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A STUDY ON THE ACCESSIBILITY AND UTILIZATION OF TRAINED TRADITIONAL BIRTH ATTENDANTS IN MAZABUKA DISTRICT

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ABBREVIATIONS

MCH	-	Maternal and Child Health
FP	-	Family planning
HIV	-	Human Immuno Virus
AIDS	-	Acquired Immuno Deficiency Syndrome
PHC	-	Primary Health Care
TBA	-	Untrained Traditional Birth Attendant
tTBA	-	Trained Traditional Birth Attendant
FGD	-	Focus Group Discussion
MOH	-	Ministry of Health
WHO	-	World Health Organization
UNICEF	-	United Nations International Children’s Emergency Fund
UNFPA	-	United Nations Fund for Population Activities
NPA	-	National Programme for Action
CSO	-	Central Statistical Office
IMC	-	International Medical Corps
NGO	-	Non Governmental organization
ZDHS	-	Zambia Demographic Health Survey

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DECLARATION

I *Leoda Hamomba* hereby declare that the work presented in this study for the Bachelor of Science in Nursing has not been presented either partially or wholly for any other degree.

Signed *Leoda Hamomba*
Candidate

Date 11/03/02

Signed *L. Simbe*
Supervisor



STATEMENT

I hereby certify that this study is the result of my own labour and independent investigation. The various sources to whom I am indebted are clearly indicated throughout the text and in the bibliography.

Signed ----- Hba. -----

Date ----- 11/03/02 -----

DEDICATION

I dedicate this Research study to my family.

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to the following people without whom this study would not have been conducted.

The Ministry of Health for the scholarship that enabled me to pursue the Bachelor of Science in Nursing, and my facilitator Mrs. L. Jumbe for her advice and guidance throughout the research project.

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This descriptive and cross sectional study was undertaken in Mazabuka District at the Health Centre. The general objective of the study was to determine the accessibility and utilization of trained Traditional Birth Attendants in the reduction of Maternal and Infant Mortality rate.

Literature review was done from the global, regional and national perspectives. The national maternal mortality has increased over the years with rates varying from 649 per 100,000 live births (ZDHS, 1996) to 940 per 100,000 live births (WHO/UNICEF, 1996). The literature review was based on the factors related to the prevention and reduction of maternal and infant mortality through the services offered by trained Traditional Birth Attendants.

A pilot study was done using convenient sampling method of 8 trained traditional birth attendants in Lusaka urban.

Data was collected from 48 trained Traditional Birth Attendants instead of the required 50 because the subjects were difficult to locate. Collection of data was done using a structured interview schedule. The sampling method used was convenient. Two focus group discussions were conducted one in the rural area and one in the urban to augment the findings. The target group for the focus group discussion were the women of childbearing age group. The data was analysed using the data master sheet and computer software SPSS and presented in tables, graphs and pie charts.

The study findings revealed that trained Traditional Birth Attendants were preferred to untrained Traditional Birth Attendants (i.e. 91.6%) and that the community therefore, well utilized and appreciated their services. However, physical accessibility was often hindered due to distance. All (i.e. 100%) of the trained traditional birth attendants walked to their clients when their assistance is required.

The study revealed that there was inadequate support from the Health Centre staff in terms of supplies and supervision. 47.7% were never supervised while 17.1% never got any supplies. The UNICEF Kits were also inadequate i.e., 66.7% of the respondents had kits while 33.3% did not. The study revealed that a high percentage (54.2%) of the trained traditional birth attendants have never attended any refresher course after their initial training.

The study revealed that 89.6% trained birth attendants were not remunerated for their services because they were either perceived as government workers and therefore they should be paid by the government. Others felt that they were volunteers.

The study showed that 89.6% of trained traditional birth attendants conducted the last delivery in the period between 0-4 months. 85.4% kept a record of the deliveries they conducted, but some of the records never reached the Health centre in the area and the district office respectively. Some deliveries were not recorded at all while others were given directly to the NGOs that trained them.

CHAPTER 1

1.0. BACKGROUND INFORMATION

Zambia is a third world, land locked country situated in the Southern part of Africa. The country covers an area of 752,612 square kilometers and shares borders with Tanzania and the Democratic Republic of Congo in the North; Zimbabwe and Botswana in the South; Malawi and Mozambique in the East; Angola in the West and Namibia in the South-west (ZDHS, 1992).

Zambia has a population of 9.4 million and it is divided into nine (9) provinces. These provinces are Northern, Luapula, Southern, Eastern, Western, Northwestern, Copperbelt, Central and Lusaka. These provinces are further subdivided into seventy-two (72) districts (Nsemukila, B. et al, 1998).

Mazabuka district is one of the seventy-two (72) districts in Zambia. It is in the Southern province. Mazabuka lies in the Northern most part of southern province, covering an area of 6,687 square kilometers. It is about 120 kilometers away from the capital city, Lusaka. Mazabuka district has a total population of 240,144. 70% of the population is either urban or Peri-urban, while 30% is in the rural areas. Mazabuka District has a total of forty (40) Health Institutions, out of which four (4) are Mission owned, seven (7) are Private/Industrial owned and twenty-seven (27) are government owned, which includes two (2) hospitals and twenty-five (25) Health Centers (Mazabuka District Action Plan & Budget, 2001).

The review of the medical care inherited at the attainment of independence in 1964 showed that although Zambia has a record of achievement in its health care system, that the country could be proud of, there were many deficiencies in the system of provision of health care services to its people. The Zambian Government declared free health care for all in 1964 at independence. This strategy placed more emphasis on curative medicine, rather than on prevention of disease. The fast growing population after independence and the rapid growth in health facilities observed in the 1970's was followed by a dramatic decline in the economy, which was due to the falling copper price which was the main source of foreign exchange. This decline adversely affected the provision of social services including health. The health status of the people declined, there were chronic shortages of drugs in health facilities, the

infrastructure was not maintained, medical equipment was deemed absolute and many qualified staff left the country for better conditions of service abroad. The communities also lost confidence in the health care system, and the free health care was then replaced by cost sharing system in 1992.

Faced with the above scenario, Zambia found the recommendations and declaration of Alma-Ata International conference on Primary Health Care (PHC) in 1978 an attractive option. The Zambian Government, through the Ministry of Health (MOH) adopted and introduced the PHC concept in 1981, with a vision to provide health for all by the year 2000 and beyond. The concept of PHC is that the health services should be provided as close to the family as possible through community participation and at a cost that the families and communities can afford. The utilization of trained Traditional Birth Attendants (tTBA'S) and Traditional Medical Practitioners was among the main features of the PHC strategy.

Traditional Birth Attendants (TBAS) have existed throughout human history in most of the developing countries in the world. They constitute an important resource in the community. TBA'S help women during pregnancy, labour, delivery and puerperium including the initial care of the newborn baby. They are well respected and accepted in the community. Most of the TBA'S are either elderly women or middle-aged women who are either illiterate or have some little education. Midwifery practice is a part time occupation to them. It is estimated that the TBA'S attend to about 80% of deliveries in rural areas. The TBA acquires her skills from relatives, through observation and apprenticeship. She also learns the preparation and administration of herbs needed for assisting deliveries. Those who seek her help are usually members of the same community (WHO, 1994).

In the second National Development Plan (1972-1976), the Government of the Republic of Zambia stated that the priority was to be given to infants, pre-school and school children, expectant and nursing mothers. Special emphasis was placed on the nutrition of these groups. Highest priority was given to all training programs especially that of training midwives and trained Traditional Birth Attendants. This was in order to increase the trained personnel attending to mothers at childbirth from 30% to 50%, and to expand and maintain the health services so that almost all mothers were under health care.

In 1973, the Zambian Government with the support of UNICEF initiated a training program for Traditional Birth Attendants. This was to enable all Zambian women have access to professional health care services. This program was in line with the declaration of Alma-Ata of 1978.

Collaboration with Traditional Birth Attendants and Traditional Healers as part of the strategy to attain "health for all by the year two thousand", was a way of bringing the health services as close to the family as possible. The Traditional Birth Attendants training program was later suspended in 1976 to enable the Government draw up guidelines and criteria for the selection and training of Traditional Birth Attendants. This was supported by the third National Development Plan (1976-1983), which stated that the training of TBA'S would be intensified. After the training they will go back to work in the communities to which they belong and the remuneration for the trained Traditional Birth Attendant was left to the community to decide. This gave the impetus for the TBA training to resume in 1977 (UNICEF, 1982).

The ultimate goal of the TBA training program was to *reduce the maternal and child mortality and morbidity rates*. The specific objectives for the program were:

- To select and train Traditional Birth Attendants with a view to improve their knowledge and proficiency of maternal services offered to the community;
- To improve collaboration between the Traditional Birth Attendants and central organized system of maternal and childcare;
- To encourage and reinforce the positive and beneficial cultural beliefs and practice whilst discouraging and eliminating the influence of the harmful practices about pregnancy and delivery; and
- To develop Traditional Birth Attendants as a multi-disciplinary group within the integrated health team and to inculcate basic health practices related to personal cleanliness (Maimbolwa M. 1998).

