Trained Traditional Birth Attendants’ Perspectives on Governments’ Decision to Stop Community-based Deliveries in Kazungula District: A Qualitative Case Study of Mukuni Chiefdom

by

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DECLARATION

I, **Chilala Cheelo** declare that this dissertation hereby submitted for the award of the degree of Master of Public Health (Health Promotion) is my own work and has not been submitted either wholly or in part for another degree to this University or any other or to any institution of higher learning.

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ABSTRACT

In 2010, the government of Zambia stopped training traditional birth attendants (TBAs) and forbade them from conducting home deliveries because they were viewed to contribute to maternal mortality. Since then, there has been no study done to get the perspectives of the TBAs after the policy ban in Zambia. This study explored the perspectives of trained TBAs on governments' decision to stop community-based deliveries in Kazungula district.

This was a qualitative case study conducted in Mukuni chiefdom of Kazungula district. It included only trained traditional birth attendants purposively selected in Mukuni area. A census was considered that included all twenty-two trained TBAs from three clinic catchment areas. Six female traditional leaders were selected one from each zone. Expert sampling was used. Data was collected through focus group discussions, in-depth interviews of TBAs and key informant interviews for leaders. Thematic content analysis was used to analyse the data after coding findings manually.

The results showed that community-based deliveries continued despite the full knowledge of the ban by government. The reasons for the continuity include the lack of health facilities in some communities, poor transition methods from community-based deliveries to institutional deliveries, long distances and poor transport system, lack of delivery services at some local clinics and too many demands put up at clinics or hospitals. Trained traditional birth attendants continued conducting home deliveries because to them it was a moral duty they had to perform hence have no option because institutional-based delivery services were far from the communities. Effects of the ban included both negative and positive effects. Positive effects included TBAs having more time to do their own work, reduced criticisms from the community in case of a complication and quick response at health facilities in case of an emergency. Negative effects included extra work, high cost for lodging at health facilities, loss of respect and recognition by the community, introduction of penalty fees and getting back to untrained traditional birth attendants a situation which was worse than before the ban.

Despite the global redirection from traditional birth attendance to skilled birth attendance, there was need to domesticate policy decisions as a nation-based on local evidence and practicality.

Kazungula district where this study was done should be exempted from the ban otherwise the policy remains a mockery when staffing levels and health facility coverage remain low.

DEDICATION

This piece of work is dedicated to my dear wife Noreen Mubita Nawa and my beloved daughters Namwiinga, Namoonga and Namweemba Cheelo for their relentless love, moral and spiritual support. Always remember the world loves winners and has no time for losers, keep on keeping on until giving up gives up on you for it always seem impossible until it is done. Work for the night is coming when man works no more.

Lastly, I dedicate this dissertation to the ever living memory of my late parents Edward Nguluka Cheelo and Pauline Muloongo Cheelo. You were the best parents that ever lived.

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OPERATIONAL DEFINATIONS

For the purpose of this study, the following words used were defined as follows:

Community:- People who live in a particular area or location and share common identity.

Midwife:- Skilled birth attendant educated, trained and certified by the ministry of health to care for pregnant mothers during pregnancy, labour and after delivery.

Perspective:- This is a prospect, or a particular way of viewing something such as home deliveries by TBAs.

Traditional Birth Attendants:- Traditional experts who help women during delivery from home and rely on traditional beliefs and customs.

Traditional Beliefs: A strong belief about what customs say.

Safe Motherhood:- The care and services that women receive in order to be safe and health throughout pregnancy and childbirth.

Maternal Mortality:- The risk of an individual woman dying due to a pregnancy related cause.

Haemorrhage:- This is excessive bleeding by expecting mothers before, during or after child delivery.

LIST OF ABBREVIATIONS

AIDS	–	Acquired Immune Deficiency Syndrome
DMO	–	District Medical Officer
FGD	–	Focus Group Discussion
IDI	–	In-depth Interviews
HIV	–	Human Immune Deficiency Virus
KDHO	–	Kazungula District Health Office
KI	–	Key Informant
MDG	–	Millennium Development Goal
MoH	–	Ministry of Health
SBA	–	Skilled Birth Attendant
SMAGs	–	Safe Motherhood Action Groups
TBA	–	Traditional Birth Attendant
tTBA	–	Trained Traditional Birth Attendant
UNICEF	–	United Nations International Children’s Emergency Fund
WHO	–	World Health Organisation
ZDHS	–	Zambia Demographic and Health Survey

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Background

In order to attain good maternal health, there is need to put in place proper and quality reproductive health services to ensure a woman's safe transition to motherhood. Inability to do this results in hundreds of thousands of needless deaths every year (WHO, 2011). Maternal health refers to the health of a woman during pregnancy, delivery and the postnatal period (WHO, 2011). Maternal mortality is the death of a woman while pregnant or within 42 days after termination of a pregnancy irrespective of the site and duration of that pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO, 2007).

Among the eight Millennium Development Goals (MDGS) adopted at the Millennium Summit is the reduction of maternal mortality ratio (MMR) by three quarters between 1990 and 2015 (MDG 5). Key to this reduction is the utilisation of antenatal, delivery and postnatal services. The current maternal mortality ratio in Zambia stands at 398 per 100,000 live births (ZDHS, 2013/14) which is still high compared to the MGD 5 target of reducing to 165 per 100,000 by 2015. This ratio is significantly lower than the MMR reported in the previous ZDHS (591/100,000) survey of 2007 (ZDHS, 2007) that indicates that maternal mortality has decreased in the last nearly two decades as well as in the last seven years. The adoption of the MDGS by Zambia and many other countries was in an effort to mitigate the high maternal mortality ratio. However, in order to reduce maternal mortality there is need to reduce the ratio of skilled manpower to the number of women of reproductive age through increased training for midwives and doctors. This ratio cannot be reduced suddenly due to the inadequate staffing levels in health institutions. As a result of this shortage, Zambia like many other countries realised the need to adopt and train traditional birth attendants (TBAs) as an interim measure until every woman was attended to by skilled personnel. Therefore in 1973, Zambia initiated the training programme for TBAs whose goal was to reduce maternal mortality rate

(Blinkhoff, 1997). This was an effort to make delivery services as close to communities as possible.

TBAs were trained because they were a familiar part of the birthing process worldwide. In most developing countries with less availability of trained personnel and health facilities, women opted for TBAs because they were the only option. Health workforce shortages are key obstacles to the attainment of health-related Millennium Development Goals and as such task shifting is seen as a way to improve access to pregnancy and childbirth care (Owalabi, 2014). In many parts of Africa and Asia there is only one midwife for every 15,000 births (Fortney, 1997). According to Shiferaw (2013), overall only 16 per cent of deliveries were assisted by health professionals, while a significant majority 78 per cent was attended to by traditional birth attendants. This leaves out 80 per cent of women without access to a trained midwife with limited choices to the type of care during pregnancy and delivery and this trend has continued for many years (Hazemba and Siziya, 2010). In some cases even with availability of trained personnel and health facilities, women still chose the services of TBAs because they are easily accessible, acceptable, affordable and are culturally appropriate and respectful (UNICEF, 1997; Shiferaw, 2013). Therefore the World Health Organisation (WHO) began to strongly advocate and support the training and incorporation of TBAs in the health systems of most developing countries.

1.1.2 Alma-Ata International Conference

The World health organisation (WHO, 1992) defined a traditional birth attendant (TBA) as a person who assists a mother during child birth and who initially acquires skills by delivering babies herself or through an apprenticeship to other TBAs. The organisation further highlighted that a trained traditional birth attendant (tTBA) is any TBA who had received a short course of training through the modern health sector to acquire more skills. The main goal of TBA training was to reduce maternal and child morbidity and mortality and to improve the reproductive health of women. It is estimated that about 60-80 per cent of the babies in the world are delivered by traditional birth attendants and this trend

happens mostly in developing counties were over 88% of the world births occur (Fleming, 1994; Shiferaw, 2013). The recognition and subsequent training of traditional birth attendants came as a result of the Alma-Ata international conference on Primary Health Care (PHC) in 1978 that advocated for the collaboration between trained health workers (biomedicine) and traditional medicine in order to provide "health for all" by the year 2000 and beyond. The health for all goals seemed a far-fetched dream by most countries due to limited facilities and inadequate trained manpower since most communities had no access to proper medical facilities and services (Vansintejan, 1988; Titaley, 2010). As a result of this serious shortfall of manpower (skilled personnel), the conference recommended the incorporation of traditional practitioners as key partners with trained personnel to help with the problem at hand as well as to act as a bridge between the traditional culture and biomedicine (Fleming, 1994; Owalabi, 2014). Since then there has been increased interest of finding best ways to improve this collaboration especially in the third world countries.

The main emphasis and progress towards this partnership has been with traditional birth attendants than with any other traditional medical practitioners (Boerma, 1990). A recent study by Owolabi (2014) equally advocated and supported the need for trained TBAs to be involved in the provision of pregnancy care owing to the fact that TBAs were already frequently used by women and that alternative options were lacking in most developing countries. He however, stressed that the extent of TBA involvement needed to be context-specific and based on evidence of effectiveness as well as evidence of need, acceptability and feasibility.

As a result of this realisation WHO declared that, traditional medical practitioners and traditional birth attendants who are found in most societies were a part of the local community, culture and traditions and continue to have a high social standing in many places, exerting considerable influence on local practices. It was

therefore, worthwhile exploring the possibilities of engaging them in primary health care and of training them accordingly (Fleming, 1994: 143).

