



THE UNIVERSITY OF ZAMBIA
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DEPARTMENT OF POST BASIC NURSING

**A STUDY TO DETERMINE COMMUNITY KNOWLEDGE AND
PERCEPTION TOWARDS TRAINED TRADITIONAL BIRTH
ATTENDANTS IN SIAVONGA DISTRICT**

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Diseases Syndrome
ANC	Antenatal Care
CSO	Central Statistics Office
FP	Family Planning
HIV	Human Immune Virus
HMIS	Health Management Information System
MMD	Movement for Multi part Democracy
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
SMI	Safe Motherhood Initiative
TTBA	Trained Traditional Birth Attendants
TBA	Traditional Birth Attendant
UNICEF	United National International Children's Education Fund
UNFPA	United National Population Fund
WHO	World Health Organization

DECLARATION

I Lucensia Himwiila declare that this thesis represents entirely my own work and independent investigation. That it has not previously been submitted for any degree or any other qualification at this or another University.

Signature.....*Lucensia Himwiila*

Date.....*18th Feb 2008*

Student

Signature.....*Phygome*

Supervising Lecturer



ABSTRACT

The aim of this study was to determine community knowledge and perception towards named TBAs in Siavonga District.

STATEMENT

The literature reviews of relevant studies revealed that TBAs have little or no impact on maternal and newborn mortality rate. A lot of births in developing countries, especially in remote areas, take place at home and despite the

I, hereby certify that this study is entirely the result of my own labour and independent investigation. I have clearly indicated the various sources to which I am indebted throughout the text and the reference.

However, TBAs remain the only source of maternal and newborn health care in communities devoid of access to health facilities. Unless the issues of social, societal and hidden causes of poor health of women are addressed the idea to improve health of women and new born in developing countries is quite far fetched (Asghar, 1999). It is for this reason that the study was conducted to

Signed.....*HAHemwila*

Candidate

A Qualitative study design was used. This study design has been found appropriate because the study is of practical concern to the community, and

Date.....*18th Feb 2008*

and implementation of research. The study was conducted in Siavonga District and the study population comprised men and women residing in the study area.

A pilot study was conducted in Morija District prior to the main study to test the data collecting instrument. A focus Group Discussion (FGD) guide was developed and used to collect data.

Stratified sampling procedures were used to select FGD participants. Men and women who were willing to take part in the study were randomly selected from each stratum. Two FGDs were conducted during pilot study and five FGDs during the main study. A total of seven FGDs with 8 to 10 participants were conducted. Three groups with men, three groups with women and one group with

ABSTRACT

The aim of this study was to determine community knowledge and perception towards trained TBAs in Siavonga District.

The literature reviews of relevant studies revealed that tTBAs have little or no impact on maternal and newborn mortality rate. A lot of births in developing countries, especially in remote areas, take place at home and despite the presence of trained TBAs most women in rural areas still prefer assistance by traditional birth attendants (African Journal, 2008).

However, TTBAAs remain the only source of maternal and newborn health care in communities devoid of access to health facilities. Unless the issues of social, societal and hidden causes of poor health of women are addressed the idea to improve health of women and new born in developing countries is quite far fetched (Asghar, 1999). It is for this reason that the study was conducted to assess community levels of knowledge and perception resulting in low utilization of tTBAs.

A Qualitative study design was used. This study design has been found appropriate because the study topic is of practical concern to the community. and members of community feel that they should have equal participation in planning and implementation of research. The study was conducted in Siavonga District and the study population comprised men and women residing in the study area. A pilot study was conducted in Monze District prior to the main study to test the data collecting instrument. A focus Group Discussion (FGD) guide was developed and used to collect data.

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Headmen. All the participants were married and were aged between 19 and 39 years of age. The FGD were conducted in quite room far from any disturbances.

Qualitative data derived from FGDs were analyzed using principles of contents analysis. This entailed reading, rereading and vigorous study of each question to come up with concept in the responses through process of coding. Notes and observations were sorted into categories representing different ideas or themes. All similar ideas and impressions were written down according to themes. The following Five themes were identified:

- Knowledge about trained TBAs
- Knowledge on health problems
- Access to trained TBAs
- Cultural values
- Attitude

The study revealed that the community members were aware of the presence of trained TTBAAs in their community and were aware of their functions. All participants in the five FGDs were knowledgeable about the common health problems of pregnancy and labour such as: swelling of feet, hands and sometimes face, bleeding during pregnancy, labour and after delivery. They observed that these problems were made worse by lack of transport to take mothers to the nearest health facility, long distances to health facilities and at the same time aggravated by poor health of women.

The participants revealed that trained TBAs were appreciated but accessibility was hindered by poverty, distance, illiteracy and cultural beliefs. Although the community showed a positive attitude towards trained TBAs, they Were not supporting them, this made their work difficult.

The major recommendations were:

1. The District Health Management Team should reduce the catchments population for trained TBAs by changing the measure of number of population to distant, with a maximum distance of 3 kilometer in diameter for remote areas where households are spaced; to enable accessibility to trained TBAs by the community.
2. The community in the rural areas to be sensitized on the need to support the pregnant women who developed problems during antenatal, labour and delivery and to refrain from bad cultural practices that are detrimental to their health.
3. The District Health Management Team (DHMT) should ensure that supportive services such as referral systems and qualified staff are available within reach, for trained TBAs to function effectively.
4. The community to provide support for trained TBAs to enable them to function effectively.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Historically, traditional birth attendants (TBA) have been the main human resource for women during childbirth. TBAs exist in almost all communities in developing countries, Zambia inclusive. They fulfill a vital community need by assisting women during labour, delivery and immediate postpartum period (Zambia Integrated Health Partnership (ZIHP), 2000). The role varies across cultures and at different times. Even today, they attend to the majority of deliveries in rural area of the developing countries. Therefore, there is little doubt that they have significant role to play when it comes to cultural competence, consolation, empathy and psychosocial support provision at birth (Ministry of Health (MOH, 2003).

Before the launch of safe motherhood initiative (SMI) in 1987, in Nairobi, Kenya, the world was not informed about the risk associated with pregnancy and childbirth in low-income countries. The aim of SMI was to raise awareness on consequences of poor maternal health and maternal health services in developing countries and to mobilize action to address the unacceptable high rates of maternal deaths and disability (World Health Organization, 2005)

Majority of births in most developing countries, particularly in rural areas, take place at home and are usually assisted by relatives or TBAs. Frequent vaginal examinations with unclean hands, applications of herbal medicines to vulvas and vagina are some of the bad practices performed by relatives and TBAs (Asghar, 1999). In an effort to provide safe motherhood and broaden the range of SMI providers and improve quality of care, many governments and international agencies have been investing in training of TBAs where professional health care

providers are not available and TBA may be the women's only source of care (Asghar, 1999).

In the years following the safe motherhood conference in Nairobi in (1987), interventions intended to reduce maternal and neonatal morbidity and mortality have come under increased scrutiny, training of TBAs is one such intervention. Multilateral agencies, national government, international and non governmental organizations have invested considerably their time, energy and money in training of TBA (WHO, 2005).

The Justification for the training of traditional birth attendants is that, a large proportion of births are attended by TBAs especially in rural areas, where access to higher quality maternal care providers such as Doctors and Midwives are limited. The fact that the access to quality maternal care is unlikely to improve in the foreseeable future, it could also be used to justify the need to train Traditional Birth Attendants (Smith, et al 2000).

In many countries the health of mothers is not making the progress, it should. Reasons which vary from country to country, may include poverty, inequalities, wars, civil unrest, destructive influence of HIV/AIDS, failure to translate, life-serving knowledge into effective actions and to invest adequately in safe motherhood, public health and safe environment. This leaves many mothers, particularly the poorest, excluded from access to affordable, effective and responsive care to which they are entitled (WHO, 2005).

Maternal Mortality Rates (MMR) in developing countries ranges from 450 per 100,000 live birth and goes up to 2000 per 100,000 live births in some areas, compared with an estimated 30 per 100,000 in developed countries. These rates vary widely between different areas of the same region or countries. For example, there may be two – fold high mortality in rural than urban (Asghar, 1999).

According to World Health Organization, reproductive health problems account for more than one third of total burden of disease in women (Asghar, 1999). WHO (2005) estimates that 500,000 women die every year from complication of pregnancy. Virtually all these deaths occur in developing countries (that is 99%) the major causes of these deaths in developing countries are anemia, hemorrhage, infection, eclampsia, unsafe abortion and complications of obstructed labour (Asghar, 1999).

A large number of TBAs are found in developing countries in most rural areas, where are no other health care facilities existing. It may take very long time before developing countries can afford to provide quality professionals to all parts of their populations (Asghar, 1999). Therefore, it is important to use the immense potential which lies in the communities themselves for providing basic health care, this makes it possible for such communities to improve their capacity for serving themselves, and TBAs constitute a large segment of that potential.