STATEMENT OF THE PROBLEM

It is estimated that nearly 600,000 women aged between 15 and 49 years die every year as a result of the complications of pregnancy and childbirth. It is also estimated that nearly eight (8) million infants die every year. (WHO/UNFPA/UNICEF/WORLD BANK, 1999).

In Zambia studies have been done to determine the maternal mortality rates. The studies show that the maternal mortality rate has increased over the years. The estimates vary from 649 per 100,000 live births (ZDHS, 1996) to 940 per 100,000 live births (WHO/UNICEF, 1996). A study that was done by Kufuna K.N et al (1993) in Mongu showed that maternal mortality rate was 889 per 100,000 live births, while Kalabo

District had 1,193 per 100,000 live births. In Kaputa, Rietsema A. (1996) found that there were 1,549 maternal deaths per 100,000 live births. Another study was done in Kasama by Banco F. L. E and Rietsema A, (1996) indicating that Kasama district had a maternal mortality rate of 764 per 100,000 live births, while Kasama hospital based maternal mortality was 543 per 100,000 live births.

In 1996, the Zambia Demographic Health Survey revealed that 53% of the deliveries were conducted at home; 41% by relatives as compared to 6% assisted by trained Traditional Birth Attendants. The utilization of trained Traditional Birth Attendants was more prominent in the Northern Province (11%) and Luapula (12%) in 1992. Despite the presence of trained Traditional Birth Attendants in the rural areas, most women in some rural areas still prefer home deliveries with the assistance of relatives or untrained Traditional Birth Attendants. This results in low utilization of trained Traditional Birth Attendants in the community (Kufuna K. N et al, 1993). Mazabuka District has eighty-three (83) trained Traditional Birth Attendants. In the year 2000, a total of 40% deliveries were conducted in the district. Out of the 40% deliveries conducted, the trained Traditional Birth Attendants conducted 1%. Deliveries assisted by trained Traditional Birth Attendants in the district have been 1% for the past two years (i.e. 1998 & 1999) against a target population of 5,810-6,027 women. The actual maternal deaths recorded were three (3) in the year 2000 (Mazabuka District Action Plan & budget, 2000).

In Zambia, Maimbolwa M. (1998) undertook an evaluative study of the TBA program in six districts, namely, Kalomo, Chongwe, Masaiti, Serenge, Katete and Senanga. The findings of this study were that 50% of trained Traditional Birth Attendants (tTBAs) were operating alone in sparsely populated areas, making it difficult for the mothers in labour to reach them; and that the tTBAs were only called upon to help when the delivery was complicated. The study also revealed that the community considered the tTBAs as Government workers and that the demand for reward for the delivery conducted prompted the communities to utilize the untrained TBAs more than the tTBAs. These findings raise a question on the accessibility and utilization of the tTBAs in the communities. How accessible and utilized are the tTBAs to the women in Mazabuka District? See table 1.

TABLE 1: UTILIZATION OF TRAINED TRADITIONAL BIRTH ATTENDANTS (tTBA'S)

SERVICES	1998		1999		2000	
	Target	Coverage	Target	Coverage	Target	Coverage
Deliveries by Trained staff	5,600	32%	5,810	29%	6027	25%
Deliveries by TTBA'S	5,600	1%	5,810	1%	6,027	1%

Source: Mazabuka District Action Plan & Budget, 2000.

1.3. **JUSTIFICATION OF THE STUDY**

The study seeks to examine the contribution of the tTBAs to the reduction of maternal mortality in relation to their accessibility and utilization of their services in the community. The many approaches to reducing the maternal mortality rate in the country needs to be put in place in order to sustain the health of the women and children. It is clear from the studies done on maternal mortality that at least 53% of deliveries occur outside the Health Institutions. Even though a higher percentage of the deliveries conducted outside the Health Institutions are done by the relatives, there is a percentage (1%, as is the case in Mazabuka District) that the tTBAs attend to. An attempt therefore to determine the factors in the community that leads to the accessibility and utilization of the tTBAs is essential. Trained Traditional Birth Attendants should not only be called upon to attend to complicated deliveries (Maimbolwa M. 1998), but also to attend to normal deliveries in order to prevent complications that may arise during delivery that will lead to the death of the woman. Trained Traditional Birth Attendants do have an impact on the maternal health and have a significant role to play in maternal and child health services.

1.4. **OBJECTIVES**

GENERAL OBJECTIVE

To determine the accessibility and utilization of trained Traditional Birth Attendants in the reduction of maternal and infant mortality.

SPECIFIC OBJECTIVES

1. To explore the knowledge and attitudes of women towards trained Traditional Birth Attendants.
2. To assess the accessibility of the services offered by trained Traditional Birth Attendants.
3. To assess the utilization of the trained Traditional Birth Attendants by the community and the health care system.
4. To describe the factors influencing the accessibility and utilization of the Traditional Birth Attendants by the community.

1.5. **HYPOTHESIS**

There is a relationship between the accessibility and utilization of the trained Traditional Birth Attendants by the community and the health care system, and the reduction of maternal and infant morbidity and mortality rates.

The higher the accessibility and utilization of the trained Traditional Birth Attendants by the community and the health care system, the lower the maternal and infant morbidity and mortality rates.

CHAPTER 2

2.0. LITERATURE REVIEW

INTRODUCTION

A number of studies have been done on various aspects of maternal and child health, especially on morbidity and mortality rate. Few studies have been done on the contributions of the trained Traditional Birth Attendants (tTBA's) towards the reduction of maternal and infant morbidity and mortality rates in relation to their participation in maternal and child health activities. Maternal and infant mortality is an important indicator for assessing the country's safe motherhood performance, and also the quality of life of half of its citizens. Maternal and infant mortality also shows the women and children's access to health care and the ability of the health care to respond to their needs. WHO/UNFPA/UNICEF/WORLD BANK (1999) says, "the death of a woman during pregnancy or childbirth is not only a health issue, but also a matter of social justice".

GLOBAL SITUATION

There is increasing evidence in the world today, and in particular less industrialized countries that maternal mortality is the leading cause of death among women in the reproductive age group (UNICEF, 1994). Worldwide, it is estimated that 600,000 women die every year from complications of pregnancy and childbirth, with the majority of them occurring in developing countries. In developed countries, the maternal mortality ratio averages around 27 maternal deaths per 100,000 live births; in developing countries the ratio is nearly 20 times higher at 480 per 100,000 live births and may be as high as 1000 per 100,000 live births in some regions (WHO/UNFPA/UNICEF/WORLD BANK, 1999). Globally, the causes of maternal deaths are hemorrhage (25%), sepsis (15%), pre-eclampsia and eclampsia (12%), prolonged or obstructed labour (8%), unsafe abortion (13%) and those due to pre-existing conditions that exacerbate during pregnancy (20%) for example, anaemia. These complications arising during pregnancy, delivery or puerperium comprise 80% of all maternal deaths (WHO et al, 1999).

In many developed countries, reduction in maternal mortality rate was as a result of a national policy favoring professional midwifery care for all births, together with the establishment of standards of quality of care. WHO et al (1999) states that Sweden had the lowest maternal mortality ratio in Europe in the twentieth century. The maternal mortality rate was around 230 per 100,000 live births compared with over 500 per 100,000 live births in the mid-1880's. In Denmark, Japan, Netherlands and Norway, similar strategies produced comparable results. In England and Wales the reduction of maternal mortality was only apparent in the 1930's, the key to this reduction being professional midwifery. In the USA, where the strategy focused on hospital delivery by doctors, maternal mortality was high. In 1930, the maternal mortality ratio in the USA was still 700 per 100,000 live births compared with 430 in England and Wales.

Sri-Lanka was reported to have a reduction in maternal mortality rate within a short period. From a level of over 1,500 per 100,000 live births in 1940-1945, the maternal mortality fell to 555 per 100,000 live births in 1950-1955 and to 95 per 100,000 live births by 1980. The figure now is 30 per 100,000 live births. The reduction in the maternal mortality rate was due to a system of health facilities around the country allied to an expansion of midwifery skills and the spread of family planning activities (WHO et al, 1999). It is interesting to note that in the 1950's, births in Sri-Lanka took place at home with the assistance of untrained birth attendants, but by the end of the 1980's, over 85% of all births were attended to by a trained personnel. Countries like china, Cuba, Malaysia that have established community-based maternal health care systems comprising prenatal, delivery and post partum care and a system of referral to a higher level of care in the event of obstetric complications, have similar evidence of the effectiveness of health care interventions. The presence of skilled birth attendants is therefore, crucial for the early detection and appropriate, timely management of complications that may arise during pregnancy, delivery and puerperium.