Therefore, throughout the 1970s and 1980s most countries started training programmes for TBAs in order to formally use them in an effort to reduce maternal mortality and improve child health. By 1985 more than fifty-two countries were running training programmes for TBAs including Zambia (Flemings, 1994).

1.1.3 History of Traditional Birth Attendants (TBAs) Training

Since the early 1920s, isolated training for TBAs were done by colonial powers and missionaries in third world countries as part of their efforts to provide free health care and education. However, it was not until the 1970s that leading policy makers identified the potential of the TBAs in lowering the high maternal and infant mortality and morbidity rates. In 1978, the Alma-Ata conference released a declaration that called for urgent and effective action to develop and implement primary health care throughout the world and particularly in developing countries. The conference noted that TBAs were, in most communities, an important part of the local setting hence it was worthwhile exploring the possibilities of engaging and integrating them into primary health care and training them accordingly (Kruske and Barclay, 2004).

WHO since then actively advocated for the recognition and training of TBAs throughout the 1970s and 1980s. In 1972, twenty-four countries had already done some training and by 1982, fifty-two countries were providing some training programmes for TBAs (Flemings, 1994). In 1982, WHO was confident that with stronger and expanded programmes, trained health workers together with trained TBAs would attend to two thirds of births by 1989. Owing to the numbers of TBAs that were receiving training throughout the 1980s, WHO encouraged health planners in 1990 to promote the provision of trained birth attendants for all

women. Unfortunately, there was in some countries little quality control in the design, content and implementation of these programmes (Barclay, 1998).

In 1987, some international agencies United Nations International Childern's Fund (UNICEF), the World Bank, the International Planned Parenthood Federation and the Population Council, WHO funded the first international conference on safe motherhood in Nairobi, Kenya. The objective of this conference was to draw particular attention to the consequences of poor maternal health in developing countries and to mobilise resources and action to address the high rates of maternal mortality and morbidity. This group of international agencies became the founding members of the Safe Motherhood Inter-Agency Group (IAG) and the Safe Motherhood Initiative was launched with the aim of reducing maternal mortality by 50 per cent by the year 2000. Since then members of the IAG had to a large extent influenced global policy development and funding support for maternal and child health services and TBA training. This group was further empowered when other international agencies such as the International Confederation of Midwives (ICM), the International Federation of Gynecology and Obstetrics (FIGO) and the Regional Prevention of Maternal Mortality Network (Africa) joined the coalition in 1999 (Starrs, 1997).

In the initial stages, the training programmes for TBAs focused on reducing maternal mortality rate by encouraging TBAs to provide antenatal care services and improve intrapartum and postpartum practices. WHO and other leading health agencies anticipated the provision of antenatal care by TBAs would lead to early detection and referral of complicated cases. Combining their traditional experiences with training, TBAs were expected to reduce infection and postpartum hemorrhage rates, which remain two among the major causes of maternal death in pregnancy and childbirth. Infection rates could be reduced by improvements of hygienic practices, among them hand washing, use of gloves and proper cord care. Hemorrhage rates could be reduced by the correct third stage management of labour. Health education during antenatal and postpartum

would promote prompt referral of complications by the TBA to other professionals though this was not able to address access, costs or acceptability of referral by women or their families (Leedam, 1985).

The training programmes differed from country to country in terms of content and length in some cases ranging from several days to several months with the majority occurring over 2 to 4 weeks. This meant that even evaluations differed and measured many outcomes including the knowledge, attitudes and behaviour of the TBA. For many government and senior policy makers, however, success was focused on only one performance indicator; the ultimate reduction of mortality rates (Leedam, 1985).

1.1.4 Impact of TBA Training on Maternal Mortality

Many studies on the impact of TBA training globally have indicated little or no maternal reduction for which they were intended. In 1990 for example, 585,000 maternal deaths were reported globally indicating 80,000 more deaths than previous estimates (WHO, 1996). Many stakeholders attributed this to practical difficulties such as poor literacy and lack of scientific knowledge by TBAs for failure to effectively contribute to maternal mortality reduction in countries that had invested in TBA training. This assumption led to the WHO, UNFPA and MCH joint statement issued in 1992 that training of TBAs were to be considered only as an interim measure until all women have access to professional and modern health care services (WHO, 1992). As a result of poor impact and increase in maternal deaths despite training many TBAs, some countries including Zambia since then stopped training them and banned community-based deliveries. However, recently some studies in various parts of the world have shown positive results with the training of TBAs in reducing maternal mortality especially if and when adequately supervised. Suggested strategies for this to be achieved included training on infection prevention and supervision of TBAs, collaboration skills for health workers, inclusion of TBAs at health facilities, enhanced communication systems and clear definition of roles. Impact on skilled birth attendance depended

on careful selection of TBAs, community participation and partnerships and addressing barriers to access. Nevertheless, the success of these approaches were context-specific (Byme and Morgan, 2011; Chanda, 2013; Shaikh, 2014, Owolabi 2014).

1.2 Statement of the Problem

Kazungula district located in southern province has a total population of 113,666 out of which 25,007 (22% of total population) are women of childbearing age (CSO, 2014). The district has no hospital hence has only one medical doctor who is also the District Director of Health giving a ratio of one doctor to 25,007 women, seven midwives against twenty-two health facilities giving a ratio of one midwife to 16,238 women needing maternal care. The district with ninety-seven trained TBAs with a ratio of one tTBA to 1,172 women needing maternal care. Skilled deliveries have dropped from 13 per cent in 2012 to 9 per cent in 2013 deliveries conducted by midwives. Institutional deliveries conducted by other health workers other than midwives and doctors from 2010 when the directive was given to 2013 stand at 39 per cent, 41 per cent, 43 per cent, and 40.7 per cent respectively (Kazungula HMIS, 2014).

Given such shortages of human resource in the district, traditional birth attendants become handy to help deliver women in the community. The probable cause of the ban by government was with the view that traditional birth attendants contributed to the high maternal and infant mortality. Without enough domestic empirical evidence government stopped trained traditional birth attendants from their practice in 2010. While this may be a plausible act given the global background, there was no research to consider the perspectives of the community in abandoning this community-based approach and to-ate there no follow up have been done to assess the perspectives of the community. A recent study done in Chongwe district (Chanda, 2013) however showed positive results following the training of TBAs hence the need to explore the possibilities of rolling out the strategies used there to other rural districts with poor staffing levels.

It is possible that there are effects both positive and negative on the trained traditional birth attendants, the neonates and the community as a whole. In the absence of research

therefore, community perspectives are critical in informing the development of the project or stopping it. This study aimed at getting traditional birth attendants perspectives on governments' decision to stop training TBAs and ban community-based deliveries. This would help the Ministry of Health and the Kazungula district to make evidence-based responsive actions to the cultural and health needs of the people to increase institutional deliveries that are low and stand at 40.7 per cent in the district (Kazungula HMIS, 2014).

1.3 Rationale of the Study

From the literature that was reviewed it clearly appears that from the time the Ministry of Health announced the ban of training and delivery services of TBAs, there has been no research done to assess how communities had responded to this order and whether they had complied or not. This research has added to the body of knowledge by bringing to light the perspectives of communities especially in rural areas where people have limited access to skilled personnel hence depended on traditional birth attendants for a long time. The research findings will also help inform policy makers whether the decision to stop TBAs from conducting deliveries need to be revisited owing to the large number of births they attended to and the limited facilities for skilled deliveries especially in rural areas. The finding shall help improve maternal and child health by planning programmes tailored to the needs and wishes of the communities whom they are supposed to benefit.

1.3.1 Justification of the Study

Currently, there is a controversy on the topic of traditional birth attendants globally and nationally for and against their practice and incorporation in the health care systems. Although the government of Zambia stopped training TBAs and discouraged community-based deliveries, some studies done in Chongwe district recently showed positive results from training traditional birth attendants. A study by Chanda (2013), advocates for TBAs sustainability owing to infection reduction among women attended to by tTBAs after the use of the new training curriculum. This study will help add knowledge to the current discussion on the

effectiveness of TBAs with a possibility of reversing or maintaining the ban. However, few studies in Zambia and elsewhere have been done to get the perspectives of the traditional birth attendants over the ban of their delivery services.

In addition, there has been no similar study done in Mukuni Chiefdom previously. The omission created a gap in the body of knowledge that has been filled by this study.

Finally this study has a great resource base because it has among other things:

(a) Stimulated policy makers in the Ministry of Health and the programme managers at Kazungula district health office to developing public health programmes, messages and guidelines that are responsive to the health needs of the communities. This will help create a competent and caring health care environment;
(b) Generated a methodological framework for studies to consider much wider research especially quantitative studies; and
(c) Interpreted TBAs opinions in order to help incorporate their knowledge and experience into the health system policy and practice for maternity care.

1.4 Research Question

What are trained traditional birth attendants' perspectives on government's decision to stop community-based deliveries in Kazungula district of southern province?

1.5 Research Objectives

1.5.1 General Objective

To explore trained traditional birth attendants' (tTBAs) perspectives on governments' decision to stop community-based deliveries in Kazungula district, Southern province.

