have been built by communities on a voluntary basis, so that the relatively satisfactory level of health enjoyed by Zambians has been due largely to the cooperation of the various communities.

The TBA has become a useful community health worker with special concern for mothers and babies thus forming part of the primary health care approach in a country. The TBA is probably the oldest prototype of birth helper who is now the subject of attention is, in fact, of the marked shortage of qualified personnel to meet the health level of the poor, especially in developing countries. (Hartouche 1983).

Kumar (1983) indicated that mortality and morbidity among women of child bearing age, infants and pre-school children continue to be inacceptably high in the developing countries. For these and other reasons the value of the contribution of TBAs is increasingly accepted.

CHAPTER 3:

METHODOLOGY

1. RESEARCH DESIGN

Polit and Hugler refer to research design as "the plan or organisation of scientific investigation. The research design used for this study was a **descriptive** survey. It was decided to use the survey research design because it was found to be the most appropriate for this study, **since** the study aimed at obtaining current information on the utilization of the TBAs in Lusaka Urban. This was in order to find out to what extent the TBAs were being utilised, and also to find out factors that would influence their performance and reinforce their utilization.

The aim of the **descriptive** survey is to look for data about the distribution and frequency in a population (Seaman and Verhonick, 1982).

Sweeney and Oliveri state that the descriptive surveys are carried out for the purpose of providing an accurate portrayal of a group of subjects with **specific** characteristics. Descriptive studies usually enhance the precise measurement of phenomena as they currently exist within a single group.

The second reason was that, the respondents were going to ^{co-operate} ~~cooperate~~ with the recorder since they were going to give information that would be recalled in a short time (Seaman and Verhonick 1982).

A descriptive survey was chosen for the study because it would portray effectively the characteristics of the population under study. All TBAs selected were able to speak Nyanja.

2. RESEARCH SETTING

The study was undertaken in Lusaka Urban compounds. The interviews were done in the urban clinics. The Lusaka Urban compounds are situated in various areas of the city. They are high density areas, which tend to be highly populated. Lusaka Urban has a population of about 800,000 people (Census 1980) The population consists of high, medium and low income groups of people, which are catered for by the health centres in the respective communities. The three different classes result in making the town of Lusaka congested and even contribute to inadequate provision of health facilities which has led to the utilisation of primary resource persons.

Traditional Birth Attendants who are trained to deliver better maternal and child health care services are part of the primary resource persons.

The existence of health facilities and that of Traditional Birth Attendants has left the population of Lusaka with much choice to make as far as the utilisation of health Services is concerned.

In conclusion, the way these health facilities are being utilised by the communities at large, depend upon what these communities feel about the services being provided.

3. SAMPLE SELECTION AND APPROACH

The target population for the study were the trained Traditional Birth Attendants practising in Lusaka Urban. The sample consisted of 20 TBAs. Sweeney and Oliveiri (1981) define a sample as a small portion of the whole population selected for use in study. The number of the sample was small due to the fact that some of this target population had left town and also some had died.

The limited time in which the study had to be submitted to the University authorities also contributed to the size of the sample. Nevertheless, the researcher felt the sample was big enough to be able to provide fairly accurate estimates of the population. The method used for sampling in this study was purposive sampling.. Selltitz and Jahoda (1985) define purposive sampling as a non-probability sampling approach, where sample elements are sometimes chosen because they fulfil certain criteria. In this study the sample elements were chosen from a list which exist at the health center. Selltitz and Jahoda, further state that this method is often used for studies and that a common strategy of purposive sampling is to pick cases that are judged to be typical of the population in which one is interested. Purposive sampling was obtained by selecting the centres which has these TBAs operating from the respective communities. This form of sampling was used because it is much simpler to use whenever the target population is small.

Another method that could have been used in this study could have been snowball sampling, which is useful in studying social networks and groups of people who are hard to locate such as the TBAs. The initial contacts may be chosen randomly or accidentally. From then on each contact provides information which leads to others. Snowball Sampling may be probability or non-probability depending on how the initial elements are chosen and the extent to which the snowball is built up. Each of the non probability methods leaves us with the problem of assessing how representative the data are.

4. INSTRUMENT USED IN THE STUDY

An interview schedule was used for collecting data from the TBA's (Appendix 3). An interview is a survey method in which a researcher asks the questions orally (Treece and Treece 1977 Polit and Hungler, 1983). The questions in an interview schedule are standardised and arranged in an organised sequence. The main reason for using the interview schedule is that most of the subjects to be interviewed were illiterate, and as a result, the method was found to be most appropriate because it can be administered to both educated and uneducated subjects. Most of the TBAs are uneducated, so that made the method most suitable.

ADVANTAGES OF INTERVIEW SCHEDULE

1. It can be used on both the literate and illiterate people. Most of the TBAs are still illiterate so the method was found to be most suitable.

2. All data obtained are useful as all items are answered as compared to the questionnaire where only some of the questions may be answered.
3. The coverage is high as more people can participate within a short period of time.
4. The interview yields a much better sample of the general population. Many people are willing and able to co-operate when all they have to do is talk (Sellitiz and Johada, 1985).
5. Another advantage of the interview is its greater flexibility. Where a subject misinterprets a question there is always a possibility of repeating or rephrasing questions to make sure that they are understood, or of asking further questions in order to clarify the meaning of a response. In addition, the interview offers a better opportunity to appraise validity of reports, since the interviewer is in the position to observe not only what the respondent says but also how he says it.
6. The interview offers an opportunity for revealing information about complex behaviour, emotionally laden subjects or for probing the sentiments that may underlie an expressed opinion (Sellitiz and Johada 1985).
7. Rapport can easily be established making it easier for the respondents to give all information even if emotional in nature (Treece and Treece, 1977 p.198).
8. The respondent does not have to fill in the responses and return the questionnaire to the researcher.