It is estimated that 60-80% of births in developing countries occur outside modern health care facilities, and that almost all the births are attended to by untrained persons; some are unattended to (WHO, 1992). According to WHO (1975), in such communities where the standard of maternity care is low and a great proportion of deliveries are assisted by untrained personnel without supervision, there is often a high rate of maternal and infant mortality and morbidity. WHO concludes by saying that the Traditional Birth Attendant (TBA) has a potential role to play in modern maternity care programs.

Traditional Birth Attendants are an important resource in the community that needs extra training to contribute to the reduction of maternal

mortality. Many countries have utilized the services of TBA'S on a widespread basis. In the Philippines, for example, deliveries in 38 rural areas attended to by TBA'S in the years 1970-1972 was 15,552 or 33.12% out of 47,287 deliveries. Other countries are India, Indonesia and most of the Latin American countries. Traditional Birth Attendants in many countries have received training in order to promote safer birth practices including clean delivery and avoidance of harmful practices. However the education, training and skills of Traditional Birth Attendants are insufficient to fulfill all the requirements for management of normal pregnancies and births and for identification and management or referral of complications. WHO et al (1999) says that "training of TBA's alone in the absence of back-up from a functioning referral system and support from professionally trained health workers is not effective in reducing maternal mortality. This means that where TBA training is undertaken, it should be a part of a broader strategy that includes a built in mechanism of referral, supervision and evaluation. TBA's may be the women's only source of care where the service of skilled professional health care is not available in many places. The training of TBA's has been associated with a reduction in maternal mortality rate.

A study that was done in Pakistan among Afghan refugee women, showed that fewer complications and deaths were associated with deliveries performed by trained Traditional Birth Attendants. The study also revealed that the trained Traditional Birth Attendants provide an effective route for educating the women they deliver about hygiene and health and thereby reduces both maternal and fetal complications and raises the level of family health (WHO, 1995).

AFRICAN SITUATION

Many African countries acknowledge that the Traditional Birth Attendant is an important resource in the community that needs to be utilized and integrated in the health system in an order to reduce the maternal and infant morbidity and mortality rates. Studies have proved that adequately trained Traditional Birth Attendants play a big role in reducing maternal and infant morbidity and mortality rates.

In Nigeria, where the maternal mortality rate is estimated at 800-1,500 per 100,000 live births, a study done by Ada-Oga A. M and Umoh, E. S (1996) pointed out that the maternal mortality rates in rural areas where access to professorial care in child birth was not available, the trained TBA'S are essential. In another study done among 52 TBA'S in South East Nigeria by Itina S.M. (1997), it was revealed that ignorance about maternal complications during childbirth and the inappropriate treatment given to the women was evident for most of the TBAS. The results clearly

showed that educational programs for TBAS and better integration into the health care system are essential for lowering maternal morbidity and mortality rates in areas where most mothers are not open to nor have access to professional care in childbirth.

The study done by Sindiga I. (1995) in Kenya sought the knowledge, functions and participation of TBAS in Maternal Child Health Care and Family planning. The study showed that they (TBAS) formed a significant feature of the medical landscape offering a wide range of antenatal, perinatal and postnatal services. Traditional Birth Attendants therefore, could be part of the official health care providers, offering services by making early diagnosis of difficult pregnant cases and providing appropriate referrals to health facilities. However they needed training to enhance their skills, and certain practices such as the use of herbal medicines rationalized through training and research.

In Ghana Smith, J.B. et al (1996) conducted a study to determine the effect of Traditional Birth Attendant's training on maternal outcomes. The study showed that the evidence for a beneficial impact of the TBA training was not compelling. The study concluded by saying that TBA training sponsors should consider alternative health investments. This indicates that the impact of tTBA'S is still being debated upon.

Currently, women in the Sub-Saharan Africa have 1 in 21 life time risk of dying from pregnancy related causes as compared to 1 in 71, 1 in 131 and 1 in 2288 life time risks for Asia, Latin America and Europe respectively (Maimbolwa, 1998). A study that was done in Madagascar, in the region of Manakara concerning the trained traditional Birth attendants showed that the trained Traditional Birth Attendants actually do play a big role in the reduction of infant mortality rate (WHO 1990).

A study done in Angola by Schaider, J et al (1999) showed that the maternal mortality rate was reduced among women managed by International Medical Corps (IMC) – trained TBAS. A reduction in the cases of neonatal tetanus was also noted. "We have noticed the differences between the untrained birth attendants and those with training. At the hospitals and Health Centers, reports of deaths among newborns and mothers have been reduced".

In South Africa, a qualitative study done in 1995 indicated that the contributions of the Traditional birth Attendants is of utmost importance in the provision of effective and efficient health services to pregnant women especially those who have no access to existing health services in rural areas (Troskie T R, 1995). Utilization of tTBA'S is therefore essential to the

lowering of the morbidity and mortality rates among pregnant women and infants.

NATIONAL SITUATION

In Zambia, literature on the trained traditional Birth Attendants is limited. The maternal mortality rates in Zambia vary from 649 per 100,000 live births (ZDHS, 1996) to 940 per 100,000 live births (WHO/UNICEF, 1996). There are parts of Zambia that indicate higher rates as outlined in the statement of the problem.

The factors that influence maternal mortality rate in Zambia as well as the Sub-Saharan African region are reproductive health, socio-economic and cultural factors (UNICEF, 1994). Mhango, C et al (1986) states that, the high maternal mortality rate in Zambia is compounded by the poor reporting system. He goes on to say that the high levels of poverty (70%), the pathogenic causes, lack of resources like equipment and supplies and deficient management have a great impact on maternal mortality. These factors contributed to 52% of maternal deaths.

Nsemukila, B et al (1998) found that the commonest causes of maternal deaths were hemorrhage (34%), Sepsis (13%), HIV/AIDS (10%), and obstructed labour (8%). According to the background factors, majority of women (60%) died after delivery, while 13% died during labour. 78% were reported to have died within the first week after delivery and about half of these women died on the same day of delivery. About 60% of those who delivered at home and were assisted by relatives and other untrained Traditional Birth Attendants died after delivery as compared to 33% of those who delivered from health institutions.

MOH (1992) states that only 50% of the rural population have access to the health facilities as compared to the urban population where access is 100%. More than half of the mothers in Zambia still prefer to deliver at home and are thus at a high risk of having poor obstetric outcomes (Maimbolwa, C.M 1998). According to ZDHS survey (1996), 67% of the Zambian population live in rural areas, where 53% deliveries are conducted at home. Relatives conduct 41% of the deliveries as compared to 6% conducted by the trained Traditional Birth Attendant. The total number of trained Traditional Birth Attendants in Zambia is 3,912 (Maimbolwa, C.M 1998).

For sometime now WHO has been promoting the involvement of the trained TBA in maternal and child health, family planning and immunization programs. This is based on the evidence that the training of TBA's and their proper accessibility and utilization have the potential to

significantly reduce maternal and infant morbidity and mortality rates (WHO, 1992). The utilization of the TBA in the reduction of maternal and infant mortality and morbidity rates through the training of TBA's was one of the main features when the Primary Health Care (PHC) concept was adopted by the Zambian government in 1980 (UNICEF, 1982). The training of TBA's was also among the approaches outlined by the National Program for Action (NPA) aimed at reducing maternal and infant mortality ratio by 50% by the year 2000, and also to increase the women delivering at obstetric facilities by 80% (Third Draft, UNICEF Report, 1999).

Concerning the utilization of trained TBA's, ZDHS (1992) showed that the trained TBA's were mostly utilized in the Northern-Western province (26.9%), Luapula (12%), Northern province (11%) and Southern Province (13%). However, Northern, Western, Southern, Luapula, Eastern and Central Provinces showed the highest percentages of home deliveries assisted by relatives and untrained TBA's. In Mongu, trained TBA's were utilized by only 10% of women (Faber et al, 1994). CSO (1997) stated that trained TBA's only assisted in 5% of all deliveries in Zambia. In a study done by Nsemukila, B et al (1998) it was shown that relatives conducted most deliveries at home and that the trained TBA was only called upon when there was a complication during delivery. ZHDS (1992) further states that Southern Province had 45% deliveries assisted by relatives and other untrained TBA's. Mazabuka district in particular recorded a total of 40% deliveries in the district with only 1% conducted by trained TBA's for the year 2000 (Mazabuka District Action Plan & Budget, 2000).

The above scenario indicates that there are limitations in the health system in meeting the health needs of the mother and child. Failure to attend Ante-Natal clinics, home deliveries, distance to the health facility and the lack of transport to transfer women with difficult labour to the health center are contributing factors to the problems faced by women (Maimbolwa, C.M 1998).

Because of the current shortage of professional midwives and institutional facilities to provide Prenatal care and clean, safe deliveries, as well as a variety of primary care functions, promotion of the TBA training program is necessary in order to bridge the gap until there is access to acceptable, professional, modern health care services for all women and children (WHO, 1992). The increased need for competent trained TBA's to help in the reduction of maternal and infant morbidity and mortality rates in the rural areas of the developing countries is obvious.