1.5.2 Specific Objectives

1. To investigate the persistence of community-based deliveries.

2. To ascertain adherence to the policy ban by trained traditional birth attendants.

3. To assess from the point of view of the social actors the effects of the ban.

4. To describe the current scenario (birthing practices) where delivery services are not available.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Since the Alma-Ata conference in 1978, there has been an increase in literature surveys on the characteristics, attitudes and practices of traditional birth attendants aimed at informing policy action on integrating TBAs. Therefore, even if survey of literature shows that little has been researched on the institution of traditional birth attendants in Zambia since the withdraw of their community-based services, this topic seems to have attracted a lot of attention the world over as health organisations in various countries, especially those with low income economies, have considered cooperation between modern and traditional midwifery. Thus, this section will not only survey literature on traditional birth attendants in Zambia but will also include those on other countries that have informed this study. The study will look at literature on traditional birth attendants in particular, the integration of this cadre into the health systems and their activities in general.

Several studies in various parts of the world have been conducted concerning traditional birth attendants and whether they play a positive role in maternal and child health services. This section of the thesis reviews studies that have been conducted on traditional birth attendants for and against their practice and incorporation in the health care systems. These studies took different approaches; some involved talking to the traditional birth attendants themselves while others involved health workers and the community. Themes according to major issues for and against traditional birth attendants have been generated. The main themes generated are health worker perspectives on traditional birth attendants, perspectives on traditional versus modern delivery services and perspectives on transition from traditional to skilled deliveries which are discussed in detail here under.

2.1.1 Traditional Birth Attendants; a Health Worker Perspective

The following publications make important contributions to the field of traditional birth attendants in an attempt to inform policy makers on what problems TBAs face. They argue for co-operation between traditional and modern midwifery in the countries of study but with different views on how to integrate the two.

Anderson (1988) describes traditional birth attendance in Botswana as possessing a rich culture that informs childbirth at local level and is considered important at community level. To show this, she explored the common practices in this kind of midwifery and the relationship the TBAs had with their communities. However, she bemoans the ignorance, non-consideration and absence of this aspect by modern medicine under the integrated system of health in Botswana (Anderson, 1988). Even though Andersons' writings are based on Botswana, her work is important to this study because she shows not only the practices of the traditional birth attendants but also the relationship that exists with modern biomedicine. This shows a non-porous and less meaningful communication between the two systems; traditional and modern medicine in the integrated Programme.

On the other hand, Maimbolwa (2004) shades more light about midwifery in Zambia and the challenges that it faced. She echoed the concerns raised at the Alma-Ata conference on how difficult the declaration on health for all was to be achieved in the field of midwifery in countries with poor economies like Zambia. Her major concern was how best to equip and improve modern midwifery. She acknowledged the importance of traditional birth attendants to maternal health in Zambia. However, she was quick to point out the need for the training in the field of traditional midwifery which she explained was based on "superstitions and myths reflecting a lack of basic knowledge of the physiology of the birth process" (Maimbolwa, 2004: 11). In another study done earlier by Maimbolwa (2003), she added that TBAs also locally known as *mbusas* in Zambia lacked understanding of the causes of obstetric complications during child birth, and had inadequate

knowledge on the appropriate management of labour. She however, said that they were very instrumental in providing social support to women during labour and delivery. Ngala (2012) agreed with this argument in a study done in Cameroun and said in many African communities, TBAs were highly respected because they performed important cultural rituals and provided essential social support to women during childbirth. In all cases, their beliefs and practices were influenced by local customs and sometimes by their religious beliefs.

The knowledge gap identified by Maimbolwa was also identified by Chanda (2013) in a study done in Chongwe but were addressed in the new curriculum for training TBAs. The training showed positive results especially on infection prevention. Echoing similar sentiments was Isenalumbe (1990). Writing on the integration of traditional birth attendants with the modern health care in Zaire (present day Democratic Republic of Congo), he observed that even if traditional birth attendants were an important part of maternal health they required some "professionalism" which they could get by training from the health personnel (Isenalumbe, 1990: 197).

Fleming (Fleming, 1994) is another author who also shared these sentiments. Covering a general world perspective on the integration of traditional birth attendants, she stated that, "traditional and cultural practices of unschooled, indigenous attendants have been alleged to compound or even create problems" in maternal health (Fleming, 1994: 143). She observed that this prompted WHO to recommend skilled personnel to be present at every birth, leading to the acceleration of the training of traditional birth attendants. This view is shared by Maimbolwa who pointed the fact that, a traditional birth attendant, with or without training was not recognised as "skilled" (Maimbolwa, 2004: 8). She explained that the difference between a skilled attendant and a midwife was that a skilled attendant focused on delivery care while a midwife's scope of practice covers sexual and reproductive health in a life perspective. This classification by Maimbolwa did not at all include the traditional midwife who was a TBA.

Maimbolwa, Fleming and Isenalumbe seem to advocate for hospital deliveries and the training of traditional birth attendants to ensure safe child delivery and motherhood. However, Bohren (2014) who analysed studies from seventeen countries in Africa argued that the emphasis placed on increasing facility-based deliveries by public health entities had led women and families to believe that childbirth had become highly medicalised and dehumanised. He further argued that when faced with the prospects of facility birth, women in low and middle income countries feared various undesirable procedures and may prefer to deliver at home with a traditional birth attendant. Bolren seems to advocate for traditional birth attendance for normal deliveries.

The literature reflects on how traditional midwifery was perceived by these authors in maternal and child health. A reflection on the above discussion indicated that the traditional birth attendants lacked knowledge and thus, must be trained for their manpower to be effective since whatever they seemed to know was mere superstition and only further aggravated the problems in maternal health. Nevertheless, the most important point to realise was that even if the traditional birth attendants could be trained they still remained and were considered "unskilled". Needful also to point out is that in the literature above the traditional midwife is referred to as a traditional birth attendant, a term that may express the view of what a traditional midwife was perceived to practically be in some medical circles.

2.1.2 Traditional verses Modern Delivery Perspectives

There is literature that is concerned with natural and traditional home births as compared to institutionalised high technology modern births like in hospitals or clinics, common in modern skilled midwifery. Even if the literature under this section does not directly address the issues of traditional midwifery per se, the issues it raised reflected on traditional midwifery as it fell in the category of home

birth on most principals, especially the practices. Therefore, such literature has a big bearing to this study.

Davis-Floyd (2001) explored institutional births as being subjected to high technology associated with western medical system; a model he called a techno medical model (David-Floyd 2001). He questioned why public health programmes like safe motherhood initiatives, are influenced by techno medical perspectives. Advocating for natural birth he argued that in the last 20 years it had become clear that most of the routine obstetrical procedures in hospitals had no scientific evidence to justify them (David-Floyd, 2001). He explained that the main problem was not the technology itself per se but the approaches employed. He further argued that the techno medical model depended so much on machines that would be a hindrance and not a solution to a safe birth. He however stressed on the nature of techno medical model as having a non-holistic approach as its main problem. He again shade more light by saying that in techno medical model everything was separated; birth was separated from nature, from home and family, from body and spirit, from mother and baby and from the human touch of mother and midwife relationship, when machines take centre stage. Alvesson (2013) in his study in Loa was also against the separation of the woman in labour from her family and tradition. In order to assure safer births and reduce high mortality rate, health centres could consider accommodating the wishes and traditional practices of the people they saved. He argued to place more emphasis on natural birth such as viewing the body as an energy system and recognising subjective knowledge such as intuition into the medical field. These sentiments were shared by Bohren et al. (2015) when he argued that besides using machines, skilled health workers were mostly abusive to their clients in labour through verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and the health care providers. This made traditional deliveries to be preferred by most women. Vogel (2015) agreed with Bohren in his study and claimed that globally many women experienced

mistreatment during labor and childbirth in health facilities which posed a barrier for women to attend health facility deliveries contributing to poor birth experiences and adverse outcomes for women and newborns.

These arguments are equally echoed by Gaskin (1978) and Langer (1998). Gaskin likened a woman in labour to elemental forces such as gravity and earthquakes in what she calls the spiritual energy of birth and recommended the use of intuition. On the other hand, Langer noted that the social support given to women during labour in a home environment, improved the birth process a lot and eliminated the common problems of the techno medical model approach such as episiotomy, forceps and caesarean section (Langer, 1998; Titaley, 2010).

Some scholars argue that in the interim before skilled health workers could be available for every delivery, traditional birth attendants could act like 'spare wheels of a car' that could be used in emergency situations when tyres fail (Chanda, 2013). She argues for the need to continue training, monitoring, evaluating and documenting of the impact of the TBAs' practices using the modified Ministry of Health TBA training curriculum in the Zambian context and the incorporation of traditional aspects to the training that are not harmful to maternal health. She concluded her study in Chongwe district by recommending the formation of an association that would advocate for tTBAs sustainability.

Literature gives researched support to some common beliefs and practices that the TBAs have been relaying on for centuries such as intuition, social support and natural forces such that it can be assumed that the traditional midwives are well knowledgeable. The literature also showed that there were various viewpoints or perspectives on the practices of birth either traditional or modern.

2.1.3 Perspectives on Transition from Traditional to Skilled Delivery

Arvidson (1998) equally explored the trends of midwifery in Zambia and hence adds more to this discussion. She elabourated how Zambia after independence conformed to the western medical delivery system which essentially meant changes from home delivery to institutional delivery with a view of providing a safer child birth. She however observes that for a meaningful transition to take place there is need to address medical issues based on their local appropriateness and hence applied accordingly. She further argues that in order to effectively engage patients in health promoting and prevention measures, health workers equally need to understand lay beliefs and attitudes. According to her, she noted that there is evidence that institutional delivery in Zambia is at odds with traditional values associated with childbirth, highlighting that, childbirth as a social event has been undermined and the fragmentation of the health services have imposed a culturally insensitive approach on the trained midwife.