Zambia is one of the developing countries in southern region of Africa. In 1991, the Movement for Multiparty Democracy (MMD) came into power. Since then, the Government has been working to ensure that the health vision, which is "To provide Zambians with equity of access to cost effective health care as close to the family as possible", is attained. It has been training TBAs since 1992 (MOH, 2004)

1.2 STATEMENT OF THE PROBLEM

Although the western type of medicine is encouraging the phasing out of trained Traditional Birth Attendants (TBAs) due to their poor performance, Trained TBAs are still a valuable asset in low income countries like Zambia where the health care professionals are not enough, such as Obstetricians and midwives to provide quality care to mothers and their babies, especially in remote areas of the country (WHO, 1986).

Zambia started training TBAs in 1992 to supplement the inadequate health facilities and health workers in remote areas (MOH, 2004). Despite training these TBAs utilization has been very low. In addition the MMR has been rising, for instance it rose from 649/100,000 in 1996 to 729/100,000 live births in 2002 (ZDHS 2001-2002), being among the highest in the world.

In Siavonga District most of the rural health centres have no skilled only three out of twelve health centres have a midwife. The District has 38 trained TBAs against a projected total of 67989 populations, for 2005. According to government policy in Zambia, one TBA is responsible for 1000 population (CSO, 2003). The few trained TBAs in the district are not fully utilized. This was evidenced by the fact that, out of the 43% assisted deliveries conducted in the district in 2004; only 10% were delivered by trained TBAs, antenatal care given by TBAs was less than one percent. The actual maternal deaths were four (4) in the same year, out of 1,220 live births (HMIS – Siavonga, 2004). Therefore, non-trained TBAs or relatives deliver most women who deliver in homes. This portrays that a lot of mothers (57%) are at high risk of morbidity and mortality due to poor maternal health services by untrained TBAs, creating a big gap in maternal services which needs to be addressed.

Moreover it is not well documented as to what happens to these women or why they are not able to access either the health workers or tTBAs. Some of the reasons could be:- inadequate number and distribution of well equipped health centres and qualified personnel. This could also be attributed to poor performance by tTBAs.

However, distance, environment, non acceptance of tTBAs by the community, inadequate knowledge on what trained TBAs can provide to help them and a number of social cultural and economic causes could be among the factors that prevent mothers from seeking help from tTBAs. Given this scenario, it was

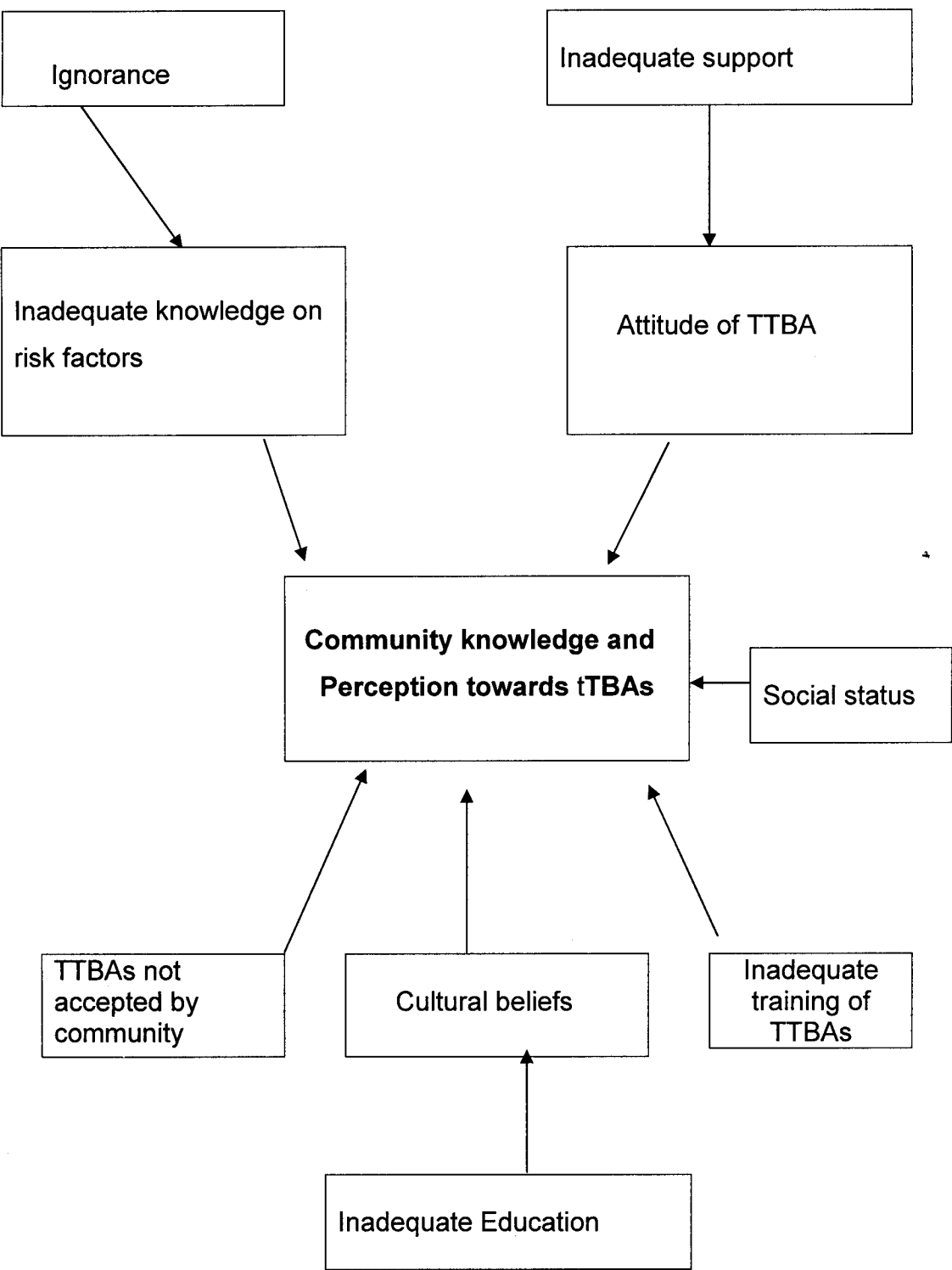
imperative that a research be done to assess community's level of knowledge and perception towards tTBAs with a view to make recommendations.

1.3 FACTORS INFLUENCING COMMUNITY KNOWLEDGE AND PERCEPTION TOWARDS TRAINED TBAs

There are many factors, which can influence community knowledge and perception towards tTBAs. These could be:

1. **Cultural beliefs:** Cultural beliefs can play an important role in depriving women their otherwise accessible health care, leading to delay in seeking health care.
2. **Acceptance by mothers:** if TTBA is not an indigenous local person, women may shun her.
3. **Social religious beliefs:** May also deprive a woman of access to health care.
4. **Attitude of tTBAs:** Trained TBAs' negative attitude towards mothers could affect community perception.
5. **Inadequate knowledge:** Inadequate knowledge by community on the importance of being assisted by trained TBAs.
6. **Inadequate infrastructure:** Leading to non-confidentiality.

FIGURE 1: FACTORS INFLUENCING COMMUNITY KNOWLEDGE AND PERCEPTION TOWARDS TTBA_s.



1.4 STUDY OBJECTIVES

1.4.1 GENERAL OBJECTIVES

To explore and describe community's level of knowledge and perceptions towards trained Traditional Birth Attendants in Siavonga District,.

1.4.2 SPECIFIC OBJECTIVES

- To assess community knowledge levels about TTBA's and their services
- To assess community attitude towards TTBA's
- To identify factors contributing to negative attitude towards tTBAs.
- To assess community support for TTBA's.

1.5 HYPOTHESIS

1.5.1 TTBA's are not performing as expected because of inadequate support.

1.6 JUSTIFICATION OF STUDY

Traditional Birth Attendants have been trained in Zambia on a wider scale since 1992. In Siavonga, training started in 1994. In spite of ten (10) years of TBA training, very few women are being assisted by these trained TBAs

A survey done in Zambia by CSO (2003), reveal that, despite the presence of trained TBAs only a limited number of TTBA's are active and most are under utilized (CSO, 2003). In spite of the presence of trained TBAs in rural area where there are no or few qualified professional Health workers there seem to be no impact of tTBAs in maternal health services, most women in rural areas still prefer assistance by untrained TBAs.

It was therefore, imperative that this study was carried out to determine the level of knowledge and perception of community towards trained TBAs, with a view to

develop appropriate educational programmes to improve levels of community knowledge and attitude towards trained TBAs.

1.7 VARIABLES

INDEPENDENT VARIABLES – Are Variables that causes changes in the dependent variables (Bless, etal, 1988).

Following are the independent variables

- Community knowledge about TTBA
- Attitude of TTBA
- Cultural beliefs

DEPENDENT VARIABLES – Variables that are influenced or caused by independent variables. These are: -

- Community perception of TTBA

Table 1: VARIABLES AND CUT OFF POINTS

	Variable	Indicator	Scale of Measure
Dependent	Community perception towards TTBA	Clients seeking services of TTBA	0-30% - poor 30-50%-fair 50-70%-good
Independent	Level of community knowledge about TTBA	Knowledge on activities of TTBA. A client who knows about TTBA	Good above 50% Average 25-50% Poor below 25%
	Social-cultural beliefs	Levels of cultural beliefs.	High above 40% Low below40%
	Attitude of TTBA	Percentage of mothers favour or complaining.	-Positive -Negative

This table illustrates the measurement of variables for analysis.