10. It enables the interviewer to observe some of the non-verbal communication.

However, the interview has some disadvantages:-

1. It is time-consuming as the interviewer has to do the questioning and filling in the responses immediately (Treece and Treece, 1977).
2. There is a likelihood of bias since the interviewer is involved in the data he is reporting. Festinger (1953) states that even if we assume the individual to be in possession of certain facts he may withhold or distort them because to communicate them is threatening or in some manner destructive to his ego.
3. Inability of the respondent to provide certain types of information. This may mean that the interview must be constructed in a way that the respondent provides raw data which are non-threatening.
4. Respondents may not easily recall some information in a short period (Sweeney and Oliveri, 1981)
5. There is no anonymity as the interview is administered face to face. Therefore true answers may be concealed.
6. The size of the sample may be reduced because of the specified time (Sweeney and Oliveri, 1981).
7. Translation of words from English into the local language the subject understands and vice-versa may sometimes alter the meaning in the words (Treece and Treece, 1977)

The above disadvantages were minimized by checking the instrument before hand with the supervising lecturer. It was checked for wording, sequence and uniformity.

The interview was administered personally so that each word was translated into a language the respondent could understand. Respondents were assured of the anonymity since their names were not asked for or recorded any where. Rapport was established by first asking the respondents general questions. Greetings and self introduction were done and the respondents were made to feel at home before commencement of the interview. Because of the small sample that was involved, "there was no rushing through of the questions".

5. A PILOT STUDY

A pilot study was not done due to the small sample.

However, the data collecting tool was checked by the lecturer in Nursing Research. Abdellah and Leviere (1979) define a pilot study as a study carried out before a research design is completely formulated to assist in:-

- (a) Getting information to improve the major study.
- (b) Determining whether it is feasible to carryout the major study as planned.
- (c) Testing the hypothesis.

Finally a pilot study is a trial run of the major study which is carried out to test the data collecting instrument to see whether the questions are clear or ambiguous. (Polit and Hungler, 1983).

6. THE INTERVIEW SCHEDULE DESIGN

Thirty-three (33) questions were drawn for the interview.

The first six (6) questions were concerned with demographic data of respondents, i.e. age and education status.

These were put first so that the respondent would feel relaxed during the interview, and be able to participate in the interview feeling interested and to motivate the respondents to want to continue. (Sweeney and Oliveiri, 1981).

Question 7 - 16, 25 - 35 sought information on the utilization of the TBA. All these questions were asked to assess the utilization of the TBA.

The rest of the questions (18) dealt with the TBAs training. The last question dealt with any remarks from the respondent concerning the job that she was performing in the community.

All these questions were asked in order to assess the performance of the TBA.

7. DATA COLLECTION

Data were collected in the month of April, 1989, because that was the period when the interview schedule was ready and that was also when the stage for data collection was reached. TBAs were interviewed on period of four successive weeks.

The interviews had no specific days on which they were to be done, they were only done when the researcher found she had some free time to do them. The interviews were usually done in the health centres in any of the rooms that were found to be free at that particular time. Although permission was sought from the Social Secretary of the Health Department of the City Council, permission had also been sought from the in-charge of the health center during a visit to each of them and self introduction made, and the purpose of the visit. After self introduction to the respondents, the purpose of the study was explained and the utilisation of the findings afterwards. Subjects were interviewed individually to avoid them from being shy or the responses to be given not to be influenced by their fellow TBAs. The respondents were very co-operative and answered all the questions, and wished for another visit for the same purpose.

CHAPTER 4

1. DATA ANALYSIS, PRESENTATION AND FINDINGS BY TABLES

This chapter is mainly concerned with presentation of data that were collected from the TBAs. The Data were analysed manually.

Raw data were first edited for completeness, uniformity and accuracy, then they were tallied on the work sheets. Responses were put into categories especially those from open ended questions. Coding was used for close ended type of responses. After this all tallied data were added and converted into actual numbers. The statistical data were put in table form in an explanatory manner. Percentages were not used because the sample was small.

2. PRESENTATION OF DATA

Data were arranged in frequency counts. Findings are presented in table form. The purpose of the study was to find out whether the TBAs were being utilised to a great extent by the communities in Lusaka Urban and also to determine if the TBAs were being motivated through incentives from the government and remuneration from the community.

It was found suitable to use tables because they summarise results in a meaningful way thus enabling the reader to understand the author's intention of the study.

Tables have been arranged according to questions in the instrument, percentages have not been used due to the small sample, and thus to avoid exaggeration that might appear if percentages were to be used.

TABLE 1: AGE DISTRIBUTION OF RESPONDENTS

AGE IN YEARS	NUMBER OF RESPONDENTS	TOTAL
20 - 24	00	00
25 - 29	00	00
30 - 34	01	01
35 AND ABOVE	15	15
NOT KNOWN	04	4
T O T A L	20	20

Table: 2 shows that the age range of respondents was from 30 - 35 years and above. Four respondents whose age was not known are not included in the range.