Maimbolwa (2004) also agreed with this sentiment when she stated that her training as a midwife did not include anything about the traditional practices and beliefs such that as a qualified midwife later, she had no idea how to deal with certain situations that confronted her when dealing with her clients. This is in agreement with a study by Shiferaw (2013) in Ethiopia which indicated the crucial role of proper health care provider-client communication and providing a more client-centered and culturally sensitive care if utilisation of existing health facilities was to be maximised. In a similar qualitative study done on the Java Island in Indonesia, results showed that the use of traditional birth attendants and home delivery were preferable for some community members despite the availability of the village midwife in the village as the community perceived the role of both village midwives and traditional birth attendants as essential for providing maternal and health care services (Titaley, 2010). Titaley advocated the formulation of Public health strategies involving traditional birth attendants that would be beneficial particularly in remote areas where their services were

highly utilised. Additionally, Ndima (2015) in a qualitative study done in Mozambique observed that the main problem in linking community health workers (TBAs) to the health care system hinged on poor supervision. Supervision was structured as directed by policy while in practice it was infrequent and irregular. When it occurred, it was felt that more focus was on fault-finding than being supportive and this demotivated them. He concluded that with proper supervision and support community health workers would work effectively and contribute to improved maternal health.

These observations revealed that while modern medicine incorporated traditional birth attendants by training them in modern methods of child delivery, health professionals themselves want very little or nothing to learn from traditions and customs. Staugard (1998) put it crystal clear when she posed questions such as "are women including TBAs in health development, partners or recipients?"

Lugina (2001) brought out another dimension to the discussion by bringing in studies about childbirth in Tanzania and the problems faced in institutional delivery. She noted that even if birth was the climax of pregnancy, it is not the end in itself. She notes that the biggest problem with institutional delivery was the "shorter stay" model introduced to most developing countries, which has created problems in the aftermath of birth where the problems and complications that women faced are not adequately addressed by the health system.

This was due to lack of capacity to make follow ups of women at home. She attributed this problem to models of care in the health system that originated from developed countries and were transferred to low income countries without serious consideration of their adaptability and cultural compatibility in such countries. She argued that the model of hospital deliveries and shorter stay after delivery was introduced to low income countries where no specific plans were developed for follow up, leading to no or poor access of professional help to women and

children once at home. She also noted that TBAs in low income countries lacked adequate knowledge and skills especially in postpartum care.

Phiri (2006) shade more light to this argument when she said "before planning of health programmes, policy makers should consider the cultural norms of local people such as language, the way they viewed illness and other such cultural aspects". However, this was not enough, there was need for local knowledge to be identified, explored and where it applies to be put to use for any sustainable development to take place. Mammo (1990) added by saying development efforts that were applied by scrapping off the old system and introducing completely new ones without appropriate continuity from the past had contributed to Africa's poverty and underdevelopment.

Many years of safe motherhood programming have demonstrated that isolated interventions would not reduce maternal mortality sufficiently to achieve MDG 5. Although skilled birth attendants (SBAs) intervened to save lives, traditional birth attendants (TBAs) were often preferred by communities. Considering the value of both TBAs and SBAs, it was crucial to review strategies for maximising their respective strengths for the benefit of the community (Byrne, 2011).

It appeared reasonable therefore, from the many studies to even assume that for decades to come, the traditional birth attendants will continue to have a substantial influence and a critical role to play in the health practices and life habits of rural populations even when modern health services are made available to them (Joseph, 2011).

A summary of the main issues coming from the above discussions indicate that although traditional birth attendants are recognised worldwide for their work, modern biomedicine wanted very little or nothing to do with the knowledge of TBAs. Many studies have shown that TBAs were useful for the improvement of maternal health if well trained, supported and constantly supervised. However,

some studies too, are against the use of traditional birth attendants and claim they were a hindrance to improved maternal and neonatal care. Their effectiveness or ineffectiveness was however context specific hence the need to have local empirical evidence for any action for or against them to be justified.

From the literature reviewed this far, it is clear that there are different points of view on the effectiveness of TBA training and their impact on reducing maternal mortality worldwide. It is from the background of lacking evidence on their positive impact that the Zambian government decided to stop training TBAs and stop them from conducting delivery services in the community in 2010. From that time to date, no research has been done to get the perspectives of the traditional birth attendants let alone the community, on the decision by government to stop community-based deliveries. None of the studies above has shown the perspectives of the TBAs since the ban hence this study will add to the body of knowledge.

2.2 Theoretical reflection and framework

It is clear that public health programmes that incorporate safe traditional beliefs and practices are a good initiative and should be encouraged. However, there seems to be a problem where modern midwifery which does not recognise TBAs' knowledge and skills. This has led to professionals to discriminate knowledge from other disciplines by that seems different from theirs. This concept is supported by feminist critiques in development who argue that more often than not the knowledge that comes from women is looked down upon and placed outside the concept of development. This undermines the success of well-meaning and well-intended programmes such as the safe motherhood initiative proposed by the Alma-Ata conference. Admittedly, no one system is perfect hence the need for dialogue and an exchange of notes between modern and traditional knowledge to come up with a more stronger body of knowledge and skills for improved maternal and child health (Engelstad et al., 2005; Shiferaw, 2013). Skilled attendance at birth is a distant reality in many developing countries Zambia inclusive and effective community-based strategies are needed to help reduce high levels of maternal mortality.

Despite having been unsuccessful in handling obstetric complications, TBAs have contributed to successful maternal, neonatal and child health interventions. The most important and key piece missing in TBA training is adequate and effective referral system which would link expectant mothers to skilled attendants due to their close ties with the community (Owalabi, 2014). Therefore, training for TBAs should be done in appropriate settings. It is imperative however, that their training should be adequately evaluated in order to develop the strong evidence base that is needed for sound policy decisions and programming (Sibley and Sipe, 2004). The study was guided by the health service coverage and evaluation theory by Tanahashi (1978).

The theory has been used widely to assess health services (Lungu, 2007). Since the TBAs were providing a service to the community, stopping them was likely to affect availability, accessibility, acceptability and affordability of the health services within their communities. Therefore this theory fitted well in this study.

Modified Health Services Coverage and Evaluation Tanahashi Theory (The Five As)

Health service coverage is regarded as a concept of the extent of the interaction between the people and the service intended for them and the ability to transform the intentions to serve people into successful interventions. The evaluation of coverage based on this concept enables management and decision makers to identify bottlenecks in the operation of the service, analyse the constraining factors responsible and select effective measurements for service improvement. Successful transformation of interventions involves scrutiny of a number of factors such as availability of resources and manpower, distribution of facilities, supply of logistics and peoples attitude towards the service (Lungu, 2007).

It is not easy to effectively observe the many processes involved in providing health care but it is possible to observe the number of people for whom the service has satisfied the criteria relating to its intended health intervention and compare that number with the

target population. Looking at the process of evaluating health service coverage and its utilisation identifies five important stages that successively lead to a desired health intervention namely *availability, accessibility*, *acceptability*, *affordability and appropriateness (*the five As).

Availability

In order for people to utilise the health service some resources like manpower (staff), facilities, drugs and equipment must be available. The availability of such resources will determine the capacity of the service which in turn decides the amount of services that a community will receive. People can only utilise what is available to them.

Accessibility

The availability of a service does not always guarantee its utilisation unless it is located within reasonable reach of the people who should benefit from it. Accessibility is considered the second condition needed for satisfactory service provision. The capacity of the service is limited by the percentage of the people who can reach it and utilise it.

Acceptability

Accessing the service is one thing and accepting it is another. Once the service is accessible by the community it needs to be accepted otherwise people will not utilise it and hence seek alternative options. Acceptability may be influenced by a number of factors such as religion, traditional beliefs and cultural appropriateness (male midwives) and satisfaction with services provided.

Affordability

Even if the health service is available, accessible and acceptable, its effective utilisation depends on how affordable it is to the community. If the cost of the service in terms of transport costs, and requirements for the baby are too high, the service will not be utilised.

This theory was used to discuss the research findings in terms of how available, accessible, acceptable and affordable traditional birth attendants' services were before the decision to stop them from conducting deliveries and compare with the availability, accessibility, acceptability and affordability of delivery services offered by health institutions after the stopping of traditional birth attendants. This helped to explore trained traditional birth attendants' perspectives on governments' decision to stop community-based deliveries.

Appropriateness

The appropriateness of the services offered though sometimes considered under acceptability factors, has been considered to be different from the other four As. The appropriateness of the services include the trust measures of the community towards the service in terms of how much the community is engaged in deciding what they deem right and correct in their cultural context.

CHAPTER THREE

METHODOLOGY

3.1 Research Design

A Qualitative case study was done to explore perspectives on experiences and meanings of trained traditional birth attendants (tTBAs) on the withdrawal of their delivery services and the discouraging of community-based deliveries by government. This study design was selected because it was suitable for understanding perspectives and insights on governments' decision to stop community-based deliveries. Case studies are useful to get in-depth exploration of a programme, activity, event, process, group of people, etc. A case is bound by time and activity and data is collected using multiple data collection methods over a sustained period of time (triangulation) which creates rich knowledge at the end of the study (Yin, 2003).