OPERATIONAL DEFINITION

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

- **Quality** – Is the proper performance according to standard.
- **Quality of care:** Care given according to proper performance to standard.
- **Infant Mortality rate:** The number of deaths of children less than one year of age in a given year per 1000 live births in same year.
- **Traditional Birth Attendant:** A person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or by working and observing with other TBAs.
- **Trained Traditional Birth Attendant (tTBA):** A Traditional Birth Attendant who has received training for a period of six (6) weeks to upgrade her skills.
- **Maternal Death:** Any death of a woman from pregnancy related condition and or dies within 42 days after termination of pregnancy.
- **Maternal Mortality rate (MMR):** Refers to, the number of women dying from pregnancy related conditions or within 42 days after termination of pregnancy in a given year per 100,000 live births in that same year.
- **Neonatal Death:** Any death of a baby occurring at birth and up to 28 days
- **Neonatal Mortality Rate (NMR):** The number of neonate dying in a given year per 1000 live births in that same year.
- **Skilled Worker (Attendant):** Refers exclusively to people with midwifery skills (such as Doctors, Midwives and Nurses) who have been trained in the skills necessary to manage normal delivery, to diagnose and manage or refer complications.
- **Knowledge:** Information needed by both mothers and TTBA's in relation to danger signs of pregnancy and labour.
- **Attitude:** The way one behaves towards something that shows how they think and feel.

- **Perception:** The way one notices things, especially with the senses.
- **Community:** A group of people who live in a particular area may be of same race, sharing same culture and or same religion.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Among human rights, the first is the right to life itself. Although it has been stated that pregnancy is a natural physiological event in life of a woman and as such, it is an obligation that a woman fulfils the sustained production of the human race (Malcokha, 1991). All pregnant women have a right to be protected from the ordeals of pregnancy labour and peuperium.

Zambia has one of the highest Maternal Mortality ratios (MMR) in the world, despite the higher antenatal attendance. Although antenatal attendants are currently estimated at 80% for urban and 68% for rural areas, MMR has increased from 649 per 100,000 live births in 1996 to 749/100,000 live births in 2002 (ZDHS-2001-2002). It is estimated that 50% MMR is directly attributed to post-partum hemorrhage; sepsis obstructed labour abortion and eclampsia. Indirect causes include malaria and anemia.

Other contributing factors include delay in accessing health care at community and health centre level. Although 90% of all pregnant women receive some kind of antenatal care only 43% deliver in health facilities (MOH, 2005).

2.1.1 TBA TRAINING

Traditional Birth Attendants have a significant role to play when it comes to cultural competence, consolation, empathy and psychosocial support at birth. It has therefore, been recommended that they should go for training, in order to improve the services they provide and therefore a criterion is used to select the trainees

i.Criteria for selecting a TBA for Training

Since the TBAs work and live within the community, the criterion for selecting them for training has been left to the community so that once someone is chosen by the community they will be able accepted, respected and supported by the communities in which they operate from. Therefore for a TBA to be recommended for training she must have the following: Must be already in the practice, an elderly woman, be literate, in cooperation with the community and chosen by the community.

li. Training

The stated goal of training is to contribute to reduction of maternal and newborn mortality and morbidity through appropriate training and improved delivery and newborn care by TBAs, especially in rural areas. The focus should be on the following: -

- Safer maternal practices
- Improved standard of safe motherhood
- Increase pregnancy spacing
- Improving skills, understanding and stature of TBAs
- Increasing the number of births conducted by trained TBAs with non-interference in labour.
- Improving links between modern health service and community through Trained TBAs.

Core training focuses on teaching TBAs to perform deliveries in more hygienic and safer conditions, discouraging harmful practices, recognizing danger signs and referring women with complications to facilities where essential obstetric care is available. Offer health education, antenatal care, delivery and post natal care, health promotion and family planning to women (ZIHP, 2000).

Training arrangements usually consists of four to six weeks of basic course and two weeks of observed practical in a health institution (hospital/health centre). TTBAAs may be asked to keep simple records with intention of allowing health system to monitor their activities (ZIHP, 2000).

Non-Governmental Organizations (NGOs) working in communities in resource poor countries frequently include TBA training in their activities. A number of governments, Bangladesh, for example, have also adopted this approach, supported by massive donor funding. International agencies including WHO, UNICEF and UNFPA have also supported TBA training. However, in recent years the value of TBA training has been increasingly questioned (Maine, 1993), although there are still groups who remain enthusiastic (De Brouwere, 2001). Evaluation of TBA training could potentially take place at several stages in implementation process. Possible consequences for evaluation include maternal morbidity or mortality, or perinatal mortality, percentage and nature of cases referred, percentage deliveries with trained TBA and behaviour change. However, the evaluation of TBA training process has not been as frequently or rigorous as might be expected.

2.1.4 ROLES OF A TRAINED TBA

The roles of a trained TBA are as follows:

- Provide health education to girls and women
- Assists in delivery of pregnant women
- Identifies and refers risks women during pregnancy and labour
- Solves problems in community concerning maternal and child health

2.1.5 FUNCTIONS

Apart from roles which are the main responsibilities of a trained TBA, they also have functions which are core tasks. The following are the functions of a trained TBA:

- Advices and prepares mothers for delivery
- Recognizes abnormalities and make referrals
- Undertakes safe delivery of normal cases in homes
- Collaborates with staff at nearest centre for registration and care of the new born.
- Participates in personal cleanliness and educate others
- Provide post natal care to mothers
- Advices mothers on traditional methods of family planning e.g. abstinence, prolonged exclusive breastfeeding for six months
- Under takes health education in community such as care for mother and baby feeding, nutrition of baby, immunizations, family planning.
- Encourage mothers to follow medical advice and treatment given at health centre or hospital.
- Inform mothers and community about the available health services and encourage them to use the services.
- Acts as a link between community and health staff.

2.2 GLOBAL SITUATION

It is now more than 10 years since the launch of safe motherhood initiative. During this time the challenges of improving maternal health and reducing maternal mortality have become widely recognized and the causes of the

problem much better understood. In many parts of the world especially in developing countries, however, this knowledge has yet to be put into practice. An intensified effort is being made by international communities to improve maternal health and reduce maternal deaths in these developing countries where majority of these tragedies occur (WHO), 2005).

According to WHO, reproductive health problems account for more than one third of the total burden of disease in women. The World Health Organization estimates that 500,000 women die every year from complications of pregnancy, including abortion and virtually all these deaths (99%) occur in developing countries. The major causes of maternal mortality in developing countries are anemia, hemorrhage, eclampsia, infections, abortion and complication of obstructed labour (Asghar, 1999).

But these deaths represent only a small proportion of the total morbidity and mortality attributed to the above causes. For every maternal death there are many more women in whom, after childbirth, disabilities develop with possible reduction in their economic activity. For example, it has been estimated that in sub-Saharan Africa for every maternal death, another 15 women are disabled or permanently crippled by incontinence, uterine prolapsed and infertility due to pregnancy of birth related causes.

Between two and three million African women are left handicapped from obstetric complications each year. Additionally, some women who survive delivery become chronically ill and eventually die from conditions such as diabetes and infectious hepatitis (Asghar, 1999).

WHO, UNICEF and UNFPA – produced a joint statement on training of TBAs, which says: "because of the current shortage of professional midwives, and institutional facilities to provide prenatal care, clean and safe deliveries, as well as a variety of primary health care functions, training of TBAs should be

promoted in order to bridge the gap until there is access to acceptable, professional modern health care services for all women and children” {Family Health International, 2005}.

However, the statement goes on to point out the limitation of concentration on TBAs training alone. Training TBAs can not be used as single approach to improving maternal and child health, without implementation of appropriate technologies and strengthening of referral and support system. Training of TBAs can be expected to reduce overall mortality and morbidity rates when poverty, illiteracy and discrimination – the underlying causes of these problems, are not addressed.

In England and Wales, women fared better than in USA. Information had been available since the first half of the nineteenth century. However, it was not until 1930 that the concept of “Primary avoidable factors” was identified and confidential investigations into maternal deaths were organized (Llewellyn Jones, 1974). Things then accelerated and in 1932, the Ministry of sent a mission to Denmark, the Netherlands and Sweden to find out how these countries managed to achieve their low maternal mortality ratios. The low Maternal Mortality Ratios were attributed to implementation of midwifery Policies (De Brouwere, 2001).

Studies in Africa and Asia have found that training of TBAs in the absence of skilled backup did not decrease women’s risks of dying during birth (Alto, 1991). However, TBAs can provide moral and emotional support to women as they are familiar with local customs and are likely to respect women’s needs (MOH, 2001).