TABLE 2: DISTRIBUTION OF RESPONDENTS
ACCORDING TO EDUCATIONAL
ATTAINMENT

LEVEL OF EDUCATION	NUMBER OF RESPONDENTS	TOTAL
NO SCHOOLING	02	02
ADULT LITERACY	00	00
PRIMARY SCHOOL	14	14
OTHER SPECIFY	04	04
T O T A L	20	20

Table 2: Illustrate that the majority of respondents (14) had achieved primary school education that is Grade 1-7. 4 of the respondents did not have primary education. They were taught to read and write by relatives. 2 had no schooling.

TABLE 3: ABILITY OF RESPONDENTS TO READ OR WRITE NYANJA.

ABILITY TO READ OR WRITE NYANJA	NUMBER OF RESPONDENTS	TOTAL
YES	13	13
NO	07	07
T O T A L	20	20

Table 3: Shows that 13 of the respondents were able to read and write Nyanja and the remaining 7 could neither read nor write Nyanja. The level of education attained was not sufficient for them to be able to read and write. The two who had no schooling are also included in this number.

TABLE 4: RESPONDENTS MARITAL STATUS

MARITAL STATUS	NUMBER OF RESPONDENTS	TOTAL
MARRIED	14	14
SINGLE	01	01
WIDOWED	02	02
DIVORCED	03	03
SEPARATED	00	00
T O T A L	20	20

Table 4: Shows that the majority of the respondents (14) were married. 1 was single, 2 were widowed, 3 were divorced.

TABLE 5: NUMBER OF CHILDREN PER EACH RESPONDENT

NUMBER OF CHILDREN	NUMBER OF RESPONDENTS	TOTAL
1 - 3	03	03
4 - 6	07	07
7 - 9	08	08
10 AND ABOVE	02	02
T O T A L	20	100

Table 5: Illustrate that the number of children for each respondent ranged from 1 - 10 and above.

TABLE 6: RESPONDENTS YEARS OF RESIDENCE IN LOCALITY

YEARS OF RESIDENCE IN LOCALITY	NUMBER OF RESPONDENTS	TOTAL
0 - 4	00	00
5 - 9	01	01
10 - 14	02	02
15 AND ABOVE	17	17
T O T A L	20	100

Table 6: Shows that most of the respondents (17) had lived in the locality for 15 years and above. There were none who had lived in the locality for less than 4 years.

TABLE 7: WHEN RESPONDENT STARTED PRACTISING AS A TBA

NUMBER OF YEARS	NUMBER OF RESPONDENTS	TOTAL
0 - 3 YEARS AGO	00	00
4 - 7 YEARS AGO	00	01
8 - 11 YEARS AGO	01	01
12 YEARS AND ABOVE	18	18
T O T A L	20	100

Table 7: Illustrates the number of years of practice by the TBA. They ranged from 0 - 12 years and above.

TABLE 8: FREQUENCY OF VISITS TO PRENATAL MOTHERS

FREQUENCY OF VISITS	NUMBER OF RESPONDENTS	TOTAL
ONCE IN 3 MONTHS	00	00
ONCE IN 6 MONTHS	00	00
ONCE IN 9 MONTHS	01	01
OTHER SPECIFY.	19	19
T O T A L	20	100

Table 8: Shows frequency of visits by majority of respondents to prenatal Mothers, most of the respondents (19) had no specific times of visiting the mothers.

TABLE 9: TIME WHEN RESPONDENTS LAST ATTENDED A BIRTH

PERIOD OF LAST ATTENDANCE TO BIRTH	NUMBER OF RESPONDENTS	TOTAL
0 - 4 MONTHS	14	14
5 - 9 MONTHS	03	03
10 - 14 MONTHS	01	01
15 MONTHS AND ABOVE	02	02
T O T A L	20	20

Table 9: Shows when respondents had last attended a birth. The months of previous attendance to a birth ranged from 0 - 15 months and above. With the majority (14) falling in the range of 0 - 4 months, 3 in the range of 5 - 9 months, 1 in the range of 10 - 14 months and 2 in the range of 15 months and above.

TABLE 10: NUMBER OF BIRTHS ATTENDED TO FROM JANUARY-DECEMBER 1988

NUMBER OF BIRTHS	NUMBER OF RESPONDENTS	TOTAL
0 - 3 BIRTHS	10	10
4 - 6 BIRTHS	07	07
7 - 9 BIRTHS	03	03
10 AND ABOVE	00	00
T O T A L	20	20

Table 10: Shows number of births attended to by respondents during the previous year. Number of births attended to ranged from 0 - 10 and above. The majority of the respondents (10) the range was between 0 - 3 births, 3 respondents the range was between 4 - 6, 3 those between the range of 7 - 9 births and 0 were in the range of 10 and above.

TABLE 11: NUMBER OF RESPONDENTS WHO KEEP LISTS OF DELIVERIES THEY CONDUCT

THOSE WHO KEEP LISTS OF DELIVERIES CONDUCTED	NUMBER OF RESPONDENTS	TOTAL
YES	11	11
NO	9	9
T O T A L	20	20

Table 11: Shows the number of respondents who keep lists of deliveries they conduct. Most of the respondents (11) used to keep lists of deliveries they conduct where as 9 were not keeping lists of deliveries conducted.