OPERATIONAL DEFINITION OF TERMS

For the purpose of this study, the following definitions will apply:

- ***Traditional Birth Attendant (TBA):*** A woman who helps the mother during pregnancy, labour, delivery and puerperium including the initial care of the newborn and has acquired her skills from relatives, through observation and apprenticeship.
- ***Trained Traditional Birth Attendant (tTBA):*** A Traditional Birth Attendant who has received training for a period of 6 weeks to upgrade her skills.
- ***Community:*** Refers to the persons living together sharing the same geographical location, practices, values and social systems.
- ***Maternal Mortality Rate:*** The number of women who die as a result of child bearing in a given year per 100,000 live births.
- ***Infant Mortality Rate:*** The number of infant deaths under one year of age per 1000 live births in a given year.
- ***Mortality:*** Refers to death occurring in a population.
- ***Morbidity:*** Refers to disease or illness occurring in a population.
- ***Primary Health Care (PHC):*** The basic essential care given by individuals in the community.
- ***Accessibility:*** Being able to reach or avail of the health services offered.
- ***Utilization:*** Being able to make (good) use of the health services offered.

CHAPTER 3

3.0. METHODOLOGY

3.1. RESEARCH DESIGN

"A Research Design is a scheme of action for answering the research question. After formulating the specific problem and thorough reviewing relevant literature, the researcher thinks through the steps to produce a workable strategy" (Treece and Treece, 1986).

The purpose of the study is to determine the accessibility and utilization of trained Traditional Birth Attendants (tTBAs) by the community and the Health Care System. The study adopted a descriptive and cross sectional study design. Quantitative and qualitative data were obtained in order to facilitate both quantification and description of the study findings.

The design used was appropriate because it revealed the extent to which the tTBAs were accessible and utilized, as well as some of the factors that influence their performance and reinforce their utilization.

3.2. RESEARCH SETTING

The study was conducted in Mazabuka District Hospital, which is situated in the Southern Province of Zambia, about 120 kilometers from the Capital City of Lusaka. Mazabuka District has a population of 240,144. 70% of the population is either urban or peri-urban, while 30% is in the rural areas. Mazabuka District has a total of forty (40) health institutions, out of which three (3) are hospitals and thirty-seven (37) Health Centers.

3.3. STUDY POPULATION

The study population involved eight-three (83) Trained Traditional Birth Attendants (tTBAs) practicing and non-practicing in Mazabuka District.

3.4. SAMPLE SIZE AND SAMPLE METHOD

The sample size was initially 50 tTBAs, but only 48 tTBAs were interviewed. This was because some tTBAs had moved from their areas and others were in hard to reach areas. Simple random sampling techniques were initially going to be used to select the 50 tTBAs.

Convenient or incidental sampling was used instead because the sampling frame given by the District Health Office did not have the actual updated number of tTBAs in the District. The Health Centers where tTBAs were available as indicated on the sampling frame were Chivuna, Kaleya, Ndeke, Lubombo, Nega-Nega, Mugoto and the Chikankata catchment area which has the following Health Centres – Chikankata, Ching'ang'auka, Chikombola, Nameembo, Chaanga and Sianyoolo. The forty-eight (48) tTBAs interviewed were from all the above mentioned Health Centres.

3.5. **DATA COLLECTION TOOL**

Data was collected using the structured interview schedule. A questionnaire was used during a face-to-face interview in order to obtain the required information because some of the subjects interviewed were illiterate.

Two focus group discussions were conducted. One in the rural area and one in the urban area. This was done in order to explore the knowledge and attitudes the women had towards tTBAs and to describe the factors influencing the accessibility and utilization of untrained Traditional Birth Attendants (TBAs) by the community. The target groups were the women of childbearing age group.

3.6. **PILOT STUDY**

The pilot study was conducted in Lusaka urban at Kanyama and Chawama urban clinics. It was conducted from 31st of July to the 3rd of August 2001 in order to identify problems with the proposed instrument and to test its feasibility, reliability and validity. The number of respondents interviewed were eight (8).

3.7. **ETHICAL CONSIDERATION**

Permission was sought from the Management Teams concerned and also from the interviewees and permission was granted. Privacy was considered, while confidentiality and anonymity was also assured.

3.8. **VARIABLES**

DEPENDANT VARIABLES

The Dependant variables were

- Accessibility of trained TBAs.
- Utilization of trained TBAs.

INDEPENDENT VARIABLES

In this case the independent variables were:

- Performance of trained TBAs.
- Trained TBAs.
- Untrained TBAs.

CHAPTER 4

4.0. DATA ANALYSIS AND PRESENTATION OF FINDINGS

The chapter is concerned with the presentation of data that was collected from the Trained Traditional Birth Attendants (tTBAs) in Mazabuka district. The data was checked for completeness and accuracy. Data was analyzed manually using the Data Master Sheet and the Computer Software Package SPSS.

Information from The Focus Group Discussion (FGD) was reviewed and completed. It was then listed according to the key themes for easy analysis. The results augmented the findings from the questionnaire.

The study findings will be presented in frequency tables, graphs and pie charts.

Table 2: SOCIO-DEMOGRAPHIC DATA

AGE IN YEARS	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
20 – 24	0	0	0	0
25 – 29	3	6.3	3	6.3
30 – 34	12	25	15	31.3
35 & Above	33	68.8	48	100
MARITAL STATUS	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Single	5	10.4	5	10.4
Married	28	58.3	33	68.8
Divorced	3	6.3	36	75
Separated	4	8.3	40	84.3

Widowed	8	16.7	48	100
NUMBER OF CHILDREN	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIV PERCENT
1 – 3	9	19.6	9	19.6
4 – 6	23	50	32	69.6
7 – 9	11	23.9	43	93.5
10 and above	3	6.5	46	100
AGE OF CHILDREN	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIV PERCENT
0 – 4 years	18	39.1	18	39.1
5 – 9 years	11	23.9	29	63
10 – 14 years	5	10.9	34	73.9
15 and above	12	26.1	46	100
YEARS IN RESIDENCE OF LOCALITY	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIV PERCENT
0 – 4 years	7	14.6	7	14.6
5 – 9 years	11	22.9	18	37.5
10 – 14 years	8	16.7	28	54.2
15 and above	22	45.8	48	100

Table 2 shows the socio-demographic characteristics of the 48 tTBAs. The age distribution in panel one shows that the majority of tTBAs 33 (68.8%) were aged 35 years and above, 12 (25%) were aged between 30-34 years, while 3 (6.3%) were aged 25-29 years. The marital status of respondents show that 28 (58.3%) were married, 8 (16.7%) were widowed, 5 (10.4%) were single, 4 (8.3%) were separated from their husbands, while 3 (6.3%) were divorced (Panel 2). With respect to level of education, Panel 3 shows that the majority of tTBAs 32 (66.7%) have attained primary education, 11 (22.9%) attained secondary education, 3 (6.2%) attained adult literacy, while 2 (4.2%) had no formal education. Panel 4 in the table shows that 23 (50%) of respondents had 4-6 children, 11 (23.9%) had 7-9 children, 9 (19.9%) had 1-3 children 3 (6.5%) had 10 children and above. The last panel 5 shows that the majority of the tTBAs 22(45.8%) had lived in the locality for 15 years and above, 11 (22.9%) lived in the locality for 5-9 years, 8 (16.7%) for 14 years while 7 (14%) had lived in the locality for 0-4 years.

FIGURE 1: RESPONDENTS WORK EXPERIENCE IN YEARS

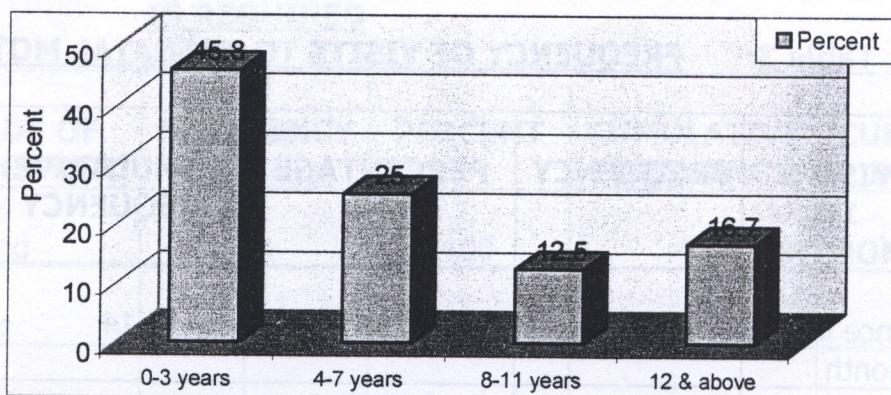


Figure 1 shows that 22 (45.8%) have been working for 0-3 years, 12 (25%) for 4-7 years, 8 (16.7%) for 12 years and above while 6 (12.5%) have been working as tTBAs for 8-11 years.