2.3 REGIONAL SITUATION

Many African national governments, international agencies and donor agencies spend large sums of money to train TBAs in Africa. The justification for this

expenditure is that a large proportion of births are attended by TBAs especially where access to health care providers with more training and or resources is limited (Wallance, 1990). But does training of TBAs ultimately result in safer births? In collaboration with regional administration in Brong-Ahafor region, evaluation of TBA training was conducted in central Ghana during the mid 1990s. The purpose of the study was to determine the impact of TBAs practices and ultimately on maternal morbidity.

The study concluded that although the training had an effect on process indicators such as record keeping hygiene and knowledge about family planning, there was little evidence to support the hypothesis that training TBAs resulted in better health outcomes for mothers. The training did not have an impact on referral, excessive bleeding, and did not lead to greater use of family planning post partum (Family Health International, 2005).

In Nigeria, Auerbach (1982) conducted a study on implication of a decision making model used in Tunisia. This model was used to provide insight into factors influencing the choice of delivery setting. In this study, 32 women in Ksar-Heilar was asked where they preferred to deliver and where they had actually delivered their children. The findings revealed that, of the 53% of women who said that they preferred to deliver at home, 47% had delivered all their children at home. Of the 28% who said they preferred the hospital, only 9% had actually delivered all their children at the hospital.

A complex set of social, cultural and economic factors were involved in decision to seek care. These factors included psychological factors such as desire for emotional support and a desire to avoid humiliation and anxiety. Other factors included cost, the perceived degree of seriousness of the woman's condition and an evaluation of the effectiveness of medical treatment. Hospitals were preferred mainly for medical reasons, such as the ability to deal with complications (Family Health International, 2005).

The Uganda Demographic Health Survey reports of 1995 and 2000/1 indicate that overall antenatal coverage was close to 90%. Unfortunately, despite the high coverage, only about 39% of deliveries took place with a doctor, nurse or midwife in attendance. Records from Arua regional referral hospital, serving the area under study indicated that, of the women who attended antenatal services, only 10% returned for hospital deliveries during the period January 1994 to December 1997. It is clear that actually most women deliver at home alone, with relatives, friends or untrained TBAs (African journal, 2004).

The role, that quality of care plays in decision making to seek care, is related to people's own assessment of services delivery. People's judgment of quality of care largely depends on their own experience with the health system and those who provide care. Thus, their evaluation of care is generally shaped by realities they have encountered in health system. The two mechanisms in which quality of care affects the decision to seek care are satisfactory and or dissatisfaction with the out come (Thaddeus et al, 1990).

In Zimbabwe, the training of TBA as a national public health strategy was implemented in the late 1970s. Since 1982, the Manica land rural health program had trained 6,000 women in 12 week courses to change their unsafe practice such as the use of an sterilized razor blades and shreds of glass to cut the umbilical cord. These practices and others had led to high rates of neonatal tetanus and maternal mortalities.

During training they learned maternal and domestic hygiene, identification of pregnancy and associated risk factors, importance of good nutrition, rest, and immunization for pregnant women, safe practices in labour and delivery and maternal care services were provided as a backup (Tinker et al, 1996). These included villages based maternity homes for women in labour, Community Health Workers and auxiliary midwives with higher-level training. A district health centre

was set up for more complicated cases. Access to better health care led to a 50% and 66% reduction in maternal and infant mortality rates respectively. In spite of advancements made, however, there are still problems to solve as unsafe practices are resorted to when TBAs forget their training. Disruptions in medical supplies handicaps TBAs in the absence of skilled decrease women risks of dying childbirth (Tinker et al, 1993).

A recent study in Senegal has attempted to compare the impact of training professional midwives with training TBAs. It was discovered that maternal mortality was higher in areas where women gave birth mainly in health care centres assisted by TBAs, than in areas where women gave birth in health facilities assisted by midwives (Denis, 2000).

2.4 NATIONAL SITUATION.

Zambia has one of the highest MMR in the world. Despite the high number of antenatal attendance, currently estimated at 80% for urban and 68% for rural areas, maternal mortality ratio has increased from 649/100,000 live births in 1996 to 729/100,000 live birth in 2002 (ZDHS, 2001/2002).

It is estimated that approximately 50% of maternal mortality is directly attributed to the post partum hemorrhage sepsis, obstructed labour, abortion and eclampsia. Indirect causes of maternal mortality include anemia, malaria and HIV/AIDS related conditions. Other contributing factors include delays in accessing health care at community and health centre levels (MOH, 2004). Interventions in this area; include training of TBAs for rural areas where skilled health workers are not available.

There are some populations in which more than a quarter of their deliveries occur without health professionals but the level of maternal mortality is below 250 per 100,000 live births, countries such as: Peru, Tunisia, Egypt and Namibia.

Conversely there are other countries having half of their deliveries with health professional and yet maternal mortality remains high above 500/100,000 live births, such as Malawi, Ghana, Bolivia and Zambia. The key words here are “access and quality of care” (DeBrouwere, 2001).

Early detection of problems in pregnancy leads to more timely referrals in case of complications. This is particularly important in Zambia where the country is large and sparsely populated, and where physical barriers are a challenge to health care delivery system. Women who do not attend or receive antenatal care (ANC) during pregnancy are at high risk of obstetric emergencies and adverse reaction (CSO, 2003).

In an effort to provide safe motherhood and improve quality of care both antenatal and delivery, the districts managements teams, together with NGOs and international organization have been training traditional birth attendants, to recognize danger signs of pregnancy and delivery and refer the women early to health centres with skilled providers (CSO, 2003).

In Zambia a substantial number of TBAs have been trained through community initiatives. However, the annual district health plans and ZDHS reports (2001 – 2002) reveal that only limited numbers of trained TBAs are active and, in most cases, under utilized. The workload of TBAs varies considerably from place and among individuals. Some trained TBAs may only attend to family members and thus conduct only two to three deliveries per year while others have a wider clientele and a higher number of deliveries. It is unusual for a trained TBA to deliver more than 20 women in a year (WHO, 1992).

Data in Zambia indicate that at present 66% of 916 rural health centres have no midwives and 11 (1.2%) of the health centres have no staff at all. Medically trained providers assist 43% of deliveries while a relative or friend assist 38%.

and 12% assisted by trained TBAs and the rest of the women delivered alone (MOH, 2001). According to ZDHS of 2001 – 2002, traditional birth attendants only provide ANC of less than one percent in urban and 3 percent in rural areas. The survey also revealed that despite high antenatal care coverage majority deliveries (57.4) take place in homes, and despite the presence of trained TBAs, most women in rural areas still prefer assistance by relatives or untrained TBAs. The findings raise doubts on impact of TBAs performance of quality care on maternal health.

Women whose deliveries are assisted by unskilled attendants are at risk of dying from complications of pregnancy and delivery. Most medical personnel often report that women with obstetric complications arrive late in hospital and health centres and are in poor state that they can not be saved. The findings raise questions on quality of care being offered by trained TBAs (Thaddeus, 1990).

Maimbolwa (1998) undertook an evaluative study of the TBA programme in six districts namely, Kalomo, Chongwe, Serenje, Masaiti, Katete and Senanga. The results showed that TBAs have little impact on maternal and child health care in those communities devoid of access to health facilities. It therefore, justifies the continuation of TBA training. The report provides need for further research on support of TBAs.

2.5 CONCLUSION

Literature review shows that in many countries, training of TBA has been an important component of strategies to improve maternal and neonatal outcomes. The main benefits from training TBAs appear to be improved referral and as links to the formal health care system, but only where essential obstetric services are available. There is no conclusive evidence that trained TBAs can prevent maternal mortality, unless they are closely linked with health services. TBA training should be given a low priority and precedence given to other programme.

options that are based on stronger evidence of effectiveness, including the provision of essential obstetric care and of skilled attendant at delivery (Bergstrom, 2001).

Unless we address the issue of societal and hidden causes of poor health of women, the idea of improving health of women in developing countries is quite far fetched (Asghar, 1999). Maternal strategies should focus on building functioning primary health centre system from first referral level facilities to community level (Lives. 2005).

There is little doubt that TTBA have a significant role when it comes to cultural competence, consolation, apathy and psychosocial support at birth. TBA training process has not been as frequent and as rigorous as might be expected. Studies that have been done present a mixed picture. Several studies report that TBAs practice what they have learnt during their subsequent work in community. However, adoption of improved practices is not universal. The extra confidence gained from training experience may lead to a higher incidence of dangerous procedures and sometimes delays in referral.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

Research methodology is a broad term involving all strategies that describe how, when, and where data is to be collected and analyzed. This section describes the study design, data collecting tools and sampling methods used in this study.