TABLE 12: FREQUENCY OF VISITS TO PATIENTS AFTER DELIVERIES

FREQUENCY OF VISITS	NUMBER OF RESPONDENTS	TOTAL
ONCE A WEEK	01	01
ONCE IN TWO WEEKS	00	00
ONCE IN FOUR WEEKS	00	00
ONCE IN SIX WEEKS	00	19
ANY OTHER, SPECIFY	19	
T O T A L	20	20

Table 12: Shows frequency of visits by respondents to mothers after delivery. The majority (19) had no specific time of visiting the mothers. They went to visit when they felt there was a need. Only 1 respondent visited the patient after deliver about once a week.

TABLE 13: LOCALITIES WHERE THEY ATTEND BIRTHS

LOCALITIES	NUMBER OF RESPONDENTS	TOTAL
RESIDENTIAL COMMUNITY	12	12
OUTSIDE RESIDENTIAL, COMMUNITY	05	05
ANY OTHER SPECIFY.	03	03
T O T A L	20	20

Table 13: illustrates localities where the respondents attend births. The majority (12) in residential community, the least were those attended to when the respondent had gone out for a visit somewhere far from their residential locality.

TABLE 14: TYPE OF TRANSPORT USED WHENEVER ASSISTANCE IS REQUIRED

TYPE OF TRANSPORT USED	NUMBER OF RESPONDENTS	TOTAL
(a) ON FOOT	19	19
(b) BICYCLE WHENEVER AVAILABLE	01	01
(c) OTHER SPECIFY	00	00
T O T A L	20	20

Table 14: Illustrates the type of transport used whenever assistance was required. The majority (19) said they walked. Only 1 respondent said used a bicycle.

TABLE 15: RESPONDENTS WHO WOULD LIKE TO BE PROVIDED WITH TRANSPORT

TRANSPORT TO BE PROVIDED	NUMBER OF RESPONDENTS	TOTAL
YES	19	19
NO	01	20
T O T A L	20	20

Table 15: Illustrates respondents who would like to be provided with transport. The majority of the respondents (19) want transport. 1 respondent felt she did not want to bother anyone with transport.

TABLE 16: PLACE OF TRAINING OF RESPONDENTS.

PLACE OF TRAINING	NUMBER OF RESPONDENTS	TOTAL
RESPECTIVE HEALTH CENTER	10	10
NEAREST DELIVERY CENTER	08	08
ANY OTHER SPECIFY	02	02
T O T A L	20	20

Table 16: Shows place of training of the respondents. Most of the respondents (10) did their training in the respective health center, 8 did theirs in the nearest delivery center. 2 did their training in their own homes and it was when the programme had just started.

TABLE 17: DURATION OF TRAINING OF TBA'S

DURATION OF TRAINING OF TBA'S	NUMBER OF RESPONDENTS	TOTAL
BELOW 30 DAYS	01	01
30 - 59 DAYS	06	06
60 DAYS AND ABOVE	13	13
T O T A L	20	20

Table 17: Shows duration of Training of TBAS the majority (13) has trained for 60 days and above, 6 had trained for 30 - 59 days, and 1 respondent had trained below 30 days.

TABLE 18: RESPONDENTS WHO FOUND COURSE TO BE BENEFICIAL

RESPONDENTS WHO FOUND COURSE TO BE BENEFICIAL	NUMBER OF RESPONDENTS	TOTAL
YES	19	19
NO	01	01
T O T A L	20	20

Table 18: Shows respondents who found course to be beneficial. The majority (19) found course to be beneficial 1 did not find course to be beneficial trained for less than 30 days.

TABLE 19: WHO CHOSE RESPONDENTS TO GO FOR TRAINING

WHO CHOSE RESPONDENT TO GO TRAINING	NUMBER OF RESPONDENTS	TOTAL
COMMUNITY LEADERS	12	12
CLINIC STAFF	08	08
OWNSELF	00	00
OTHER SPECIFY	00	00
T O T A L	20	20

Table 19: Illustrates the people who chose the respondent to go for training, the majority (12) were chosen by community leaders, 8 were chosen by clinic staff.

TABLE 20: RESPONDENTS GIVEN INCENTIVE AFTER TRAINING

INCENTIVE GIVEN AFTER TRAINING	NUMBER OF RESPONDENTS	TOTAL
YES	18	18
NO	02	02
T O T A L	20	20

Table 20: Shows respondents given incentive after training the majority (18) were given incentives after training, (2) were not given incentives.

TABLE 21: FREQUENCY OF VISITS TO THE HEALTH CENTRE FOR SUPPLIES

FREQUENCY OF VISITS TO HEALTH CENTRE FOR SUPPLIES	NUMBER OF RESPONDENTS	TOTAL
ONCE IN 3 MONTHS	00	00
ONCE IN 6 MONTHS	00	00
ONCE IN 9 MONTHS	00	00
ONCE IN 12 MONTHS	00	00
NEVER GO THERE	12	12
ANY OTHER SPECIFY	08	08
T O T A L	20	20

Table 21: Showing frequency of visits to the health center. For supplies by respondents. The majority never used to go there, the 8 said they went there only when referred patients.

TABLE 22: WHETHER RESPONDENTS EVER HAD BEEN TO THE HEALTH CENTRE FOR DISCUSSIONS

RESPONSE	NUMBER OF RESPONDENTS	TOTAL
YES	03	03
NO	17	17
T C T A L	20	20

Table 22: Showing respondents who have been to the health Center for discussions, the majority (17) had never been there and 3 had been.