3.2 Research Setting

The study was conducted in Mukuni chiefdom of the Tokaleya speaking people and the three health facility catchment areas in Kazungula district of Southern province that fall under this chiefdom. The district was purposively selected owing to relatively low skilled and institutional deliveries (40.7%), high home deliveries by tTBAs and other relatives and because it is a rural district in which the researcher lived for over ten years hence knew the setup very well. Kazungula district has a total population of 113,666 (CSO, 2014) with twenty-two health facilities. The district has no hospital but depend on Livingstone General Hospital and Mwandi hospital for referral cases. All twenty-two facilities offer antenatal and postnatal services while delivery services are not offered in some facilities Manyemunyemu in Mukuni chiefdom, the area under study (Kazungula DHMT HMIS, 2012). Of the total population, 25,007 were women of child bearing age (22%) and 6,138 expectant mothers (5.4%). Kazungula district shares boarders with Livingstone, Sesheke, Zimba, and Kalomo districts and an international border with Botswana. The people of Kazungula district are mainly subsistence farmers, fishermen

and a few small-scale entrepreneurs. Politically, the district falls under Katombora constituency.

3.3 Study Population

3.3.1 Traditional Birth Attendants

Inclusion criteria

In this study, the study population included only traditional birth attendants who had undergone additional training and were recognised by government as trained traditional birth attendants.

Exclusion Criteria

All traditional birth attendants who were not trained by government or were not present or were present but were not willing to participate were not included in the study.

3.3.2 Traditional Leaders

Inclusion Criteria

Only female traditional leaders who were the custodians of all matters related to women including family issues were included in the study. All the six female leaders were included with one from each of the six zones in Mukuni chiefdom is. This was on the same job or job title basis as they are information rich on traditional matters affecting women and are the representatives of women before the chief in their zones.

Exclusion Criteria

Female traditional leaders who are not appointed by the chief as *bana bedyango* in the six zones were not included in the study.

3.4 Data Collection Tools

3.4.1 Sample Size and Selection

Key Informants (KIs)

An expert sample for key informant interviews comprised all female traditional leaders (*bana bedyango*) from all the six zones (Gundu, Libala, Kayube, Makoli, Mulindi and Manyemunyemu) into which the chiefdom is divided making a total of six key informants. These were selected based on the fact that they were members of the same group (*bana bedyango*) and because their views were important since they were experts in traditional matters and responsible (heads) for all issues related to women including maternal health issues in their zones. These interviews were done in their homes which gave them maximum freedom to express themselves.

Focus Group Discussions (FGDs)

Three Focus Group Discussions (FGDs) were conducted that comprised all trained traditional birth attendants (a census was considered) purposively selected until saturation was reached. Trained traditional birth attendants were purposively selected because they were key persons directly affected by governments' decision hence the only ones that could tell us their perspectives. They were recruited based on same role or job title basis. All trained traditional birth attendants (tTBAs) available were included because they were less than thirty in total twenty-two, were information-rich and had the greatest insight on the topic. A total of three FGDs were conducted (one per clinic catchment area in the 3 clinics under chief Mukuni namely Katapazi, Mukuni and Manyemunyemu). Katapazi had seven participants, Mukuni had seven participants and Manyemunyemu had eight participants respectively.

Focus Discussion Procedure

Before the commencement of the focus group discussion, the facilitators obtained background information of the participants such as their age, marital status and number of years in service as a trained traditional birth attendant and other relevant information. Once this was established, the following steps were followed:

(i) A brief introduction after which the purpose of the discussion was explained;

(ii) Participants were asked to introduce themselves and give a short background of themselves;

(iii) The discussion was structured around the key objectives using the probe questions that were prepared in advance;

(iv) During the discussion, all participants were given the opportunity to give their views; and

(v) A trained rapporteur captured the discussion in written and noted the non-verbal expressions of participants. A tape recorder was used as an additional tool.

A variety of moderating tactics were used to facilitate the group some of which included stimulating participants to talk to each other and not necessarily to the moderator. Shy participants were encouraged to contribute by frequently asking them to speak. In-depth probing methods were used without leading the participants. Close attention was paid to what was said to encourage other participants to give their views. Dominant participants were controlled through verbal and non-verbal cues like taking advantage of a pause and suggesting that the subject could be discussed in a different session and calling on other participants to say something.

Prior to the discussion day, logistical arrangements were done including invitation of participants a week or two before the day and reminding them two days before the actual day through letters and talking to their headmen.

Venue

The focus group discussions were conducted at community health posts where 6-10 persons sat and were assured of privacy. These were neutral places free from detractions and where participants talked openly unlike the clinic. Key informant and in-depth interviews were conducted in the respective homes of the study participants who were eligible. Consent was obtained both verbally and in written.

Seating Arrangement

The seating arrangement was in a semi-circular manner which facilitated interaction among participants because it allowed them to freely see and hear each other.

Timing

While waiting for other participants to arrive, the team used this time for ice breaking by getting information about their background. To avoid boredom the focus group discussions did not exceed one hour.

In-depth interviews (IDI)

There were nine trained traditional birth attendants selected from the three clinic catchment areas who were eligible for the study. They were recruited purposively using a maximum variation criterion. Maximum variation sampling involves selection of participants to reflect diverse characteristics, knowledge and views of the study participants, in this case the number of years worked as a trained traditional birth attendant was used. Thus three from each catchment area were

selected based on the highest number of experience, the medium and the lowest in order to triangulate the sources of information and helped generate in-depth unique insights and shared patterns that cut across the duration of experience.

Only traditional birth attendants who were trained and agreed to participate in the study by signing written consent forms were enrolled into the study. Face-to-face individual in-depth interviews were conducted with eligible study participants using an in-depth interview guide in Chitonga, the local language widely spoken in the area. Interviews were recorded using a digital audio recorder in the homes of respective participants to give them maximum freedom of expression. Data was collected until no new information emerged, a stage commonly called data saturation.

3.5 Data Collection Technique

The study used qualitative methods of data collection. Focus Group Discussions (FGDs), in-depth interviews (IDI) and key informant interviews (KII) were used to collect data for qualitative analysis. Key informant interviews included Female Traditional Leaders (*bana bedyango*) in the six zones into which the chiefdom is divided. Focus Group Discussions (FGDs) included only traditional birth attendants who were trained by government whose services were since stopped. Three FGDs were conducted one per clinic catchment area. Manyemunyemu had eight participants, Mukuni eight participants and Katapazi seven participants. Focus groups can be used to assist in decision making before, during or after an event, programme or the implementation of a policy (Krueger & Casey, 2000). In-depth interviews were done because they are suitable for identifying and eliciting in-depth insights into the perspectives related to trained traditional birth attendants since the decision to stop community-based deliveries by government.

3.6 Data Processing and Analysis

Qualitative Data

The qualitative data that was derived from the FGDs, in-depth interviews and key informant interviews were listened to repeatedly in order to capture the context and meaning and transcribed manually. The transcripts were shared with the two supervisors

for verification and review. The data was categorised thematically (identified common themes, CUT and PASTED themes together), coded and analysed by thematic content and theoretical analysis (health services coverage and evaluation model). The steps followed in data analysis were as follows:

(i) Field notes and recorded interviews were listened to and read many times to capture the context and meaning;
(ii) Memoirs of key statements, ideas and attitudes were noted down using as much as possible the words in the text. These were sources of codes;
(iii) Similar codes were then grouped together;
(iv) The codes were then compared for similarities and differences;
(v) Codes were finally grouped into themes; and
(vi) The modified health services coverage and evaluation model was used for discussion of findings.

3.7 Results Dissemination Plan

The results from the study were shared through presentations at the graduate forum, department of public health, Kazungula district health office, the provincial medical office and community meetings in Mukuni chiefdom. The findings were also published in an international journal.

3.8 Ethical Considerations

Approval

This study involved human participants whose rights needed to be protected and as such, approval and clearance was sought from the Excellence in Research Ethics and Science (ERES) reference number 2014-May-020.

Permission

Written permission was sought from Kazungula District Health Management Team (KDHMT) to conduct the study in their area. Verbal permission was also sought from his

Royal Highness Senior Chief Mukuni '*Munokalya*' and '*Bedyango*' the Chieftainess who is responsible for all traditional matters affecting women in the area.

Informed Consent

Oral and written informed consent were obtained from each participant after explaining the purpose, nature, benefits and risks and how the information would be utilised while assuring them that the information would be held in confidence. The signing of consent forms was only done after all questions and possible doubts from participants had been cleared. Only those that agreed to participate in the study signed the forms but even after signing, they were still free to withdraw from the study at any time if they so wished without any consequences. Those that couldn't write endorsed the consent form using their right thumb prints.

Respect for Participants and Confidentiality

Study participants were assured of anonymity since participants' names were not to be written on the FGD interview guide, in-depth interview guide and key informants were interviewed individually and privately from their homes. Only serial numbers appeared on the interview guides. All data was anonymised. This maximised the participants' confidentiality. No other person apart from the researcher had access to the research data that was collected.

This also applied to the time of data analysis where all data collection tools used to gather information were destroyed after publication of results. The report does not bear any names and participants were assured that the information collected would be used only for academic purposes as well as provide information for the improvement of health services.

Beneficence

The benefits and likely risks were communicated being that the research findings though may not benefit the participants immediately but was to be used to inform policy makers

in order to improve the health care system. The participants were also assured that no physical harm was anticipated in the study as the study did not involve administration of invasive medical equipment.

Autonomy

Participants were informed that they had the right to decline participation in the study from the onset or withdraw from participation at any time during the study.

Justice and Fairness

Everyone who was eligible for the study was given an equal opportunity to participate or to decline.

Plan for Disposal of Research Materials

All research materials that contained participants' responses will be destroyed after seven years in line with ethical approval standards. All voice recordings were deleted immediately after completion of transcription.