3.2. RESEARCH DESIGN

A descriptive study design was used utilizing qualitative research method. The purpose of a qualitative study is to generate knowledge of social events and processes by understanding what they mean to people, exploring and documenting how people interact with each other and how they interpret and interact with the world around them. It also seeks to elucidate patterns of shared understanding and variability in those patterns (Ulin et al 2000)

The purpose of study was to explore and describe the community knowledge and perception towards trained TBAs in Siavonga District. The study design was chosen because the topic of research is of practical concern to the community. (Wilson, 1996). Qualitative research employs non-numerical data, collected through interviews, observations and narrative text or stories by some experts. Therefore, it made the study participants collaborate more actively with the researcher, generating rich, detailed data through expressions of their own views and experiences.

3.3. RESEARCH SETTING

The study was conducted in Siavonga District, one of the rural districts in the Southern Province of Zambia, situated 200km from the capital city Lusaka.

The district has a population of 70,081. It is connected to the capital city and the rest of the country. The rest of the roads are feeder roads, which are usually impassible especially in rainy season. The district has two first level hospitals, one district hospital (Government) and a mission hospital. These two hospitals are supported by twelve rural health centres, which are poorly staffed and in very hard to reach areas, yet most of the population live in these remote areas.

The climate is hot most of the year with very little rainfall; the landscape is hilly and rocky making agriculture and communication difficult. Most of the people of Siavonga District are poor and illiterate. Compounded with these problems, the provision of accessible quality health care services has been a problem, hence the training of TBAs.

The researcher chose Siavonga District as a study setting because the district is under developed. Most of the health centres are dilapidated and very far, communities have to walk long distances to access health services by qualified staff from these facilities.

3.4. STUDY POPULATION

The study targeted all men and women in the community where trained TBAs were found. This is because women get pregnant and are the ones involved in deliveries, while men (husbands) usually choose where to take their wives for delivery and pay and pay for the services. In short men are decision makers.

3.5. SAMPLING METHOD

The study utilized stratified sampling random sampling methods. Stratified random sampling is a variety of simple random sampling, in which, the population is first divided into two or more strata or subgroups (Polit and Hungler 1997). The aim of stratified sampling is to obtain a greater degree of representation. According to Brick (1996), stratified sampling designs subdivide the population into homogenous subsets from which an appropriate number of elements can be selected at random. The stratification may be based on wide variety of attributes such as age, sex, gender and occupation. In this study the investigator first divided the area in groups or strata and random sampling of pre determined size was obtained in each stratum.

3.6. SAMPLE SIZE

The sample size is “A subset of a population selected to participate in a research study” (Polit, 1995). The sample size comprised men and women who were assigned to five Focus Group Discussions. The five groups comprised of two groups of men and two groups of women plus one group of headmen. Both men and women were categorized by sex and age as indicated below:

- Young men aged – 30 years and below
- Older men aged 31 years and above
- Younger women aged 24 years and below
- Older women aged 25 years and above
- A group of Headmen in one of the selected areas

The group of participants comprised of 8 to 10 participants per group.

3.7. DATA COLLECTING TOOL

The study utilized a focus discussion guide to collect data from both men and women (see appendix 5). A total of five groups consisting of 8 to 10 people were formed. AFGD guide is an important tool for keeping the discussion centered while encouraging participants to speak spontaneously generating rich, detailed data from through expressions of their own views and experiences. FGD as a data collecting toll has advantages and disadvantages.

Advantages of FGD

The advantages of FGDs are, It:

- Enables researchers to obtain in depth information from participants
- It enables the researcher to obtain information from several people at the same time.
- It allows participants to share their thoughts and ideas, in this way they spark off new ideas and consider a range of views before answering the researcher's questions.
- Useful for programme evaluation purpose.
- It can help to identify strength, weakness and needed improvements.

DISADVANTAGES OF FGD

The disadvantage of FGD is that some people are uncomfortable talking in groups. The other disadvantage is that, the researcher who wants to use FGD must be skilled in facilitating group discussions.

3.8. DATA COLLECTION TECHNIQUE

Data was collected from 20th October to 22nd December 2006. To preserve confidentiality, FGDs took place in the veranda of the health post or under a tree far from noise and other activities. One and half days training for five research assistants was conducted. This was done prior to the starting of data collection. There was a need to train research assistants to help with recording of information from the discussion.

The researcher, with the help of research assistants, conducted five group discussions. Respondents were from a population of men and women who were willing and available to take part in the discussions. One group discussion was conducted at a time per day and was conducted in local language then transcribed into English later. The FGD provided the researcher an opportunity to observe interactions and relationships. The group interactions enriched meaning in the data.

The duration of the discussion took one and half hours. The researcher moderated the discussions. A tape recorder was used during FGD with permission from the group, ensuring that it did not disturb the participants. The FGDs were tape recorded to preserve data that may have been missed while taking notes. Tape recording minimized the need for detailed recall on the part of the researcher, thus, enhancing the accurate interpretation of data. Another advantage was that it gave the researcher the opportunity to focus on the informants than on taking notes.

The researcher introduced herself and the note taker and explained the role of each. Then the participants were requested to introduce themselves. Thereafter, the researcher explained the purpose of the discussions and continued guiding the discussion. At the end of the discussion the researcher summarized the discussion and thanked the participants.

3.9. CREDIBILITY

Pilot and Hungler (1997) points out credibility as one of the factor which can be used to access the rigor of qualitative data. Credibility refers to having confidence in the truth of the findings. In this study credibility was checked by the researcher by doing peer debriefing and talking to clinicians who work with trained TBAs and the communities at large, asking similar questions and evaluating the consistency of the informant's answers.

3.10. PILOT STUDY

A pilot study is a small scale study which is done before the main study on a small number of subjects. The subjects should be from a population with similar characteristics as that intended for the eventual project, but not from the actual study population (Bless and Achola, 1988). The purpose of the pilot study was to investigate the feasibility of the proposed study. The researcher was able to iron out any inconsistency in the test instrument.

A pilot study was conducted in Monze District from 9th October to 14th October 2006. Participants were randomly chosen from the selected strata on the basis of age, marital status and sex. This mini study was done to ensure clarification of questions and the data collecting tool. Two Focus Group Discussions (FGDs) were conducted one of males and one of females aged 25 to 30 years, and living in areas which had trained traditional birth attendants, that is, in Rusangu and Manungu catchments areas. This helped to modify and improve the instrument and methodology of the study.

3.11 ETHICAL CONSIDERATION

Ethical consideration refers to the respect and protection of the rights of the participants. Wilson (1996) states that “Protecting the rights of human subjects who are involved in research has become a high priority throughout all the professional and conscientious investigators when it comes to respecting the rights of subjects (Brink 1996).

To conform to the international code of ethics, the investigator obtained ethical clearance from the University of Zambia Committee (see appendix3). Permission to conduct the pilot study was obtained from Monze District Health Office, and for the main study it was obtained from Siavonga District Health Office.

An orientation meeting was convened with community leaders (that is, headmen) in order to allow the researcher to conduct focus group discussions. Those who accepted were requested to raise hands if not able to write while the literate were asked to sign the informed consent form (see Appendix 3). Participants' identities remained anonymous throughout the study. Participation was voluntary and respondent were allowed to discontinue at any stage of the process. If they so wished. However, none of the respondents declined to participate in the study.

3.12. STUDY LIMITATION

- The study was conducted at a small scale and in rural areas, therefore, can not be used to represent urban and per-urban communities where literacy and social-economic status are different.

CHAPTER 4

4.0 DATA ANALYSIS AND PRESENTATION OF RESEACH FINDINGS

4.1 DATA ANALYSIS

The qualitative data derived from FGD was analyzed using the principles of content analysis. Content analysis is a process of organizing narrative information according to merging themes and concepts (Ulin, et.al 2000). This entailed reading and rereading and vigorous study of each question in order to come up with concepts in the responses through the process of coding. Notes and observations were sorted into categories representing different ideas or themes.

Data was reviewed for completeness and accuracy. Clarification and interpretation of meaning and context were added to the transcript, major themes were identified. Themes were placed on a matrix of visual display of data for each group discussion. From the matrix (across groups and within groups) ,analysis was performed, all the similar ideas and impressions were written down according to themes. Audio taping of the discussion was done to allow for reported review of data and to achieve comprehensive interpretation against recorded statements.

4.2 PRESENTATION OF RESEARCH FINDINGS

4.2.1 Socio Demographic Data

The informants included 19 men between ages of 24 – 39 years (mean aged 32 years, mode -35 years), 20 women between ages of 19 to 35 (mean age – 27 years mode 28) and 7 headmen. The ages raged from 19 to 39 years. The educational level of the participants was generally low; most had not completed

primary education. Most participants were peasant farmers with limited finances. All the participants were married with children.

The study aimed at assessing community knowledge and perception towards TBAs, exploring factors leading to low utilization with a view to improve maternal and neonatal health. Five themes were identified which are:-

- (i) Knowledge about trained TBA
- (ii) Knowledge on health problems
- (iii) Access to trained TBA
- (iv) Cultural values
- (v) Attitude

4.2.2 Knowledge about trained TBA

The community knows about the presence of trained traditional birth attendants (TTBAs) within the community. They understood that trained TBAs were in a better position to help in problems of labour and delivery than the untrained TBAs. They know that TTBAs have been trained so that, they can identify problems and refer mothers to health centres and or hospitals early, as evidenced by the following statement, made by one female participant, *“Tulizi kuti bakaiya kuti kabakozya ku fwambaana ku bona mpenzi ciindi ca ku tumbuka a kufwambaana kutumya ku cibbadela”* translated as “We know that they have been trained to identify problems during labour and delivery, so that they can refer us to hospitals early.”