TABLE 23: WHETHER RESPONDENTS HAVE EVER HAD A REFRESHER COURSE

RESPONSE	NUMBER OF RESPONDENTS	TOTAL
YES	03	03
NO	17	17
T O T A L	20	20

TABLE 23: Illustrates whether respondents have ever had a refresher course. The majority (17) have never had a refresher course before. The 3 who had been to a refresher course were also community health workers.

TABLE 24: WHETHER RESPONDENTS EVER GET PAYMENT AFTER HELPING A WOMAN DELIVER

RESPONSE	NUMBER OF RESPONDENTS	TOTAL
YES	08	08
NO	12	12
T O T A L	20	20

Table 24: Shows whether respondents ever get payment after helping a woman deliver. The majority (12) never got payment after helping a woman deliver. 8 had payment after helping a woman deliver.

TABLE 25: WHOSE RESPONSIBILITY IT IS THE RESPONDENT FEEL TO PAY HLW

RESPONSE	NUMBER OF RESPONDENTS	TOTAL
THE GOVERNMENT	12	12
THE COMMUNITY	08	08
ANY OTHER, SPECIFY	00	00
T O T A L	20	20

Table 25: Illustrates whose responsibility the respondents felt to pay them. The majority (12) felt the Government should pay them, 8 felt the Community should be paying them after helping a woman deliver.

TABLE 26: WHY RESPONDENTS DECIDED TO BECOME A TBA

REASONS FOR BECOMING A TBA	NUMBER OF RESPONDENTS	TOTAL
PRESTIGE	00	00
BENEFITS	00	00
ENCOURAGEMENT FROM FRIENDS	01	01
DEVOTION	19	19
ANY OTHER SPECIFY	00	00
T O T A L	20	20

Table 26: Shows why respondents decided to become a TBA. The majority (19) of the respondents felt it was devotion, and 1 respondent said it was because of benefits.

TABLE 27: WHETHER THE RESPONDENTS FEEL THAT THE COMMUNITY APPRECIATES THEIR WORK.

RESPONSE	NUMBER OF RESPONDENTS	TOTAL
YES	19	19
NO	01	01
T O T A L	20	20

Table 27: Shows respondents who felt their work was being appreciated by the community. The majority (19) felt if their work was being appreciated by the community, 1 respondent felt the community did not appreciate her work.

CHAPTER 5

DISCUSSION OF FINDINGS, NURSING IMPLICATIONS, CONCLUSIONS,
RECOMMENDATIONS AND LIMITATION OF THE STUDY

The purpose of the study was to determine the extent the TBAs were being utilised by the community, and also to find out if the community were showing appreciation of the work by the TBAs by giving them remuneration. Another factor was to find out if the government was giving the TBAs incentives i.e. UNICEF TBA Kit and certificate for them to feel confident and therefore be able to perform better and in turn reinforce their utilisation by the community.

Table 1 shows the age distribution of respondents. The age range in years was 30-35 and above. ^{Fifteen} (15) respondents were aged 35 years and above, 4 respondents did not know their age and had no valid documents to that would help in determining their age. One (1) respondent was aged between 30-34 years. The one (1) subject who said was under 35 years of age was not very sure of her actual age.

This explains the fact that the TBAs were between the desired age group, therefore they are the acceptable age to practice midwifery within the community. Traditionally one cannot practice midwifery within the community when she is considered young, usually before before the age of (30).

Table 2 shows the distribution of respondents according to ^{al} education/attainment. Fourteen (14) of the respondents had primary education that is Grade 1-7; four of the respondents had no formal education which means that they learnt to read and write through either relatives or friends. Two respondents had

no schooling. This means that the majority (14) were able to understand the nature of their job better than their colleagues.

Table 3 shows that 13 of the respondents were able to read and write Nyanja, Seven could neither read nor write Nyanja. The level of education attained was not sufficient enough for them to be able to read and write.

Table 4 shows that fourteen (14) respondents were married, three (3) were divorced, two (2) were widowed whereas one (1) respondent was single. None of the respondents was separated from their husbands. The single lady among the group could be partly due to the fact that when the programme started, some unmarried clinic cleaners were chosen to train as TBAs to alleviate the shortage of staff in health centres. Traditionally a single lady cannot practice midwifery within the community as she would be regarded as being inexperienced and not mature enough, and therefore, would not be acceptable in the community as a midwife.

Table 5, shows number of children per each respondent. Eight (8) respondents had 7-9 children, seven (7) had 4-6 children, three (3) had 1-3 children whereas two (2) had 10 and above children. According to the respondents, the number of children were those who were living. Some respondents had children who had died. Traditionally within the community one cannot practice midwifery before she has a baby of her own and usually the age of having the first baby is between fifteen (15) to twenty (20) years.

Table 6 shows respondents years of residence in locality. Seventeen (17) respondents had lived within the local community for

a period of 15 and above years, two had lived in locality for 10-14 years and one (1) had lived in the locality for 5-9 years. This explains the fact that for one to be accepted to practise as a traditional midwife in the community she must have lived there long enough, usually about ten (10) to fifteen (15) years. This also suggests that most of the TBAs had lived long enough in the local community to be accepted there, and in any case it meant that the community had confidence in them. In case of only one (1) TBA who had lived in the community for less than ten years, she might have come on transfare from some other place.