FIGURE 2: SELECTION FOR TRAINING

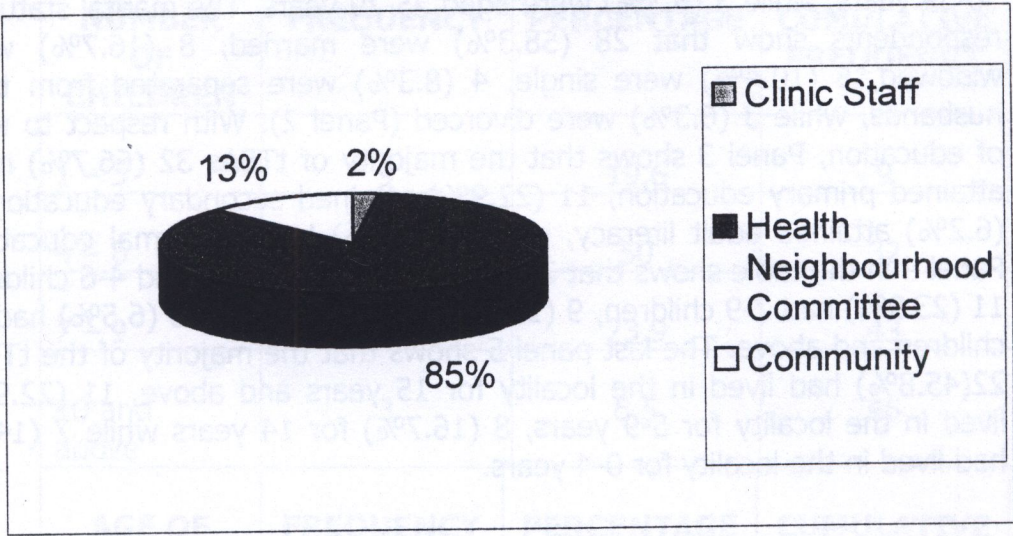


Figure 2 shows that 41 (85.4%) of tTBAs were selected by the community, 6 (12.5%) were selected by the health neighbourhood committee, while 1 (2.1%) was selected by the clinic staff.

Table 3: FREQUENCY OF VISITS TO PRENATAL MOTHERS

VISITS IN MONTHS	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIV E PERCENT
Once in a month	14	29.2	14	29.2
Once in 2 months	2	4.2	16	33.3
Once in 3 months	22	45.8	38	79.2
Nil	10	20.8	48	100

Table 3 shows that 22 (45.8%) tTBAs visit prenatal mothers once in three months, 14(29.2%) once in a month and 2 (4.2%) once in two months while 10 (20.8%) tTBAs do not visit prenatal mothers at all.

Table 4: FREQUENCY OF VISITS TO POSTNATAL MOTHERS

VISITS IN MONTHS	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Once in a week	33	68.8	33	68.8
Once in 2 weeks	6	12.5	39	81.3
Once in 3 weeks	6	12.5	45	93.8
Nil	3	6.3	48	100

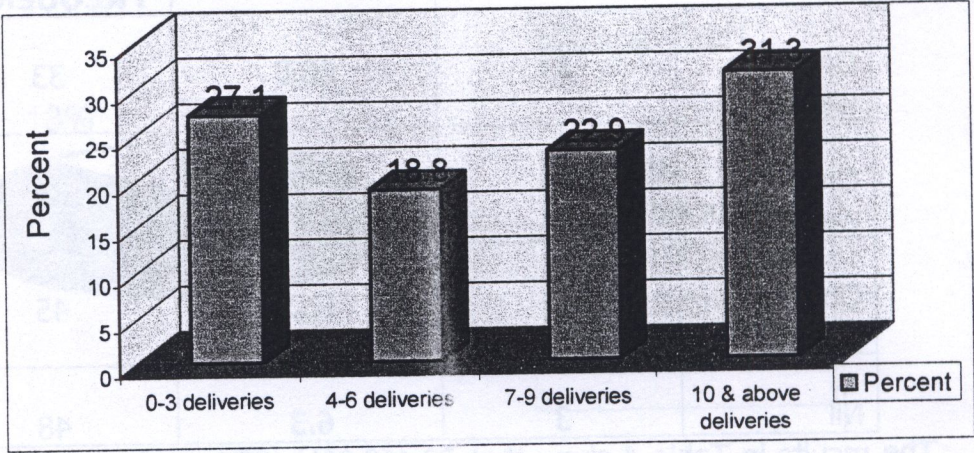
The results in Table 4 show that 33 (68.8%) tTBAs visit postnatal mothers once within the week of delivery, 6 (12.5%) once in two weeks, 6 (12.5%) once in three weeks and 3 (6.3%) do not visit.

Table 5: TYPE OF TRANSPORT USED WHENEVER ASSISTANCE IS REQUIRED

MODE OF TRANSPORT	FREQUENCY	PERCENT	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Walking	48	100	48	100
Bicycle	-	-	-	-
Vehicle	-	-	-	-
Other	-	-	-	-

Table 5 shows that all the respondents 48 (100%) walk to their client's whenever their assistance is required.

FIGURE 3: NUMBER OF DELIVERIES CONDUCTED BY RESPONDENTS IN THE PAST YEAR (JANUARY – DECEMBER 2000)



The results in Figure 3 shows that 15 (31.3%) of tTBAs conducted 10 and above deliveries in the past year. 13 (27.1%) conducted 0-3 deliveries, 11 (22.9%) conducted 7-9 deliveries, while 9 (18.8%) conducted 4-6 deliveries in the year 2000

Table 6: TIME WHEN RESPONDENTS CONDUCTED LAST DELIVERY

ATTENDANC E TO LAST DELIVERY IN MONTHS	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
0 – 4	43	89.6	43	89.6
5 – 9	5	10.4	48	100
10 – 14	0	0	0	0
15 and above	0	0	0	0

Table 6 shows that 43 tTBAs (89.6%) last attended to a delivery within the past 0-4 months, while only 5 tTBAs (10.4%) last conducted a delivery within the past 5-9 months.

Table 7: NUMBER OF RESPONDENTS WHO KEEP A RECORD OF DELIVERIES CONDUCTED

THOSE WHO KEEP A RECORD OF DELIVERIES CONDUCTED	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Yes	41	85.4	41	85.4
No	7	14.6	48	100

Table 7 shows that 41 (85.4%) of tTBAs keep a record of the deliveries they conduct, while 7 (14.6%) do not.

FIGURE 4: NUMBER OF RESPONDENTS WITH UNICEF KIT

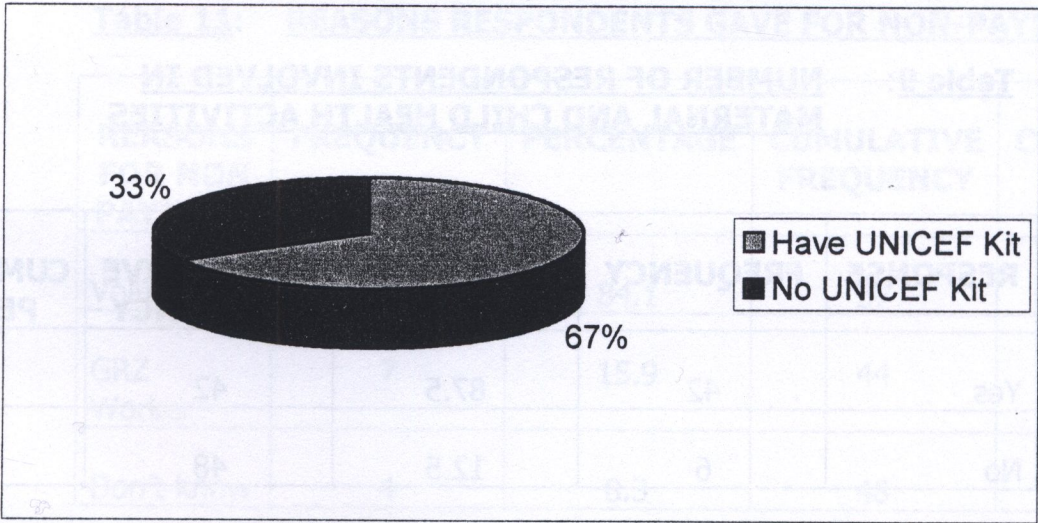


Figure 4 shows that 32 (66.7%) tTBAs were given UNICEF Kits after training, while 16 (33.3%) were not given UNICEF Kits.

Table 8: SUPPORT GIVEN BY HEALTH CENTRE STAFF THROUGH VISITS AND SUPPLIES TO tTBAs

HEALTH CENTRE SUPPORT	SUPPORT IN MONTHS				
	ONCE IN A MONTH	ONCE IN 3 MONTHS	ONCE IN 6 MONTHS	NIL	TOTAL
Visits	18 (37.5%)	0	7 (14.6%)	24(47.7%)	48(100%)
Supplies	21 (43.8%)	0	14 (29.2%)	13(27.1%)	48(100%)

Table 8 shows that the Health Centre Staffs visited 18 (37.5%) tTBAs within a month, 7 (14.6%) tTBAs were visited once in 6 months while the Health Centre Staff never visited 24 (47.7%) tTBAs. 21 (43.8%) of tTBAs get supplies from the Health Centre once in a month, 14 (29.2%) tTBAs get their supplies from the Health Centre once in 6 months and 13 (27.1%) never got supplies from the Health Centres.