One of the responsibilities of the trained TBAs is to assist trained professional staff during ante natal and child health clinics, that is, taking weights for both mothers and children. Others distribute family planning pills in the community, but can not conduct ante natal clinic on their own as expressed in the following statement by one female participants, *“Tabapimi mada, ba boola buyo kutumbusya, baitwa.”* They do not conduct ante natal clinics; they just come to

assist during delivery when called upon. Most of the times they do not even know which pregnant women have reached term within their areas.

All participants perceived the trained TBA as a woman who assists mothers during normal labour and delivery and refers mothers with problems of labour and delivery to health centres and or hospitals. They concluded and emphasized on TTBA's being a link between community and health providers as some participants explained, *"kuti na waunka kucibbadela akagwalo antela bakusindikila, inga a bama nurse balafwambaana kukubona"* "If you go to the hospital with a letter or escorted by a trained TBA, the nurses will attend to you immediately". The majority of the participants acknowledged having taken part in the selection of TBAs for training, but some stated that, they were chosen by health workers while others by headmen.

4.2.3 Knowledge on Health Problems

All the participants (community) in the five groups were aware of at least three to four health problems faced by women who are pregnant and in labour such as:

- Headache
- Swelling of feet, hands and sometimes face
- Hemorrhage
- Retained products of conception
- Difficult and prolonged labour
- Dying of women in labour and after delivery.

According to the participants, the above mentioned conditions are worsened by lack of transport, long distances to health facilities. In addition, inadequate health care providers lack of equipment at health centre and very few health centres are also some of the factors that compound the situation. Generally, ill health of women due to over working was stated among women participants. One woman said *"Akubeleka, tobamakaintu tulabeleka maningi, wuunke kuteka meenda, akwalo kule, utebbe nkuni, anchito zimbi zyamaanda, kunyina a ciindi ca"*

kulyookezya.” ” As women we work very hard, you go to draw water from very far, go to fetch fire wood plus house hold chores, there is no time to rest.”

4.2.4 Access to Trained TBAs

Almost all participants cited poverty as a major cause of low utilization of trained birth attendants as most people could not afford to pay for the services. Moreover participants did not see the need to pay for the services considering that TTBAAs could not handle all problems faced by pregnant women. The majority of the people in the area sampled are peasant farmers with no extra income or income generating ventures.

Poverty made women vulnerable and helpless when it came to payment of services. Participants revealed that most of them were unable to access TTBAAs because they demanded a lot of money such as 5,000.00 to 10,000.00 or paying in kind. This means that they had to part away with some valuable utensils used during labour and delivery, as stated in the following statement by one participant, *“Na baku tumbusya balabweza mutiba uusambila mwana acibbafa cisambila batumbu, antela kufumbwa cabelesengwa mucindi ca kutumbuka”* translated as “when a TTBA assist you in delivery she will demand to get the dish used to bath the baby or container used by the mother or whatever has been used during the process of labour, delivery and post partum.” This indicates that because of poverty, they were not ready to part away with probably the only item they had (basin, pot and so on) since they could afford to buy another one.

The participants also expressed displeasure at some actions of trained TBAs as stated in this statement by one man who said. *“Wa mu leta TTBA ooyu wamubbadela, kwamana wakutuma kucibbadela ooko kuyandika cakweendela amali aakubbadela kuti na cakatazya kutumbuka. Nchibotu kuti batuyakila*

cibbandela babika a zyibesho, abalaaluziyibo mbuli midwife aba doctor” translated as “when you call this TTBA, , you pay her and she refers you to the hospital, now going to the hospital you need transport which you do not have and at the hospital you will need money for payments. It is better they build us proper health centres, well equipped with professional health workers like midwives and Doctors”.

Participants preferred having a health professional within their reach so that they incurred no extra expenses when the patient is referred for further treatment to the health centre or hospital. Villages in rural areas are scattered. This means, most people stay very far from the nearest TTBA. Couple with lack of transport, only very few women are able to access the trained TBA especially at night because of inadequate security. Due to security issues, trained TBAs refuse to be called at night, especially in places where they have to walk for 20 minutes or more. They feared for their lives as narrated by participants *that “Balayoowa nkaambo mazuba ayinda bakaintu bakajaigwa a mulumi wa mukaintu wakali kutumbushigwa nibaali kumusindikila cut ajokele ku Nganda yakwe”,* “The tTBAs fear to assist mothers at night because , some time back a trained TBA was killed by a husband of the woman she had assisted to deliver, as he escorted her back after delivering his wife”.

With regards to community work, working together as a single unit for the benefit of the entire community is a rare phenomenon. As a result most problems are solved at family and / or at individual level. This is attributed to high level of illiteracy. Participants believed that problems of pregnancy by nature were family problems, for example, transport to take a woman to the hospital is a responsibility of that particular family. In many instances families that are assisted by the good Samaritans in the community are expected to pay back later as described by one participant, *“Bakugwasha kkuzyiba kuti welede kuyo josyo,”* “if you are helped you should be ready to pay back later”. This has led to community problems such as: women not accessing services by the trained

TBAs. Lack of support to trained TBAs by community increase the low utilization of TTBA as only those who can afford to pay something can access them.

4.2.5 Cultural Values

Most participants in the FGD acknowledged that there were some cultural beliefs related to pregnancy which are still practiced in the community. Examples of socio cultural beliefs are:

- A pregnant woman should not stand in the door way as this would delay labour.
- A pregnant woman should not take a piece of meat from a pot to eat half of it and put back the other half as this could lead to placenta delivered in pieces and some pieces remaining in the uterus causing bleeding. A pregnant woman should not wear belts or necklace as this could cause the cord to go around neck or knots along the cord, causing fresh still birth.
- “**Nselezya**”, African medicine to easy up labour should be taken from 7 months or at the onset of labour. This helps to Quicken and eases labour and delivery.
- Both husband and wife should not have extra marital relations if the woman is pregnant, as this may caused obstructed labour.
- After delivery baby stays indoors for one month bathed in special herbal medicine and given the same water to drink. This is to prevent evil spirits from causing illness to the baby. Only close relatives are allowed to see the baby

The participants revealed that the main problem with trained TBAs is that they refuse to practice some of the above values even when they could not give any solution to the problem. It is believed that a woman with a delayed 2nd stage of labour was caused by standing in door ways and would be helped by bringing a small child on the doorway of the labouring and the child quickly pushed inside

then outside the room. This according to participants hastens the delivery of the baby.

If prolonged or obstructed labour is associated with adultery by pregnant woman, the woman would be made to confess. However, if it is her husband who committed adultery, he was also made to confess and the labouring woman made to drink water in which her adulterous husband's pant is first soaked. It is believed that once these processes are done the woman would deliver normally.

These practices are not practiced by trained TBAs and this makes them unpopular compared to non- trained TBAs and relatives, as revealed by women participants. The woman also reported that it was shameful for a pregnant woman to always request for assistance on issues related to pregnancy and labour. They would rather deliver alone at home. In this way she will be admired by many as being a real woman.

4.2.6 Attitude

Majority of both men and women in this FGD acknowledged that trained TBA were better than untrained TBAs in that, they have the knowledge of what exactly takes place during delivery, what could cause problems and that they are able to refer cases early enough than untrained TBAs, as indicated in the following statement by one participant. *"Luzyibo balijsi alimwi bali kabotu kwiinda bataikaiya. Babisya biyo kubbadelesha, akati balakatazya kujana, nkaambo bakkala mulemule abantu banji."* "Trained TBAs have knowledge and are better than those untrained. The only problems are, the fees they charge and the fact that they stay very far from most of the people they serve".

Accessibility to trained TBA is hindered by their demands after helping a woman. They are also reluctant to be called at night because of fear of being killed. Four (4) out of 5 groups narrated, as stated earlier, on how a trained TBA was killed by

a husband of the woman who had been attended to at night. This happened as she was being escorted back to her home after assisting his wife to deliver. This brought fear among trained TBA and the woman to be delivered, as revealed by both men and women in the following statement, *“Akaambo kaako tulayoowa kubaita masiku, kuyoowa kuti inga kabaya kubajaya Bantu bambi, bamana bakutamikizya nkaambo cakalicitikile kale.”* “Because of this we fear to call them at night, fearing that other people may kill them and put the blame on the one who called her because it had happened before”. The participants continued to say, *“Abalo lwabo bama TTBAAs bakatalika kukala baitwa masiku.”* This could contribute to low utilization of trained TBA.

The community also cited that most times these trained TBA stay very far away from the majority of the people and therefore, it is difficult to reach them especially that there was not form of transport to take them to where they could get help or for the trained TBAs to travel to where they are needed.