Table 7 shows years of practice of TBA. Eighteen respondents had practised 12 years and above, one (1) had practised for 4 years and the last one had practised for 8-11 years. This suggests that before one is chosen by the community to train as a midwife she must have practised trational midwifery for a period of about 5 years and above, for her to be regarded as experienced and mature midwife.

Table 8 shows frequency of visits by respondents to prenatal mother. Ninenteen (19) respondents had no specific times of going to visit their clients, they were there whenever they felt the need to do so. One (1) respondent said she visited her clients once in 4 months. This suggests that the TBAs did not attach importance to antenatal care. Most of the TBAs felt it was not necessary for them to be visiting their clients quite often since they were already attending antenatal clinics. Another factor being that some of them feared to visit their clients personally because of the beliefs existing that if an expentant mother happened to miscarry or have a still birth, they would be held responsible for the mishap.

Table 9 shows when the respondents last attended a birth. Fourteen of the respondents had attended a birth within a period of four (4) months, three respondents had attended a birth about five (5) to nine (9) months back, where as two (2) respondents had attended to a birth about 15 months back one (1) respondent had attended to a birth within 10-14 months.

Table 10 shows number of births attended to from January to December, 1988. Ten (10) respondents had attended 0-3 births, ^{Three} seven (7) had attended 4-6 births, and the last (3) had attended 7-9 births. Since some of the subjects did not have records of the births that they conducted, this information may not be accurate. On the average each TBA conducted about 6 deliveries in one year.

Table 11 shows number of respondents who keep lists of deliveries they conduct. Eleven (11) respondents were keeping lists of deliveries conducted. Nine (9) respondents did not keep any lists of the deliveries that they conducted. Some of the TBAs said they did not keep lists of deliveries conducted because they had no books to record them.

Table 12 shows ^{frequency} of visits by respondents to patients after delivery. The majority of the respondents nineteen (19) said they had no specific times of going to see their clients after deliveries, they went there almost everyday until the umbilical cord stump was healed. They were going there to assist in cooking and housework especially if the client had no one to help her with house work. Also to help the client with looking after the baby especially where the client was having the first baby. They felt it was their responsibility to teach the client how

to look after the baby. After that the link between the TBA and the respondent remained. One (1) respondent said she visited her clients about once a week after delivery. This is the one respondent who had her training period for a period of about 30 days then she left the course.

Table 13 shows localities where respondents attended births. The majority twelve (12) respondents attended births within the localities where they lived, five (5) respondents said they attended births outside the localities where they lived. Three (3) respondents said they conducted births in their villages when they had gone for a visit or any other nearby village where their assistance was required or where the delivery was an urgent one, such as when they were travelling.

Table 14 shows the type of transport used by respondents whenever their assistance was required. The majority nineteen (19) respondents said they walked on foot, despite whether it was at night or during the day when they were called. One (1) respondent stated that she used a bicycle when available.

Table 15 shows the respondents who would like to be provided with transport. The majority, nineteen (19) respondents, said they would have liked some form of transport for example a bicycle to be used whenever they go to conduct deliveries, since some of the places they are called to attend births are very far. One (1) respondent remarked that she did not want to be provided with transport, not even a bicycle because she could not ride, and another reason being that she was only conducting deliveries when she was called by family members, so she did not feel the need for transport.

Table 16 shows place of training of the TBAs. Ten (10) of the respondents did their training in their respective health centres, eight (8) did their training in the nearest delivery health centres, the reason being that some of the health centres are not delivery centers, so, for their practical experience the TBAs had to travel to the nearest health center for them to be able to conduct deliveries. Two (2) respondents did their practical training in the home. They were among the first TBAs trained when the programme had just started and the emphasis was to do deliveries in the environment similar to one where the TBA would be working.

Table 17 shows duration of training of TBAs.

The majority, thirteen (13), did their training within the required period of 60 days. Six (6) respondents did it within 30-59 days and One (1) respondent did her training within less than 30 days. This suggests that most of the respondents were trained for the required period. The one (1) respondent who trained for less than 30 days did not complete her course, and she was not given any form of incentive. That is a UNICEF TBA Kit or a certificate. She left because she heard that they would be no payment from the Government for the work the TBAs were to be doing.

Table 18 shows respondents who found the course to be beneficial. Nineteen respondents said they found the course to be beneficial since they felt they had gained additional knowledge, and one (1) felt she did not find the course to be beneficial. This is the one respondent who did not complete her training.

Table 19 shows who chose respondents to go for training. Twelve (12) respondents were chosen by community leaders to go for

training, and eight respondents were chosen to go for training by the health centre staff.

Table 20 shows respondents given incentive after training. The majority eighteen (18) were given a UNICEF TBA Kit and a certificate on completion of training. Two (2) respondents were not given any incentive. One (1) respondent did not complete her course, the other one had a certificate but no UNICEF TBA kit. She was told to share a TBA kit with a colleague, since there were not enough TBA Kits at the time of completion of the course.

Table 21 shows how often the respondents went to the health centre for supplies. Twelve (12) respondents said they ^{never} go there. Since the deliveries were not many so they always had enough supplies, among them some said they rarely went there since each time they went for supplies they were told that supplies were out of stock. Eight respondents (8) said they had no specific times for going for supplies, they went there anytime they needed some more supplies.

Table 22 shows respondents who have ever been to the health centre for discussions. The majority never went there, they said because the health center staff were not cooperative in that sometimes they were chased away or the reception by the members of health center staff was not usually good. Three (3) respondents said they went there only if they were called by the health center staff for discussions concerning their work in the community.