Table 9: NUMBER OF RESPONDENTS INVOLVED IN MATERNAL AND CHILD HEALTH ACTIVITIES

RESPONSE	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Yes	42	87.5	42	87.5
No	6	12.5	48	100

Results in Table 9 show that 42 (87.5%) of tTBAs are involved in MCH activities, while 6 (12.5%) of tTBAs are not involved in MCH activities in their catchment areas.

Table 10: WHETHER RESPONDENTS EVER GET PAYMENT FOR SERVICES OFFERED

RESPONSE	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Yes	5	10.4	5	10.4
No	43	89.6	48	100

Table 10 shows that 43 (89.6%) of tTBAs do not get payment or remuneration for the services rendered, while 5 (10.4%) of the tTBAs do get payment for the services they provide.

Table 11: REASONS RESPONDENTS GAVE FOR NON-PAYMENT

REASONS FOR NON PAYMENT	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Volunteer	37	84.1	37	84.1
GRZ Worker	7	15.9	44	91.7
Don't know	4	8.3	48	100

Table 11 shows that most of the tTBAs 37 (84.1%) are considered volunteers by the communities they serve, 7 (15.9%) are considered as Government workers and 4 (8.3%) do not know why they are given any payment for their services.

Table 12: PRESENCE OF UNTRAINED TBAs IN THE COMMUNITY

PRESENCE OF TBAs	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Yes	45	93.8	45	93.8
No	3	6.3	48	100

Table 12 shows that 45 (93.8%) respondents acknowledged the presence of untrained TBAs in their community while 3 (6.3%) denied the presence of untrained TBAs.

Table 13: APPRECIATION OF SERVICES OFFERED BY tTBAs

APPRECIATION OF SERVICES	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Yes	46	95.8	46	95.8
No	2	4.2	48	100

Table 13 shows 46 (95.8%) of the community appreciate the services of tTBAs, while 2 (4.8%) respondents indicated non-appreciation of services.

FIGURE 5: PREFERENCE OF tTBAs TO TBAs BY COMMUNITY

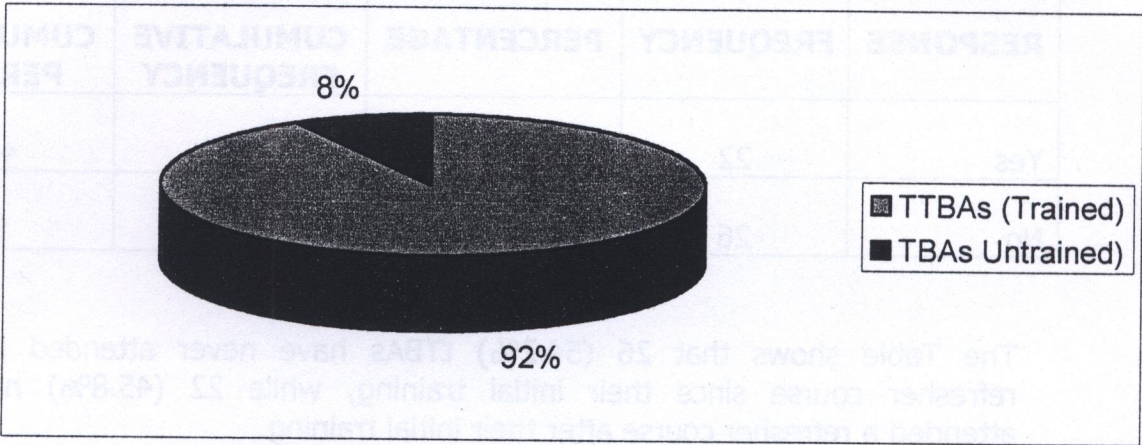


Figure 5 shows that the majority 44 (91.6%) of women in the community prefer tTBAs to TBAs 4 (8.3%).

Table 14: WORKING RELATIONSHIP BETWEEN tTBAs AND TBAs

WORKING RELATIONSHIP	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Very Good	8	17	8	17
Good	22	46.8	30	63.8
Fair	13	27.7	43	91.5
Poor	3	6.4	46	97.9
Very poor	2	4.2	48	100

Table 14 shows that 22 (46.8%) of the respondents (tTBAs) have a good working relationship with the TBAs, 13 (27.7%) have a fair working relationship with the TBAs, 8 (17%) have a very good working relationship with the TBAs, 3 (6.4%) have a poor working relationship and 2 (4.2%) have a very poor working relationship with TBAs.

Table 15: NUMBER OF RESPONDENTS WHO HAVE ATTENDED A REFRESHER COURSE

RESPONSE	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Yes	22	45.8	22	45.8
No	26	54.2	48	100

The Table shows that 26 (54.2%) tTBAs have never attended any refresher course since their initial training, while 22 (45.8%) have attended a refresher course after their initial training.

Table 16: COMMENTS OF RESPONDENTS CONCERNING THEIR WORK

RESPONSE	FREQUENCY	PERCENTAGE	CUMULATIVE FREQUENCY	CUMULATIVE PERCENT
Long distance	12	25	12	25
Non payment	18	37.5	30	62.5
Inadequate tTBAs	3	6.3	33	68.8
Appreciation by community	13	27.1	46	95.8
No Health Center Staff Recognition	2	4.2	48	100

The table shows that 18 (37.5%) of the respondents complained about non-payment for services offered, 13 (27.1%) respondents said that the community

appreciates their services, 12 (25%) complained about the long distances they cover on foot to their clients when called to assist, 3 (6.3%) complained that they were few tTBAs hence are overworked, 2 (4.2%) complained that the health center staff do not recognize the work they do.

CHAPTER 5

5.0. DISCUSSION OF FINDINGS

One major reason that has been clearly identified by Who and other organizations in an attempt to increase the trained personnel attending to mothers at child birth in rural areas where modern Maternal Health Care Services are inaccessible, is the trained traditional Birth Attendant (tTBAs). The study shows that 31.3% of tTBAs conducted the highest number of deliveries (i.e. 10 and above) in the past year (2000), while 27.1% of tTBAs conducted 0-3 deliveries. The results also show that 89.6% of the respondents last attended to a delivery within the past 0-4 months, while 10.4% last conducted a delivery within the past 5-9 months. 5.4% of the respondents keep records of the deliveries they conduct. This shows that the tTBAs are actually contributing to the provision of Maternal and Child Health services to the community thereby reducing the incidence of a maternal death. Few records of deliveries however reach the Health Centers. The reasons given were that the Health Center staff did not appreciate the records and that the tTBAs were not given books from the Health Centers for recording the deliveries. The other reason given in some areas was that the tTBAs take their records of deliveries to the NGOs that trained them. Other respondents as a result prefer to conduct deliveries at home without recording them. This probably explains the inadequate records of deliveries by tTBAs at the Health Centers and the District Office respectively. It therefore may account for the reason of the 1% deliveries being attended to by tTBAs in the past two years (1998-2000) in Mazabuka District. This shows that an unrecorded number of deliveries are being performed more by tTBAs than TBAs.

The study revealed the 66.7% of the tTBAs were given UNICEF Kits after their training, while 33.3% were not given. The reason given for the lack of UNICEF Kits was that they were not available. Some tTBAs were given improvised delivery kits with inadequate materials to use for delivery. The materials (like gloves, cotton wool, blades, spirit etc) used for delivery were not replaced when they run out. As a result, tTBAs asked pregnant women to buy these materials. Those pregnant women who could not afford to buy these materials went to the Health Center for delivery. The study also revealed that the Health Center staff visited 37.5% of tTBAs once a month, while the Health Center staff never visited 47.7% of tTBAs. The study showed that those visited were mostly from Chikankata area. 43.8% of tTBAs get supplies for their delivery kits from the Health Center

or those NGOs that trained them, while 27.1% never get any supplies. This shows that the inadequate support and supervision from the Health Center staff and the lack of UNICEF delivery Kits make the tTBA less utilized by the community.

The study results revealed that 95.8% of the community appreciated the services offered by the tTBAs. 91.6% of respondents showed that tTBAs were preferred to TBAs by the community. The reasons given were that the tTBAs were trained and had the knowledge to be able to conduct a safe delivery and to detect early any complications that may arise during labor and therefore refer the women to the Health facility quickly, in that way save their lives. The focus group discussion supported the findings.