CHAPTER FOUR

FINDINGS OF THE STUDY

4.1 Socio-demographic Characteristics

The twenty-eight participants that took part in the study were aged between 30 years and 70 years out of which twenty-two were trained traditional birth attendants and the remaining six were female traditional leaders (*bana bedyango*). The majority (nine) of them were aged between 40 and 44 years old while most of the participants (seventeen) had undergone junior secondary education. Despite all the participants indicating that they went to one denomination or the other, the majority (nine) were Catholics.

4.1.1 Attributes of TBAs

In this study, the women who were found to be trained traditional birth attendants (TBAs) had varying attributes among them that qualified them to attend to mothers. The common attributes were maturity by age, being an indigene and having some education. Others included being a mother should have had children, being kind and respected by members of the community. Even when one was well educated and respected in the community but was not an indigene, it disqualified them from being chosen as a traditional birth attendant. The local leaders and the community at large met to choose who they deemed worthy entrusting with this job. There was however some attributes that did not cut across the TBAs like having a relation particularly a mother or grandmother who was a trained traditional birth attendant herself. The job never ran in families and anyone could have been chosen as long as the community thought it fit. Below is a Table that shows the ages, educational level and religious backgrounds of the participants.

Table 1: Characteristics of Participants

Characteristics	Number of Participants
Age	
30-34	4
35-39	5
40-44	9
45-49	3
50-54	2
55-59	2
60-64	2
65+	1
Total	**28**
Educational level	
Grade 1-7	4
Grade8-9	17
Grade 10-12	6
Tertiary Level	1
Total	**28**
Religious Background	
Baptist	5
Pentecostal	1
SDA	6
Catholic	9
Jehovah's witness	2
Zion	1
Church of Christ	3
Total	**28**

4.2 Knowledge of the Ban and Perceived Reasons

4.2.1 Knowledge of the Ban

The trained traditional birth attendants were all aware of the decision by government to stop community-based deliveries. All the six key informants were also aware of the ban.

4.2.2 Perceived Reasons for the Ban

The two groups had various reasons they thought led government to come up with the decision to ban community-based deliveries. Most of the respondents said they were not officially informed and attributed it the ban to mere speculations. The reasons they thought led to the ban included reduction of HIV transmission, avoidance of complications, prevention of maternal and infant deaths, limited skills and equipment of TBAs and delays in making decisions at community level.

(a) ***Reduction of HIV Transmission:-*** one of the most common reasons given for government ban of community-based deliveries was to reduce the spread of HIV and AIDS in communities. All the participants mentioned that probably government was trying to reduce the spread of the infections from mothers to their unborn babies during labor and delivery. The respondents agreed that they had little knowledge on how to prevent the transmission of HIV and AIDS and that could have led government to stop their delivery services in the community. This reason was exemplified by the quotes below:

> *I just thought that maybe it is because of this HIV and AIDS that has gone so much into the communities. Government was trying to reduce the spread of the disease from mothers to their babies during delivery because the people that used to conduct these deliveries were not fully knowledgeable on how to prevent the same disease. Otherwise it is just thinking we were not given any reasons why the decision was made* (Key Informant 5).

> *We asked why, and we were told it is because of the many diseases especially HIV and AIDS because sometimes we could work without gloves when they ran out* (42-year old tTBA).

(b) ***Complications:-*** the other perceived reason mentioned for stopping community-based deliveries was the avoidance of complications which happened in the communities. The complications mentioned included breech presentation of babies, a baby born with yellow skin (jaundice), excessive bleeding during and after delivery, umbilical pro-lapse (umbilical cord coming out before the baby was born), retained placenta (placenta not expelled 30 minutes or more after the baby was born), and the placenta being expelled before the baby was born. Some of the participants had this to say:

> *As traditional birth attendants, we have no much knowledge on how to handle complicated cases like when the child is breech so at the clinic they know how to handle such cases. Sometimes the child maybe born with a disease like born with a yellow skin and we don't know what to do in such cases, all we know is how to deliver (*Respondent 2, FGD 1).

> *The reasons I was told were many including the reduction of infant and maternal deaths and many other complications that are common in the community* (30-year old tTBA).

(c) ***Prevention of Maternal and Infant Deaths:-*** participants also mentioned that the prevention of Maternal and infant deaths was one of the reasons for the ban. This was evidenced from the following quotes:

> *I think government was trying to reduce deaths due to complications of delivery, both the mothers and their babies* (Respondent 2, FGD 2).

> *The reasons I was given, though the nurse was not sure also were that a lot of women would die in the hands of TBAs so government wanted to reduce such deaths* (58-year old tTBA).

(c) ***Limited Skills and Equipment:-*** the other reason that was mentioned for stopping TBAs was the limited skills of the trained traditional birth attendants and lack of equipment to handle complicated cases in the community. On that

> *We are trained but we do not have the skills like those of nurses and doctors and we don't have the equipment to use except the foetoscopes* (Respondent 1, FGD 1).

(d) ***Delays to Make Decisions:-*** community-based deliveries were stopped due to delays in making decisions at community level to take a woman to the clinic or hospital when a complication was identified which led to more complications and even death at times. This can be confirmed from the following respondent who said that:

> *I had a case where this woman took time to deliver until the following morning that is when we took her to Zimba Mission Hospital and was operated on because the baby was big. Unfortunately the baby died because we had no transport to take her to hospital early enough. So the government was trying to prevent such things from happening* (Respondent 7, FGD 1).

4.3 Persistence of Community-based Deliveries and the Reasons Behind Them

4.3.1 Persistence of Community-based Deliveries

Findings from this study suggest that community-based deliveries have persisted despite the decision by government to ban them and advicing all women to deliver from health facilities. Despite the knowledge of the dangers and complications involved, community-based deliveries have continued and a number of reasons came out from the respondents. Some respondents said this in confirmation:

> *There is no way they can all stop. If government had said when a woman's pregnancy reaches eight months she needs to go and stay at the clinic maybe*

> *that would work. But the way labour begins it is sudden for some women and personally it used to happen to me on a number of deliveries. Before I could think of the clinic the baby would be born, maybe my uterus was weak I don't know … you see. In short, women are still delivering from their homes (*Key Informant 1).

> *Women still come to me sometimes and I don't blame them* (58 years old tTBA).

4.3.2 Reasons for Persistence

The reasons given for persistence of community-based deliveries included lack of health facilities within some communities, lack of delivery services at some local clinics, too many demands at the clinic or hospital, poor staff attitude, tradition, shortage of trained staff and poor transition method.

(a) ***Lack of Health Facilities within Some Communities:-*** on the number of reasons cited for the persistence of community-based deliveries, lack of health facilities within the community was mentioned as attested to by one of the key informants who said:

> *How do they stop when we have no clinic here? I am sure they are still delivering from the community and even if we had a clinic there are problems that make some women fail to go to the clinic no matter how near it may be. It is not possible that all women can be going to the clinic for delivery it is very far from here* (Key Informant 5).

(b) ***Lack of Delivery Services at the Local Clinic:-*** apart from the fact that some communities did not have clinics within easy reach, the findings revealed that some communities had the clinics within easy reach and yet the despair that was there was that the local clinics available did not provide delivery services. Among the three available clinics in the chiefdom namely Katapazi, Mukuni and Manyemunyemu clinics, the later (Manyemunyemu clinic) did not

provide delivery services despite having trained personnel. The reason for this was that the clinic had no equipment to conduct deliveries not even a delivery bed. Two respondents had this to say on the situation:

> *We were better off before the decision. If you look at people in the urban areas they have no problems with this decision because all clinics can offer delivery services and they have all they need to handle the cases. But for this community it doesn't make sense because the clinic only deals with other services not delivery services. So when they stopped trained traditional birth attendants from conducting community-based deliveries, they put an extra burden on a community that is already underprivileged. Our plea is that let them allow trained traditional birth attendants to work in our community until all things are in place at our clinic then we can talk of a different story. Other clinics and hospitals are far from here* (Respondent 7, FGD 3).

> *It is very hard to stop conducting deliveries in a community like this one (Manyemunyemu) where the only clinic we have does not provide delivery services. Traditionally, you can't chase away someone who is helpless and comes to you for help, even God wouldn't bless me … (looks agitated)* (36-year old tTBA).

(c) ***Too Many Demands at the Clinic or Hospital:- a***according to most of the respondents both from the focus group discussions and the key informant interviews, one of the reasons for continued community-based deliveries was due to many demands put forward by the clinic and hospital staff whom they claimed sometimes sent away some women who did not meet the requirements. These demands were among others the preparation pack consisting new baby blankets, shawl, nappies, "*chitenge*" materials, a bucket, JIK and money to use for transport in case of a referral to a bigger hospital. They claimed that at home used anything available for the baby but at the

clinic there were certain standards. This was confirmed by the following quote:

> *Sometimes they need certain things at the clinic like a K50 for every woman who goes to deliver just in case there is a problem that money would be used for transport to hospital. Some people don't have such money and as a result they opt to stay home and deliver there. At the clinic they also need clothes for the baby, they want JIK and about two new "chitenge" materials for the new born baby, a shawl and baby suits. So when someone doesn't have these things they fear that maybe they will be chased* (Key Informant 1).