Table 23 shows respondents who have ever had a refresher course. The majority seventeen (17) said they had never been for a refresher course. The three (3) respondents were also community Health

workers, and the refresher courses did not involve their work of Midwifery.

Table 24 shows respondents who get payment after helping a woman deliver. Twelve (12) respondents never got any kind of payment after helping a woman deliver, neither did they get any service from the woman to show appreciation. Eight respondents had payment in form of either money, a bottle of vaseline, a ~~chitenge~~ material and anything that the woman could afford.

Table 25 shows whose responsibility the respondents feel it is to pay them for the work that they do. Twelve (12) respondents felt it was the responsibility of the government, eight felt it was the responsibility of the community i.e. the person who has been assisted.

Table 26 shows reasons why the respondent decided to become a TB. The majority of the respondents said they chose to do midwifery because they were devoted to work and one (1) respondent said it was because of benefits. The one respondent who did not complete the course.

Table 27 shows whether the respondents feel the community appreciated their work. The majority of respondents (19) felt the community appreciated their work, as was shown by more people coming to seek help from them, and one (1) respondent felt the community did not appreciate her work.

2. NURSING IMPLICATIONS

"Traditional midwifery is one of the oldest prototype of birth helpers who is now the subject of attention in view of the marked shortage of qualified personnel to meet the health needs of the people especially in developing countries like Zambia (Hartouche 1983).

Quite often the TBA is given less recognition either by the community she is serving or by the health center staff.

The study has revealed that motivation of the TBA by the community through remuneration and by the government through incentives such as giving of UNICEF TBA Kit and certificate would reinforce the motivation of the TBA, since this will make her feel more confident and even work harder.

Most of the respondents were willing to carry on with *their duties of conducting deliveries in the community* but they lacked motivation through remuneration by the community. The community need to be made to understand the role of the TBAs. The community should assist the TBAs for example where transport was needed. It has been found out through this study that the TBAs were not being utilized very much by the communities as is evidenced from the number of deliveries they conducted throughout the whole year, assuming the community preferred to go to the health centers for deliveries.

The government was motivating the TBAs by giving incentives such as UNICEF and TBA Kit and a certificate. It is not advisable though to generalise these findings because:-

3. CONCLUSION OF THE STUDY

This study revealed a lot of insights for both the reader and the researcher. In this study it has been shown that the TBAs are being utilised to a less extent by the communities, as evidenced by their performance. The fact that women go there for assistance shows how the TBA is still relied upon by the community in the field of midwifery. It is therefore the duty of the communities where the TBAs are serving to motivate them through remuneration or services such as helping them with their work.

The government should continue motivating the TBA through incentives such as UNICEF TBA kit and issuing of certificate, but it should also show concern in areas like conducting refresher courses for the TBAs. It has been proved that the TBAs can do a better job in the field of midwifery to be able to relieve the health centres of the congestion that exists, all that is needed is for the communities to be supportive. The communities should be encouraged to use the TBA services when necessary.

4. RECOMMENDATIONS

The study has revealed that TBAs play a vital role in traditional midwifery.

It is therefore recommended that:-

1. The training of TBAs should continue and be intensified.
2. Training personnel should ensure that TBA Kits and

and certificates are made available at the time of graduation.

3. Health personnel should should supervise the work of TBAs
4. The community should be encouraged to pay the TBA after being helped to deliver.
5. Collaboration between TBAs and Health Center Staff to be improved through committees.
6. Learning is a continuous process as a result, there is need for refresher courses or any other training programme to be organised for the TBAs.
7. There is also need to evaluate the impact of the TBA Training programme, throughout the country.

5. LIMITATIONS OF THE STUDY

1. Lack of literature on the utilization of TBAs.
2. Inadequate time was allocated to conduct the study due to other academic pressures.
3. It was difficulty to locate the subjects for the study as most of them had changed residence.
4. The size of the sample was too small for making generalisations.

APPENDIX I

STUDY NUMBER:

INSTRUMENT FOR DATA COLLECTION

CHECKLIST FOR RECORDS AND AVAILABLE DATA

QUESTION SEQUENCE:

QUESTIONS : 1 - 6 deal with Demographic data.

QUESTIONS : 7 - 16, 25 - 33 deal with Utilization of the TBA.

QUESTIONS : 17 - 24 deal with the TBA's Training.

STRUCTURED INTERVIEW SCHEDULE FOR TRAINED TRADITIONAL BIRTH ATTENDANTS

FOR OFFICE USE ONLY

NUMBER

☐

DEMOGRAPHIC DATA

1. How old were you at your last birthday?

1

☐

(a) 20-24 years

☐

(b) 25-29 years

☐

(c) 30-34 years

☐

(d) 35 and above

☐

(e) Not known

☐

2. Did you have an opportunity to go to school?

2

☐

(a) yes

☐

(b) No

☐

3. If yes, what level of education have you attained?

3

☐

(a) Adult Literacy

☐

(b) Primary School

☐

(c) Secondary School

☐

(d) Any other

☐

5. What is your marital status?

(a) Married

☐

(b) Single

☐

(c) Divorced

☐

(d) Widowed

☐

5

☐

6. How many live children do you have?

(a) 1 - 3

☐

(b) 4 - 6

☐

(c) 7 - 9

☐

(d) 10 and above

☐

6

☐

7. UTILIZATION OF TBA:

For how long have been living in this locality?