One other reason cited for trained TBAs being unpopular was the fact that these trained TBA's did not conduct antenatal clinics and do not follow up antenatal mothers. This reduces the trust pregnant women have in the trained TBA's. The community expressed that; they would prefer somebody caring for them from antenatal through to labour and delivery. Another draw back is that most trained TBA's did not follow cultural values.

The community acknowledged taking part in selecting who is to be trained as BA. They said that trained TBAs were good for consultations when problems arose and would like to see more being trained. However, they would want to see the government help in supporting them, for example, paying the trained TBA some income to help the community to access them. As one male participant put it; *“Bakaiya bali kabatu nkaambo inga mwabuzya cakucita mwapatila. Tulomba mfulumende kuti kababapa asyooonto biyo kutengwa katwaanguluka kubaita.”*

“The trained TBAs are good because you can consult them for any problem on pregnancy. We are only requesting the government to support them so that we can easily access them.” They said that, it could be better if there could be a TTBA in every village, no matter how small, as most households were far apart from each other.

Recommendations by the Community:

The participants gave suggestions on how TTBA utilization could be increased. The participants suggested that the government should provide TTBA with some incentives since they are trained and recognized to ensure all women access them. The participants felt that the government should pay salaries to these TBAs and ensure that each village has a TTBA. They also recommended review of TBAs training curriculum so as to make them more competent. They would like to see that these trained TBAs are well equipped otherwise there is no need to train them partially. It would be better for have qualified health workers within the community.

The community also suggested that TTBA be provided with means of transport to reach women and for referring women to hospital as many women have died due to lack of transport, if possible, it is better to built more health facilities. The participants also cited that in the absence of qualified health practioners and health facilities trained TBAs were a better choice.

CHAPTER 5

5.0 DISCUSSION OF RESULTS AND IMPLICATION TO NURSING

5.1 Introduction

Each year, millions of women, new born and children die from preventable causes. While the interventions that could save their lives are widely known, they are often not available to those in need (Sines et.al, 2006). According to Rudolf, et.al, (2005) more than sixty million deliver at home without skilled care. Moreover, nearly all (99%) maternal, new born and child deaths occur in low and middle income countries (Sines, et al, 2006). A continuum of care could meet these challenges and improve the health and survival of women, new born and children in such countries, which include Zambia.

Worldwide countries have turned to training of TBAs as a response to improving safe motherhood in areas where there are no health facilities. This study, has been done to assess the community knowledge and perception towards the trained TBAs with a view to improving quality of care by TTBA's and increase TTBA's utilization.

5.2 DISCUSSION OF RESULTS

In this study, the communities reported having knowledge of existence of trained TBAs within the community. They reported that trained TBAs were chosen by communities and that their work was to assist mothers during normal deliveries and refer complicated deliveries to health facilities. They also escorted maternal cases to health facilities for better and immediate service delivery.

Trained TBAs were also reported to be educating mothers in different health topics such as benefits of ANC, Nutrition in pregnancy, Personal hygiene and Family Planning. Participants revealed that these trained TBAs were very useful in the absence of a qualified health worker.

The participants in this study expressed knowledge of at least three to four health problems faced by women who are pregnant and in labour. Health problems like headaches, swelling of feet, haemorrhage, retained products of conception and difficult or prolonged labour were the most common health problems reported. The participants also revealed that these problems were made worse by lack of transport to take mothers to hospital or health centres, poverty and very little community support to pregnant mothers who develop complications at any stage of labour. They reported that these problems were compounded by inadequate health facilities in the area, poor health of mothers due to poverty, hard work and discrimination.

Majority of the participants agreed that more support to these TBAs in terms of equipment, transport and personnel emoluments were needed for TTBAAs to work better. The results from this study agrees with other researches done on trained TBAs by Maimbolwa, (2003) and who, (2005) which revealed that trained TBAs could not perform effectively without support services like referral services, and provision of qualified staff within reach and that trained TBAs were under utilized. They recommended that trained TBA should receive more education to make them more competent in handling complicated maternal and neonatal cases.

The community stated that the TTBAAs should be allowed to use some traditional ways of solving complicated deliveries especially where there was no transport to take the woman to the hospital. The community reported financial constraints (poverty) as one of the most challenging aspect countering accessibility of trained TBAs services. Inadequate support to trained TBAs by government contributed to inaccessibility of trained TBAs' services by mothers. Many mothers

are unable to access trained TBAs because of inability to pay. This was made worse by very little community support to pregnant mothers who developed complications during pregnancy. The problems are left to the close relatives to solve.

They also revealed that women sought medical help very late. They always wanted to try to deliver on their own or with the help of relatives, as this made them feel proud of their motherhood. Participants felt that, if the trained TBAs were conducting antenatal clinic, more mothers would be encouraged to consult them more often. Most women sought help by trained TBA when there was problem. This makes trained TBAs be perceived as consultants who can be consulted for any complication in the absence of a qualified health worker in communities devoid of access to health facilities. The participants appreciated the many ways in which trained TBAs were helping in service delivery, but at same time they felt that the help often offered by these trained TBA was inadequate in meeting their needs.

The FGDs also revealed that trained TBAs were not practicing cultural practices when assisting delivery of complicated cases, yet some times they were not even in a position to render help and no means of transport available to transport a woman to a health centre or hospital. This contributed to trained TBAs being unpopular and lowering the demands for their services. It has been discussed that some of the beliefs and practices instill rules and regulations that had to be followed or rituals that had to be performed. It is the beliefs that are harmful to mothers that need to be addressed.

The communities are calling for increased government financial support through building better roads, health centres and provision of transport such as ambulance services for maternal cases. The participants stated that there should be a trained TBA in every 3km diameter, to allow better accessibility.

Nevertheless, they would prefer midwives and well equipped health centres as close to them as possible.

Participants of this study echoed the ambivalence expressed by World Health Organization (WHO) (2003) and Family Health International (2005) that TTBAAs can not perform effectively nor help in reduction of maternal mortality without the support services. However, with present poverty levels prevalent country wide, the community agree to the fact that trained TBAs remain the only source of maternal and child health care in remote areas and therefore, until such time that there will be adequate professional health workers and facilities, trained TBAs should continue to be trained.

5.3 NURSING IMPLICATIONS

The study results indicated that the community required additional information about conditions and complications of pregnancy, labour and delivery. The few nurses in rural areas could play a critical role in meeting the informational role needs of the community. The results show the need for explaining to community about bad cultural practices and their effects on pregnancy and labour .However for the nurses and midwives to be able to discuss bad cultures with the community it is important that they learn and know the culture of the communities they serve. The health workers should emphasize on the need for the community to support each other and the trained TBAs and the importance of unity in the community. Education should include risk factors, causes and signs of pre-eclampsia and eclampsia. Prevention of Mother to Child Transmission (PMTCT) should be discussed with the community.

Nurses and midwives are well positioned to identify and implement health self advocacy for pregnant women and children. All nurses and midwives must collaborate with the trained TBAs for them to contribute effectively towards health care delivery at grass root level by involving them in out reach activities, having regular meetings with them and updating the trained TBAs with any new

development ensuring that trained TBAs know all the pregnant and postnatal mothers who need follow up after discharge from a health facility. Through such good relations, nurses and midwives could encourage and help to increase the utilization of trained TBAs by the community. Educative health talk may help change the community attitude towards supporting pregnant women who develop problems during pregnancy and labour. Community should also be made to realize that TBAs need support especially in security matters for them to work effectively.

5.4 CONCLUSION

This study was undertaken to assess the community knowledge and perception towards trained TBAs. The findings of the study show that the communities were aware of the presence of the trained TBAs among themselves the benefits they get from these TBAs. The communities were also aware of the common problems pregnant women faced in the community.

Accessibility to the trained TBAs was hampered by pregnant women' inability to pay, compounded by cultural beliefs, distance and lack of transport. The study revealed that a number of cultural beliefs which could be a danger to pregnant mothers were still being practiced. Therefore, there was need for health workers to enlighten the community on the importance of stopping these bad practices and encourage the good practices through Information, Education and communication (IEC).

However, the study also revealed that community had a positive attitude towards the trained TBAs, but lacked the knowledge that these trained TBAs needed their support and security. Another important finding was that Women acquired social prestige by being able to deliver in their homes; therefore, would only call for help when there was a problem. The study echoed the ambivalence expressed by

WHO (2003) and Family Health International (2005), who concluded that trained TBAs were usually used as consultants when there is a problem. The study proves the hypothesis that, trained TBAs are not performing as expected because of inadequate support, resulting in low utilization of them by community.

The community raised a number of issues hindering utilization of trained TBAs such as poverty, distance, social prestige, illiteracy and cultural beliefs. Although they appreciated trained TBAs, they stated that they would prefer professional health workers within their reach and not always having to travel long distances ,to places where there were no relatives to help and support them.

5.5 RECOMMENDATION

Based on the findings of this study the following recommendations have been made.