(d) Negative Attitude of Staff:- some of the respondents reported that the staff at the local clinics and nearby hospital had negative attitudes towards women in labour and this discouraged them from going to deliver there. The negative attitude included scolding, detaining them and sometimes chasing them away. One traditional leader and a trained traditional birth attendant had this to say on the attitudes of staff in the health institutions:

> *It is serious because they chase women away from the hospital if they don't have what is required. If they don't chase you, they will detain you until your husband brings what is required that's when you will be discharged. Some women have reported such cases to me* (Key Informant 3).
> *… I escorted a woman whom I thought I would not handle. She delivered quiet well at home but the placenta couldn't come out. When we reached there the nurse at first refused to attend to her saying me who started the whole process should handle it and she was shouting in the presence of other people … she was a bit rough on the woman and the woman latter said she wished she had just remained home to die if it was God's wish* (33-year old tTBA).

The other traditional leader from Mukuni area narrated how she and her daughter were treated when the latter went to deliver at the local clinic:

> *Looking down … as am seated here I can't tell lies. It personally happened to me when I took my daughter for deliver at our clinic. We took her there quite alright but the nurse who came at night walked straight in and shouted at my daughter saying, 'who told you to sleep on that bed?' So my daughter tried to explain that she came to deliver and was told by the nurse we found to sleep where she was. This nurse just shouted,' I don't know you and have not been told by anyone about you'. So my daughter called me from outside where I was seated and I met her by the door with a bag going out. So I inquired on what was happening and she narrated how she was shouted at for sleeping on a bed. I had to plead with my daughter who was determined to go home to stay since we were already at the clinic. While I was still pleading with her the same nurse came I think she realised she was wrong, called her in an office I don't know what they discussed but after some minutes she came out and went to sleep on the same bed ….*

Negative Staff Attitude can Result in Unsafe Delivery

> *… after some time she asked to go to the toilet not knowing that it was the baby about to come out. She delivered behind the labour ward on the way to the toilet and the same nurse still refused to come out and help out saying she was trained to deliver from the ward and not from outside and that if we couldn't get the girl back on the bed it would be our own fault. Are you sure that is the way nurses should work and yet that is their job? (Getting emotional) … she made a big mistake. We had to carry the girl back on our own to the ward with the help of another woman I found at the clinic. That is when she started doing her things here and there. I didn't want to tell her who I was because she was new. Some nurses are okay but others are really bad* (Key Informant 1).

(e) ***It is Just Tradition:-*** some respondents also echoed the fact that some women opt not to deliver from health institutions simply because they are traditionally used to delivering at home and they saw no need to deliver at health institutions now. This is exemplified by the following statements:

> *Firstly we are traditional people who have been delivering from our homes for a long time and that decision some people look at it as a way of looking down on traditional ways of doing things. Before the clinics came into being, how were the women delivering? Traditionally of course and in the comfort of their homes* (Key Informant 5).

(f) ***Shortage of Trained Staff:-*** shortage of trained manpower in the clinics was cited by almost all respondents as contributing to the unwillingness of women to go and deliver from the health facilities as they saw no need of going there when they would end up being delivered by their own relatives and friends. This greatly discouraged them and didn't see the difference between home delivery and institutional delivery in that regard. The quotes below prove this point:

> *Sometimes you can go to lodge there maybe four days or more but at the clinic there is no trained staff to attend to you. It happened to me when I took my daughter there. We stayed for four days until she went into labour and she was delivered by a cleaner who is just like me in terms of skills. So one would wonder why go to the clinic when they would be delivered by a traditional birth attendant similar to the one they left at home. So that also discourages people from going there* (Respondent 1, FGD 2).

> *What is more painful is to walk for hours to the clinic and only to find cleaners there without any trained personnel* (56-year old tTBA).

(g) ***Poor Transition Method:-*** respondents highlighted the fact that the method of transition from community-based deliveries to institutional deliveries was poor as the communities were not prepared before the decision was made. The decision though appreciated by some of them was not done in the best interest of the poor and this resulted in more problems than before the ban on community-based deliveries. According to them government was supposed to

have informed communities well and to endeavor to employ more staff in the clinics before the decision to ban community-based deliveries. Some communities thought since trained traditional birth attendants were stopped, they would then go back to untrained women:

> *The biggest problem is that there was no smooth transition from home deliveries to hospital deliveries. When they stopped us without information, people thought that maybe the old untrained traditional birth attendants can still do the work. So women resorted to people they used to know years back as experienced in deliveries. If government had first told us to educate women why it was necessary to go to the clinic for delivery, am sure very few women would still be delivering from the community. Let government tell us where we should operate from and things will move* (Respondent 2, FGD 3).

4.4 Non-adherence to the Policy Ban by Trained Traditional Birth Attendants

4.4.1 Trained Traditional Birth Attendants still Delivering

It is one thing to make a decision and pass it to the people but quite another to have people comply with the directive. Adherence to the policy directive was reported to be difficult by the trained traditional birth attendants and most of them including key informants reported having difficulties citing a number of reasons. The trained traditional birth attendants agreed that they still conducted community-based deliveries. Some of them had this to say:

> *If they want traditional birth attendants to stop existing, it's up to them because in the first place it was their idea that they train us. So if we were delivering before they trained us we can as well deliver without their knowledge …* (Respondent 1, FGD 1).

> *In short, I still conduct deliveries only to those that fail to go to the clinic because there are many*

> *things that stop people from going there* (66-year old tTBA).

4.4.2 Reasons for Non-compliance

Asked why they have not complied with the policy ban, most respondents said they delivered as a matter of moral duty and sometimes they conducted deliveries that happened on their way to the clinic. It was a matter of emergency to which they had no option but to help out. Some of them put it this way:

> *In some cases we have no option but to conduct the deliveries because it is no ones' fault we were on the way to the clinic but the baby was born on the way. There the government should understand that it's not our fault. But we will not just end there we would still proceed to the clinic so that the woman and the baby are checked by the staff* (Respondent 6 FGD2).

> *… it is a moral duty we are Christians* (Respondent 1, FGD 1).

A 58-year old tTBA during an in-depth interview explained in the following way:

> *… some health workers are very rough to women in labour and I have witnessed this several times … So government wants women to go to people who are so uncaring sometimes. In short because of what we experience at the clinics it is not possible for me to stop assisting women in my community when am called upon.*

4.4.3 Some Compliance:- on the other hand however, a few said they no longer conducted any deliveries but instead escorted women to the clinic for delivery and while there, they left the delivery function to the nurse unless the nurse was not available at the clinic. Some of them stayed too near from the clinic to continue community-based deliveries. The following quotes confirm their claim:

I don't deliver in the community I just escort these women to the clinic and when I reach there I just assist the nurse in whatever she sends me to do like getting cotton wool for her, if she says she wants to go and answer the call of nature I remain to observe the patient unless she is not there because it happens (Respondent 1, FGD 1).

At first I was very disappointed by the decision because I was only a few years in the job after training but now I think I appreciate the decision because times have changed and women need to get used to hospitals unlike being delivered in the villages. I don't deliver women anymore though at first they would come to call me but maybe because I stay near to the clinic they don't come anymore. I only go to offer health education to antenatal women at the clinic at times but not very often (30-year old tTBA).

4.5 Effects of the Ban

Findings from this study revealed that the decision by government to ban community-based deliveries had both negative and positive effects on communities even if negatives seem to outweigh the positives.

4.5.1 Positive Effects:- despite respondents acknowledging that communities had not stopped delivering from their homes and that some trained traditional birth attendants were still conducting deliveries in the community, the respondents still identified some positive results following the ban especially for women that had delivered from the clinics. The positives reported included faster transportation for further management, enhanced community hygiene or clean deliveries, early detection and management of complications, more time spent on their businesses, reduced deaths in the community, reduced criticisms and enhanced HIV and AIDS prevention and better management of post-natal conditions.

(a) ***Faster Transportation for Further Management*:-** it was identified that when women delivered from the health facilities, it was easier to refer and transport them to high level management clinics or hospitals if and when need arose. Some respondents put it this way:

> *If a complication arises while at the clinic it's easier for someone to contact the hospital unlike in our homes because some of us come from distant places and our roads are very bad* (Respondent 4, FGD 1).

(b) ***Enhanced Community Hygiene or Clean Deliveries*:-** it was felt by some respondents that since some women would manage to deliver from the clinic it had enhanced hygiene and clean deliveries. This was so because some women would deliver from their kitchens in the community and this compromised hygiene practices for the home. One tTBA highlighted:

> *I think it has helped to improve the hygiene in the community because when we were still delivering in the community we would just do it on the floor on a mat or sack with a plastic on top but at the clinic there are beds there and they clean those rooms better with chemicals. One time, I delivered a woman from her kitchen outside because she was staying in a one room hut and the husband and other children were in the house at night. Now this is the same place where food is prepared so I think on that one, it is a good idea to just go to the clinic* (30-year old tTBA).

(c) ***Early Detection and Management of Complications:-*** was one of the positive things that were identified and this is exemplified in the quote below:

> *Also at the clinic if the placenta delayed to come out for example, they inject certain drugs to hasten the delivery but in the community we don't do anything like that and the more we delay, the placenta may rot and cause other problems* (Respondent 1, FGD 2).

(d) ***More Time for tTBAs:-*** respondents reported that since they were stopped from their work they had more time to do their own work and business. One respondent said this:

> *Now it's okay because there is very little for us to do if government thought it was punishing us it is okay we have no work to do. In the past you would be called anytime even when you are cooking or eating to go and attend to women but now we are at peace* (Respondent 4, FGD 1).

(e) ***Reduced Deaths in the Community*:-** some respondents said because of the decision it was rare to hear of women dying during labour and delivery in the community but instead they heard of such cases in the hospitals. To them government 'transferred' the deaths from the community to the hospitals. This was explained in this way:

> *On one side I would say there are no women and babies dying in the community. In the past we would hear of women dying in the community during labour but because of that decision we don't hear of such deaths instead we hear such deaths in the hospitals themselves. So it is like government transferred the death from the community to the hospitals* (42-year old tTBA).