According to the study findings, 87.5% of the tTBAs are involved in Maternal and Child Health activities at the Health Centers in their catchment areas and also in outreach sessions. This shows that they are not only confined to labor and delivery but also other aspects of the Maternal and Child Health. It also shows that tTBAs are utilized by the Health Center staff to improve the life of the mother and child. The community is well aware of the function of the tTBAs as they expressed in the focus group discussion, that they do not only attend deliveries but also to antenatal mothers, family planning, growth monitoring, nutrition, as well as giving health education. It is through these services that there will be reduction of maternal and infant mortality. The study done by Sindiga I. (1995) in Kenya, showed that the functions and participation of the tTBAs in MCH and Family Planning was significant and that they however, needed training enhance their skills.

Distance acts as a natural barrier and disincentive to attendance by either the tTBA in reaching her clients or by the women in the community in accessing the services of the tTBA. The study results show that all the 48 (100%) tTBAs walk to their clients when their assistance is needed. Long distances with walking as a mode of transport affects the visits that the tTBAs make to their clients antenatally and also postnatally. The study shows that 45.8% tTBAs visit prenatal mothers once in three months, while 20.8% do not visit the prenatal mothers at all. 68.8% tTBAs visit postnatal mothers within the week of delivery while 6.3% do not visit at all. The study showed that there was unequal distribution of tTBAs, because some areas did not have any tTBAs. This was also reflected in focus group discussions (urban and rural) where the women complained about the few number of tTBAs (e.g. Ndeke compound in Mazabuka urban has 4 tTBAs (2 practicing) against a population of 12,000 people). The result is also supported by the study done by Maimbolwa, C.M (1998)

where she indicated that tTBAs were operating alone in sparsely populated areas making it difficult for the women in labor to reach them.

The age distribution of the respondents show that the majority 68.8% are 35 years and above. This shows that the tTBAs were within the desired age group, and therefore were accepted by the community to practice midwifery. This is also supported by the findings from the focus group discussions where the women preferred to be delivered by elderly women and shunned to be assisted by tTBAs who were under age. It was also reflected in the study done by Maimbolwa, C.M (1998) that some mothers refuse to be delivered by tTBAs who were under age. As regards education, 95.8% of tTBAs had an opportunity to go to school and attained primary education and 4.2% had no formal education. This shows that the majority were able to understand the nature of their job and that their education skills can still be further improved. The majority of the respondents were married 58.3% and about 47.9% had children between 4-7 years. Again this shows that they are accepted and respected in the community and therefore more utilized. A married woman with children is respected in her community traditionally. This is reflected in the study done by Makumba, R. (1989) where she states that a married woman with children is more accepted by the community to practice midwifery. 45.8% of the respondents have lived in their locality for 15 years and above, while only 14.6% have lived in their present locality for less than 4 years. This shows that the majority of the tTBAs are known by the community and they know the community. This leads to increased accessibility and utilization of the tTBAs. In Mazabuka District the majority of the tTBAs (45.8%) have been practicing as tTBAs for 0-3 years while 12.5% have been practicing for 8-11 years. This shows that most of the tTBAs were trained recently and therefore very difficult to determine their impact on the maternal mortality, which has been steadily increasing in the country. They were trained by NGOs like Plan International and other donors who saw the need to increase the number of births attended to by trained Traditional Birth Attendants in the rural areas.

The community selects a high percentage (85.4%) of the tTBAs while the Health Center Staff selected only 2.1%. The selection of the tTBAs has a bearing on their accessibility and utilization. Since they are selected by the community, they are accepted by them and can therefore be more utilized. In her study, Maimbolwa, C.M (1998) showed that some tTBAs were less utilized in conducting normal deliveries because a minority in the community selected them.

As regards to refresher courses, the study revealed that the majority of the tTBAs (54.2%) have never attended a refresher course after their initial training while 45.8% had attended once after their training. Refresher courses are necessary in order to continually update the knowledge and skills of the tTBAs. This will make them more efficient in their work.. WHO et al (1999) states that "Training of tTBAs alone in the absences of back-up from a functioning referral system and support from professionally trained health workers is not effective in reducing maternal mortality". Maimbolwa, C.M (1998) in her study also reflected that without the provision of equipment, supplies and refresher courses, the tTBAs could be under utilized.

93.8% of the respondents acknowledged the presence of the TBAs in their communities. Their working relationship between the tTBAs and TBAs is good. 46.8% of the respondents said that the working relationship is good, while 4.2% said it was very poor. This was augmented with the results from the focus group discussion held in rural areas. The women said that the TBAs refer women to the tTBAs because they say they have the knowledge because of their training. The women said that even though they would go to the untrained TBA because she is near for urgent help, the TBA and the community would still call for the tTBA to come and assist with the delivery. The tTBAs were not only called for complicated deliveries only, but also for normal ones. This is contrary to the findings of Maimbolwa, C.M (1998) in her study where she states that "the study shows that the tTBA was only called to assist when there was a complication during delivery". This shows that women have confidence and trust in the tTBA and shows increased utilization of tTBAs.

In relation to remuneration, this study shows that 89.6% of tTBAs are not remunerated for the services they offer. Reasons given for the lack of remunerations were that the community considered tTBAs as Government workers (15.9%) and therefore should be paid by the government who trained them, 84.1% of the respondents said that they were considered volunteers of the community, and so may or may not be remunerated. This result reflects the statement made by UNICEF, 1994 that now that TBAs have been trained by government, and given equipment to use, they are perceived as employees of the government." These findings on remuneration concurred with the findings of the focus group discussion where the tTBAs were seen as government employees because they trained them. They therefore expected the government to pay them. Others considered tTBAs as volunteers. Other women said they would like to give the tTBAs some form of payment, because they appreciated their work, but they have no means of doing so.

When asked to comment about their work in the community, 37.5% of the respondents complained about the lack of remuneration, 27.1% said that the community appreciated their work and 25% complained of the long distances they cover on foot when called to assist a woman in labour. They appealed for bicycles. The focus group discussions held with women of childbearing age also pointed out the fact that they really appreciated the work of the tTBAs in the community. They wished that more TBAs could be trained to serve their communities.

5.1. IMPLICATIONS TO THE HEALTH SYSTEM

According to the results from this study, it is clear that the trained Traditional Birth Attendants are an important resource in the community towards the reduction of Maternal and Infant mortality.

The implication on the Health System is that the tTBAs urgently need the support of the Health System in order to be of service to their communities. The Ministry of Health, at national level, provincial level, District level and the Health Center level needs to put in place a strategy or establish a community based maternal health care system comprising of prenatal, delivery and postpartum care, which is supported by professionally trained health workers and a system of referral to a higher level of care in the event of obstetric complications.

It is a worldwide concern, and especially Zambia as a nation, that the maternal mortality rate has increased over the years, and will still increase if the available resource (i.e. TBAs in the community) is not utilized. Maternal deaths occur in the community, and hence the Ministry of Health needs to start dealing with the problem of maternal mortality from the community level. The Ministry of Health does not only need to train more TBAs to cover rural populations but most importantly support them in terms of supervision and material supplies if there is to be a reduction in maternal mortality.

CHAPTER 6

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The study revealed that the tTBA is well appreciated by the community and preferred to the untrained TBA. The tTBAs conduct more deliveries in the community than the TBA, some of which are unrecorded due to the poor recording system.

In this study it has been shown that the tTBAs have a lot of setbacks, which makes their contribution to the reduction of maternal and infant mortality rate ineffective. The setbacks are: The lack of transport, the long distances the tTBAs have to walk to reach their clients, lack of incentive, lack or inadequate support from both the Ministry of Health/Central Board of Health and the Community they serve, lack of delivery Kits, lack of refresher courses to update their knowledge and skills, and above all the few number of tTBAs covering large populated areas.

If these setbacks were looked into and the needed logistics and materials supplied as required, the contribution of the tTBAs towards the reduction in the Maternal and Infant mortality rate would be very significant.

6.2 RECOMMENDATIONS

In view of the study findings, I wish to recommend the following:

1. The training of TBAs should continue, in order to serve the community at large.
2. Refresher courses should be held at least once a year to update the knowledge and skills of the tTBAs.
3. The health personnel at the Health Centers sensitise communities on their responsibilities towards the tTBA.
4. The Health Center Staff should give technical support and supervision to the tTBAs and visit them regularly in their villages.
5. There should be some monitoring and support systems.
6. Trained Traditional Birth Attendants should be given bicycles in order to reduce the long distances covered to their clients.
7. A recording system of all the deliveries conducted, referrals and maternal deaths have to be established.
8. The tTBAs in Mazabuka District have to be made aware that it is their duty to report all the deliveries to their Health Centers in the catchment area and then to their sponsors so that an up to date record is kept at the Center and later sent to the District.
9. At National level, the Ministry of Health should look into the provision of delivery Kits for the tTBAs and work hand in hand with co-operating partners interested in maximising the use of TBAs in the communities.