(a) 0 - 4 years

☐

(b) 5 - 9 years

☐

(c) 10 - 14 years

☐

(d) 15 years and above

☐

7

☐

8. When did you start practising as a TBA?

8

(a) 0 - 3 years ago

☐☐

(b) 4 - 7 years ago

☐

(c) 8 - 11 years ago

☐

(d) 12 years and above

☐

9. How often do you visit your patients when they are pregnant?

9

(a) Once in 3 months

☐☐

(b) Once in 6 months

☐

(c) Once in 9 months

☐

(d) Any other

☐

10. When was the last time you attended a birth?

10

(a) 0 - 4 months ago

☐☐

(b) 5 - 9 months ago

☐

(c) 10 - 14 months ago

☐

(d) 15 months and over

☐

11. How many births have you attended last year
(January - December 1988)?

11

(a) 0 - 3 births

(b) 4 - 6 births

(c) 7 - 9 births

(d) 10 and above

12. Do you keep a list of the deliveries you conduct?

12

(a) Yes

(b) No

13. How often do you visit your patients after delivery?

13

(a) Once a week

(b) once in two weeks

(c) Once in four weeks

(d) Once in six weeks

(e) Any other

14. Name all localities where you attend births?

14

15. How do you reach your patients whenever your assistance is needed?

(a) On foot

(b) Bicycle whenever available

(c) Vehicle whenever available

(d) Other specify

16. Would you have liked to be provided with transport, lets say a bicycle?

16

(a) Yes

(b) No

TBA'S TRAINING:

17. Where did you train as a TBA?

17

18. For how long was your course?

18

(a) Below 30 days

(b) 30 - 59 days

(c) 60 days and above

19. Did you find your course beneficial?

19

(a) Yes

(b) No

20. If yes, in what way?

20

21. If no, why?

21

22. Who chose you to attend this course?

23

(a) Community leaders

☐☐

(b) Clinic staff

☐

(c) Ownself

☐

(d) Other specify

☐

23. Were you given a certificate at the end of your course?

24

(a) Yes

☐☐

(b) No

☐

24 : Were you issued with a UNICEF TBA KIT?

25

(a) Yes

☐☐

(b) No

☐

UTILIZATION CONTINUED

25. How often do you go to your nearest Health Centre
for supplies?

26

(a) Once in 3 months

(b) Once in 6 months

(c) Once in 9 months

(d) Once in 12 months

(e) Never go there

(f) Any other

26. Have you ever had a meeting with the Health Centre
Staff?

27

(a) Yes

(b) No

27. If yes, What is discussed?

28

28. If No, Why not?

29

- (a) Very far
- (b) Very busy
- (c) Not interested
- (d) Other, specify

☐
☐
☐
☐☐

29. Have you ever attended any course since your initial training?

30

- (a) Yes
- (b) No

☐
☐☐

30. Do you ever get payment after helping a woman deliver?

31

- (a) Yes
- (b) No

☐
☐☐

31. Whose responsibility do you feel it is to pay for the work that you do?

32

- (a) The Government
- (b) The Community
- (c) Any other, specify

☐
☐
☐☐

33

32. Why did you decide to become a TBA?

☐

(a) Prestige

☐

(b) Benefits

☐

(c) Encouragement
from friends

☐

(d) Devotion

☐

(e) Any other specify

☐

34

33. Do you feel the community appreciates
your work?

☐

(a) Yes

☐

(b) No

☐

Do you have any comments regarding your work in the community?

Thank you very much for your cooperation.

APPENDIX II

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P O Box 50011
LUSAKA.

10th March 1989

The Social Secretary
Lusaka Urban District Council
P.O. Box 30077
LUSAKA.

u.f.s. The Head
Department of Post Basic Nursing

Dear Sir/Madam

re: STUDY PROJECT

I am a student of the above named school currently studying for a Bachelor of Science in Nursing. In partial fulfilment of the requirements for my studies I am required to conduct a research study within the area of Community Health Nursing. The topic I have chosen is "The Utilization of TBAs in Lusaka Urban."

I would therefore be grateful if you could kindly allow me to use George, Matero Reference Centre, Mtendere, Chawama, Kaunda Square, Chipata and Chelston Health Centres. I intend to interview TBAs living in areas served by the above mentioned health centres.

Your approval will be greatly appreciated.

Yours faithfully,

Rosaleen E. Makumba (Mrs)

c.c. Provincial Medical Officer, Lusaka Province

APPENDIX III

Lusaka Urban District Council
Social Secretary's Dept
P O Box 30269
LUSAKA.

10th April 1989

Mrs Rosaleen E Makumba
The University of Zambia
School of Medicine
Dept of Post Basic Nursing
P O Box 50110
LUSAKA.

Dear Madam,

re: STUDY PROJECT - "THE UTILIZATION OF TBAs IN LUSAKA URBAN"

With reference to the above underlined and your letter dated 10th March, 1989 I am pleased to inform you that permission has been granted for the conducting of the said study research.

I wish you success in your research.

Yours faithfully,

I.K. MWENDAPOLE
for/SOCIAL SECRETARY

c.c. The District Executive Secretary
The Senior Nursing Officer

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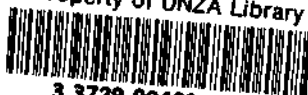
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