1. Government to fight poverty through community development projects in order to empower communities and improve community participation and involvement in their health.
2. More TBAs to be trained by DHMT and the catchments area for a TBA should be reduced from 1000 population to 3 km diameter for remote area, irrespective of number of people in the designated area since homes are scattered and it is difficult for trained TBAs to travel from place to place especially at night.
3. DHMT should ensure that supportive services, such as, referral systems and qualified health professionals are available and within reach.
4. The DHMTs to ensure Logistics are always available for trained TBA to use at all times.
5. Government to pay some form of personal emoluments to TTBA's so that all mothers access them.

6. Training of TBA to emphasize more on identifying of risk factor during ante-natal care by TTBA for early referrals.
7. The health workers should sensitize community on the need to support the trained TBAs and pregnant women in the community.
8. Government should help build health centres through self help projects in remote areas and ensure presence of qualified staff.
9. Policy makers should ensure good policy on retention of professional health workers in remote areas.
10. Replication of this study using a large sample and wider rural community to include opinions and practices of rural trained TBAs.

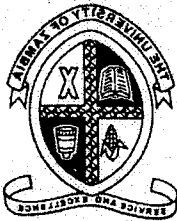
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THE UNIVERSITY OF ZAMBIA

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Ridgeway Campus
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Assurance No. FWA00000338
IRB00001131 of IORG0000774

20 September, 2006
Ref.: 026-06-06

Ms Himwiila Lucencia
Siavonga District Health Office
P.O. Box 16
SIAVONGA

Dear Ms Himwiila,

RE: RESEARCH PROPOSAL ENTITLED: "A STUDY TO DETERMINE COMMUNITY KNOWLEDGE AND PERCEPTION TOWARDS TTBA_s IN SIYVONGA DISTRICT"

The above research proposal was presented to the Research Ethics Committee meeting on 30 August, 2006 where changes were recommended. We would like to acknowledge receipt of the corrected version with clarifications. The proposal has now been approved. Congratulations!

CONDITIONS:

This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.

If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this Committee every six months and a final copy of your report at the end of the study.

Any serious adverse events must be reported at once to this Committee.

Yours sincerely,

Prof. J. T. Karashani, MB, ChB, PhD
CHAIRMAN

Date of approval: 20 September, 2006

Date of expiry: 19 September, 2007

APPENDIX 2

INFORMATION SHEET

Dear Participant,

You are requested to carefully read or have the information sheet read to you on the above study.

Introduction

I am Lucensia Himwiila a post graduate (MSc N) student at the University of Zambia conducting s study – **To determine community knowledge and perception towards TTBA's in Siavonga District.**

Purpose of Study

This study will mainly assess community knowledge and attitude towards the TTBA's, in order to improve community utilization of TTBA's. Data is therefore, required from you in regards to TTBA's utilization, accessibility and acceptability. I will ask you questions about TTBA's and other general issue on maternal and newborn health. You will also be given information on how you can work together with TTBA's.

Benefits and risks

Although this study will not benefit you directly, the information to be obtained may help to improve maternal and newborn health services within the community by TTBA's and guide managers in setting priorities in an environment of limited resources. There are no risks to you or your families by sharing the information.

Confidentiality

The discussions will be held in a quite place where there is no noise or any disturbances. You will be put in groups according to age groups and sex. Each discussion will take about one to one and half hours. This will allow each group member to consult each other and share ideas and problems. Your responses to the discussion will not be given to any one outside the research team and your names will not be written any where in the discussions. Even when the study is reported your identity will not be revealed.

You are informed that, participation in the study is voluntary, that you can withdraw your participation at any point of the discussion without any penalty. If you have any questions about the study, please feel free to ask me (Lucensia Himwiila) or write to me or my supervisor (Mrs. Ngoma) of the Chairman at the following address

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

or The Chairman
Research Ethics Committee
Ridgeway Campus
P.O. Box 50110
LUSAKA

APPENDIX 3

INFORMED CONSENT FORM

Declaration

I understand that my participation in this study is voluntary, that I may refuse or withdraw my consent at any time without penalty.

I.....here freely consent to take part in this research study.
(Participant's name)

Signature / Thumbprint..... Date.....

INVESTIGATOR

I have discussed the above points with the participants. It is my opinion that the participant understands the risks, benefits and obligations involved in participating in this study.

Signature of Investigator..... Date.....

APPENDIX 3b

University of Zambia
School of Medicine
Postgraduate
Department of PBN
P.O. Box 50110
LUSAKA

8th August 2006

The District Director of Health
Monze District Health Office
P.O. Box
MONZE

UFS: The Head
Department of Post Basic Nursing
Postgraduate
P.O. Box 50110
LUSAKA



Dear Sir

RE: STUDY PROJECT: - "The study to determine community knowledge and Perception Towards TTBA's in Siavonga District."

I am a postgraduate student at the above-mentioned institution, currently pursuing a Masters of Science degree in Nursing majoring in maternal and child health (MCH).

In partial fulfillment of the MSN degree, I am required to conduct a research study within the area of MCH.

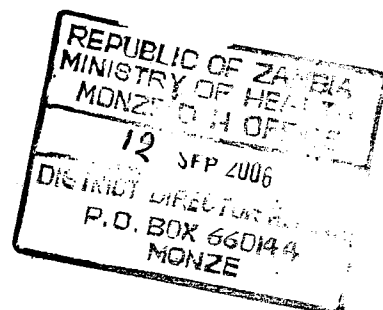
I would, therefore, be most grateful if you would grant me permission to conduct a pilot study to men and women in your catchment area where there are TTBA's. The study will be conducted in September 2006 with an aim to identify community knowledge and perception toward TTBA's in order to improve services by TTBA's and in turn contribute to reduction in maternal mortality and morbidity.

Your favourable response will be highly appreciated .

Yours faithfully

Lucensia Himwila

LUCENSIA HIMWILA (Miss)
RN, RM, BSc Nursing



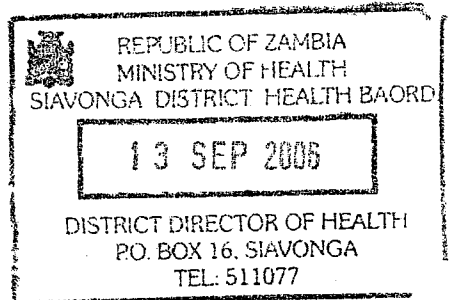
APPENDIX 3a

University of Zambia
School of Medicine
Postgraduate
Department of Post Basic Nursing
Box 50110
LUSAKA

8th August 2006

The Executive Director
Siavonga District Health Board
P O Box 16
SIAVONGA

UFS: The Head
Department Of Post basic Nursing
Postgraduate
Box 50110
LUSAKA



Dear Sir

RE: STUDY PROJECT: - "The study to determine community knowledge and perception towards TTBA's in Siavonga District."

I am a postgraduate student at the above-mentioned institution, currently pursuing a Masters of Science degree in Nursing majoring in maternal and child health (MCH).

In partial fulfillment of the MSN degree, I am required to conduct a research study within the area of MCH.

I would, therefore, be most grateful if you would grant me permission to conduct FGD to men and women in your catchment area where there are TTBA's.

The study will be conducted with an aim to identify community knowledge and perception towards TTBA's in order to improve services by TTBA's and turn contribute to reduction in maternal and newborn mortality and morbidity.

Your favourable response will be highly appreciated.

Yours faithfully

Lucensia Himwila

LUCENSIA HIMWIILA (Miss)
RN, RM, BSc Nursing.

Permission granted.
Dr. Rakungo J.
J.S.
Aug. P.P.H

APPENDIX 5

FOCUS GROUP DISCUSSION GUIDE

Purpose

To identify community knowledge and perception towards TTBA's in order to develop strategies to address the under utilization of TTBA's and improve maternal services.

Objectives

- To obtain information on community knowledge and perception towards TTBA's.
- To explore factors which could lead to low utilization of TTBA's?
- To obtain community input concerning potential strategies for improving maternal and new born health.

Discussion Topics

KNOWLEDGE

1. Do you have trained TBAs in your catchment area? If yes what do they do?
2. How far is the nearest TTBA's?
3. What are the maternal health services offered in your area?
4. Are you able to access these services? If not what are the reasons?
5. What are the health problems that women face in your area?
6. How far is the nearest health centre?

ATTITUDE

1. Are you able to access these TTBA's? If not why?
2. Would you prefer a trained or a non-trained TBA to attend to you during delivery?
And why?
3. Do you think it is necessary to continue training TBAs?
4. How often does a TTBA visit pregnant / lactating mothers?
5. Who chooses a TBA to go for training?
6. Do you support the TBAs after training? If so how
7. What are the social and cultural beliefs related to pregnancy in your area?
8. Out of those which ones are being practiced and why?

Suggestions for addressing the problem of low utilization of TTBA's.

- What are you doing as community to improve maternal and newborn health services?
- What would you like the government to do in your community to address the problems related to pregnancy and childbirth?
- How would you like TTBA's be helped in order to improve their work?

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