6.3. **LIMITATIONS OF THE STUDY**

1. Inadequate literature on the accessibility and utilization of the tTBAs and TBAs.
2. It was difficult to locate the subjects for the study due to the lack of transport to get to the hard to reach areas where the tTBAs were found.
3. Inadequate funding compelled the researcher to have a small sample, thus the difficulty in generalising the findings to all the TBAs in the District.
4. The study had to be completed within a given time, thus there was inadequate time due to other academic activities.
5. The District Health Office did not have an updated list of trained TBAs in the District. As a result only 48 tTBAs were interviewed instead of 50.

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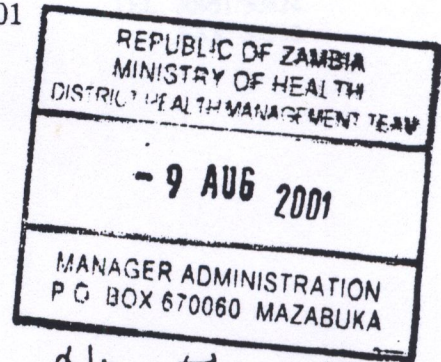
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The University of Zambia
School of Medicine
Dept. of Post Basic Nursing
P.O. Box 50110
LUSAKA

23rd July 2001



The Executive Director
Mazabuka District Health Board (DHMT)
P.O. Box
MAZABUKA

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

Dear Sir

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 Accessibility and Utilization of the tTBAs in Mazabuka District".

I would therefore be grateful if you could kindly allow me to interview tTBAs (50) in the district.

Your approval will be greatly appreciated.

Yours faithfully

UP

LEODA HAMOMBA



REPUBLIC OF ZAMBIA

CENTRAL BOARD OF HEALTH

OFFICE OF THE DISTRICT HEALTH DIRECTOR
MAZABUKA DISTRICT HEALTH MANAGEMENT BOARD

P.O. BOX 670060

MAZABUKA

TEL: 30951/30624

FAX: 30532

12th September, 2001.

Leoda Hamomba
UNZA,
School of Medicine,
Dept. of Post Basic Nursing,
P.O. Box 50110,
LUSAKA.

Dear Madam,

RE: STUDY PROJECT (YOURSELF)

I refer to your letter of 23rd July, 2001 in which you have applied to conduct a study project in our district.

Your request has been considered. Go ahead with your intended interviews of TBAs (50) in the district.

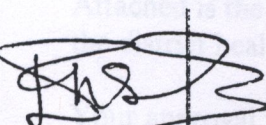
Wishing you a success in your studies.

Yours Faithfully,

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
DISTRICT HEALTH MANAGEMENT TEAM

12 SEP 2001

HUMAN RESOURCES
P.O. BOX 670060, MAZABUKA


Mujansi E. (Mr)

Acting Manager Administration

for DISTRICT DIRECTOR OF HEALTH.

CC: Training File

The University of Zambia
School of medicine
Dept of Post Basic Nursing
P.O. Box 50110
LUSAKA
16th August, 2001

The Executive Director
Chikankata Mission Hospital
Private Bag S- 2
MAZABUKA

U.F.S. The MCH Co-ordinator
Chikankata Mission Hospital

Dear Sir

RE: STUDY PROJECT

I am a 4th year student of the above mentioned school currently studying for a Bachelor of Science in Nursing. In partial fulfillment 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 accessibility and utilization of the TTBA's in Mazabuka District"

I would be grateful if you could kindly allow me to interview at least twenty (20) trained Traditional Birth Attendants in your catchment area.

Attached is the structured questionnaire and a photocopy of the permission granted me by the district health management team to carry out the research in the District.

Your approval will be greatly appreciated.

Yours faithfully



Leoda Hamomba

The Salvation Army : Chikankata Health Services

**PRIVATE BAG S-2
MAZABUKA
ZAMBIA**



4th October 2001

Leoda Hamom̧a
UNZA
School of Medicine
Dept of PBN
P.O. Box 50110
LUSAKA.

Dear Madam,

RE: PERMISSION TO INTERVIEW TTBA's

Reference is made to your application to interview TBAs in Chikankata Health Services catchment area.

I am pleased to inform you that you may go ahead.

Sincerely yours,

M.M. Chaava
Manager CH&D
For Director CHS

A STUDY ON THE ACCESSIBILITY AND UTILIZATION OF TRAINED TRADITIONAL BIRTH ATTENDANTS

INTERVIEW SCHEDULE

SERIAL NO.

INSTRUCTIONS FOR THE INTERVIEWER

1. Introduce yourself to the respondent and explain the purpose of the interview.
2. Do not write the name of the respondents on the questionnaire.
3. Circle the most appropriate response to the Questions
4. All information provided by the respondents must be held in strict confidence.
5. The respondents should be free to ask questions during the course of the interview.
6. Thank the respondent at the end of each interview

SECTION A

DEMOGRAPHIC DATA

1. How old were you on your last birthday?

- (a) 20 – 24 years
- (b) 25 – 29 years
- (c) 30 – 34 years
- (d) 35 years and above

--

2. What is your marital status?

- (a) Single
- (b) Married
- (c) Divorced
- (d) Separated
- (e) Widowed

--

3. (a) Did you have an opportunity to go to school

- (a) Yes
- (b) No

--

(b) If yes, what level of education have you attained?

- (a) Adult Literacy
- (b) Primary School
- (c) Secondary School
- (d) College

--

4. How many children do you have?

(a) 1 – 3

(b) 4 – 6

(c) 7 – 9

(d) 10 and above

--

5. What is the age of the youngest child?

6. For how long have you been living in this locality?

(a) 0 – 4 years

(b) 5 – 9 years

(c) 10 – 14 years

(d) 15 years and above

--

SECTION B

WORK EXPERIENCE

7. How long have you been working as a TBA?

(a) 0 – 3 years ago

(b) 4 – 7 years ago

(c) 8 – 11 years ago

(d) 12 years and above

--

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

- (a) Once in 3 months
- (b) Once in 6 months
- (c) Once in 9 months
- (d) Other

--

9. How many deliveries have you attended to in the past year?

- (a) 0 – 3
- (b) 4 – 6
- (c) 7 – 9
- (d) 10 and above

--

10. When was the last time you attended to a delivery?

- (a) 0 – 4 months ago
- (b) 5 – 9 months ago
- (c) 10 – 14 months ago
- (d) 15 months and over

--

11 (a) Do you keep a record of the deliveries you conduct?

- (a) Yes
- (b) No
- (c) If

--

(b) If no, explain _____

12. How often do you visit your patients after delivery?
- (a) Once a week
- (b) Once in two weeks
- (c) Once in four weeks
- (d) Once in six weeks
- (e) Any other
13. How do you reach your patients whenever your assistance is needed?
- (a) Walking
- (b) Bicycle whenever available
- (c) Vehicle whenever available
- (d) Any other
14. (a) Do you get payment after helping a woman deliver?
- (a) Yes
- (b) No
- (b) If no, explain _____
15. (a) Do you think women appreciate the services you provide in the community?
- (a) Yes
- (b) No
- (b) If no, explain _____
- _____
- _____

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16. Are there TBAs in your area?

- (a) Yes
- (b) No

--

17. (a) Do women prefer to be delivered by TBAs than tTBAs?

- (a) Yes
- (b) No
- (b) If no, explain

--

18. How is your working relationship with tTBAs?

- (a) Very good
- (b) Good
- (c) Fair
- (d) Poor
- (e) Very poor

--

19. How often do you go to your nearest health centre for supplies?

- (a) Once in 3 months
- (b) Once in 6 months
- (c) Once in 9 months
- (d) Once in 12 months
- (e) Any other

--

20. How often do the health personnel visit you?
- (a) Once in 3 months ☐
- (b) Once in 6 months ☐
- (c) Once in 9 months ☐
- (d) Any other ☐
21. Do you assist the health personnel carry out Maternal? and Child Health services (MCH)
- (a) Yes ☐
- (b) No ☐
22. Who chooses you to go and train as a tTBA?
- (a) The Community Leaders ☐
- (b) Clinic Staff ☐
- (c) Own staff ☐
- (d) The Health Neighbour Committee ☐
- (e) Other ☐
23. (a) Were you issued with a UNICEF TBA Kit?
- (a) Yes ☐
- (b) No ☐
- (b) If no, explain _____
24. Have you ever attended any course since your initial training?
- (a) Yes ☐
- (b) No ☐

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

Thank you very much for your co-operation

FOCUS GROUP DISCUSSION GUIDE

INSTRUCTIONS

1. Introduce yourself and the topic.
2. Explain the purpose of the discussion.
3. Do not ask for names and addresses of respondents.
4. Take notes as the discussion proceeds.

QUESTIONS FOR WOMEN OF CHILD BEARING AGE GROUP

1. Where do women in this community deliver?
2. Why do they deliver from this place?
3. Who decides that they deliver from this place?
4. Who assists them deliver?
5. Are there trained TBAs in the community?
7. Would you prefer to be delivered by a TBA rather than a trained TBA?
8. Do you have any comments regarding the trained TBAs in your community?