(f) ***Reduced Criticisms:-*** from the members of the community were equally reported. Owing to the decision by government, the trained traditional birth attendants said there were fewer criticisms that used to come from communities especially when a complication arose as they would be blamed for negligence. One respondent said:

> *It helped us from criticisms from the community. For example, a woman dies while in labour the community will just say that TBA never took good care of the woman besides why did she deliver someone who had complications she can't handle. So government saved us very much* (Respondent 2, FGD 2).

(g) ***Enhanced HIV and AIDS Prevention and Better Management of Post-natal Conditions:-*** there was a general feeling among the participants that because of the ban of community-based deliveries, there was reduced transmission of HIV and AIDS from mothers to their babies and better management of complications as seen below:

> *Yes government did well somehow. I say so because in the past people would get pregnant without knowing their HIV status and babies would died unknowingly. So with that decision everyone is tested and those that need help are helped and babies are born healthy. Even suspicions of witchcraft are reducing because people know about HIV and AIDS* (Key Informant 4).

4.5.2 Negative Effects of the Ban

Despite the positive things that were talked about by the respondents, a number of negative issues were also identified from the time the decision was made to stop community-based deliveries. The negative issues that came out included extra workloads, cost of lodging, loss of respect and recognition, introduction of penalty fees, colonisation, being neglected, women going back to untrained traditional birth attendants and negative reception at health facilities.

(a) ***Extra Work:-*** was reported by most of the respondents because one of the negative effects of the ban as the trained traditional birth attendants walked long distances to escort women to the clinic for delivery thereby spending more time away from home. Some of them had this to say:

> *So the government has given us extra jobs to 'lift' the work you could do at home and take it to do it at the clinic thereby spending so much time at the clinic instead of developing ourselves at home* (Respondent 1, FGD 1).
>
> *… because of the SMAGs I do a lot of walking escorting women to clinics far away from here but once there I do nothings at all* (36-year old tTBA).

(b) ***Cost of Lodging:-*** Lodging at the relatives' shelters was another problem identified as the trained traditional birth attendants had to spent personal money and food for the days spent while waiting for the women escorted to deliver. To them this meant running two separate homes. One of them complained and said:

> *Staying at the relatives' shelter entailed running two separate homes. Women have to share the little food between those that remain at home and those that go to the clinic and this is expensive for us in the community. So we don't know how government thought on that one because it never came to the people to explain* (Respondent 1, FGD 1).

(c) ***Loss of Respect and Recognition:-*** respect and recognition from the community and health facilities were discussed by a good number of participants. They said because of the decision they were no longer respected as before and they had lost their influence in the community which reduced their social standing and explained why Safe Motherhood Action Groups (SMAGS) have not yielded the expected results. This was exemplified in the following quotes:

> *We don't do much except may be teaching women once in a while at the clinic. Besides we were made to join the safe motherhood action groups (SMAGS) to identify women that were pregnant, keep a register of them and the days they were likely to deliver. This group is not even active because we are no longer influential in the community. Whatever you want to advice people they don't follow and they say what can they tell us when we know that they were stopped from their work? In the end we just sit and watch things happen the way they happen* (Respondent 1, FGD 3).

> *I don't often go to the clinic though at first I would go frequently … pauses … ah! it's like they don't need us there anymore. Although the nurses don't say it verbally but their actions show that am not needed. You can go there and they see you but they*

> *will just greet you and they get busy with whatever they are doing so I felt out of place most of the times and I stopped* (30-year tTBA).

(d) ***Introduction of Penalty Fees:-*** paying fees was another problem that was discussed where the discussants said because of the decision; women were made to pay penalty fees for failure to go and deliver at the health facilities. This included refusal to be given children's clinic cards and payment of cash up to K100. As a result women went to the clinic out of fear to pay the penalty and not out of free will. Some respondents explained that:

> *I just hear that issue from the community but I have not been told by anyone from the clinic officially. I just hear that people pay between K50 and K100 before they are given other services* (Key Informant 1).

> *Firstly, women are not given under-five cards until they pay a small fee. When they pay the penalty fee that's when they are given the cards and do all that is supposed to be done* (Respondent 2, FGD 2).

Looming Disease Outbreaks Due to Penalty Fees: this situation to some respondents paused a great danger to the children as they would delay in accessing immunisation to preventable diseases and this was a potential source of disease outbreaks. This was exemplified in the following statements:-

> *… she only started taking the baby to under five clinic when the child was about five months old meaning that the child was not protected from diseases. So if a disease broke out that child can easily get infected all because people have no money to pay. It is like bearing a child has now become an offence and one had to pay K100 for it. That is not fair and we don't even know how that money is used* (66-year old tTBA).

> *A good number of women still deliver in the community by untrained women and for fear of being fined at the clinic they don't even go for*

postnatal or take their children early for vaccinations. I can foresee a situation where a disease will break out and most children here will be affected for not being vaccinated in time and the blame will go to clinics that are chasing away women indirectly by fining them. K100 is a lot of money here in communities and before you pay this money they don't give children's cards (45-year old tTBA).

However, some respondents were of the idea that the penalty actually made some women to deliver from their homes because they knew that they will just pay the fee and it ends there. A few said that it was a good idea especially for those that delivered at home deliberately. This is what they said:

That idea of giving a penalty fee to women who don't deliver from the clinic in a way encourages them to deliver from home; some women may think that since I have the money they need at the clinic then I can as well just deliver from home after all I will just pay and forget. So it's better for us who are trained to start doing this work again so that mothers are attended to by people who have some knowledge and skills (Respondent 2, FGD 2).

(e) ***Colonisation:-*** some respondents felt that the decision by government was a way of colonising them in an indirect way by forcing women to go to the clinic whether they liked it or not. Some of them had this to say:

We have gone back to the colonial times (chibbalo) where we are forced to do something whether we like it or not (45-year old tTBA).

So it is like the poor people are being robbed of the little money they struggle to make because of this same decision. I am not saying the decision was totally wrong; it can work very well in urban areas not here in the villages. Please it is not fair. Some women deliver on the way to the health facilities and that is even more embarrassing than delivering from your house. It is slavery (nchibbalo) my son (Key Informant 5).

(f) ***Feel Neglected*:-** respondents felt neglected by government because they were not consulted and no clear guidelines were given on the way forward for them after stopping them from conducting deliveries. Some of them narrated that:

> *It's like government just wasted it's time to train us. Because it is them (Government) who trained us and then stopped us from doing what we were trained to do meanwhile people who were never trained are doing the job. It was a waste of time to train us, beside we were left without clear guidelines of how and what we should do then. We were left like chicks without a mother hen! We were just thrown away like that* (Respondent 4, FGD 2).

> *It's rather annoying because they damped us like street kids. But what is surprising is that when they want something from us like information in the community they come back to us. So they just want to use us when they are stuck* (Respondent 6, FGD 3).

Some respondents also said since the decision was made and communities were aware of the ban, the support they used to get from the community which to some was a source of livelihood was completely lost and this has made their lives very difficult. Some trained traditional birth attendants had this to say on the matter:

> *I remember some time back people would organise themselves especially during the rainy season to come and cultivate the fields for me just as a way of appreciating what I used to do for their wives but since they heard that we were stopped by government they have stopped. Only my relatives come to help me out or unless I pay someone to do it for me which never used to happen before. It is like we have been labelled incompetent by government and the community has also followed the same route* (42-year old tTBA).

> *Some would give you chitenge materials not as payment but just as appreciation. But since we were stopped and communities heard that we are no longer important personally, I would say I have lost*

> *my source of income. My life has changed so much because I am a widow ...* (58-year old tTBA).

(g) ***Back to Untrained Traditional Birth Attendants*:-** from the time the decision was made, the findings suggest that women, instead of heeding to governments' directive that all deliveries should be supervised by trained personnel, have gone back to having their babies delivered by untrained traditional birth attendants. This situation according to the respondents was worse than when the women were delivered by trained traditional birth attendants who felt belittled by the decision and the consequences. This was expressed by both the trained traditional birth attendants and the key informants. The quotes below exemplify their expressions:

> *Yes that's what government did. They threw us out and then people who were not trained take over our job. It's very painful. One time one woman was delivered at home by her grandmother but the umbilical cord was not well tied hence after two days the baby was brought to the clinic bleeding. The upper part of the cord had some pus coming out. Me I stay near the clinic and work there most of the times so I was there when the baby was brought. So the nurse had to put another cord clamp beneath to stop the bleeding. So you can see that it's a problem for women to be delivered by untrained people in the community. If the child was not brought it would have died from bleeding* (Respondent 3, FGD 2).

> *… people that are not trained, the old women and relatives are the ones delivering in the community now* (45-year old tTBA).

One respondent made an appeal to government to reconsider the decision if the spread of HIV and AIDS was to be reduced in the communities. She expressed herself this way:

> *I think government should rethink on their decision especially for rural areas; because initially they thought it would work out as they planned but since*

> *it's not the case they should rethink because people are stuck in these communities. Besides even the delivery kits that we used to receive through the clinics to use in the community are no longer being supplied so one wonders what the untrained women use when they conduct deliveries more so in the face of HIV and AIDS. I don't know if they even use gloves when they conduct their deliveries which is very dangerous* (Respondent 3 FGD 1).

(h) ***Negative Reception at the Clinics*:-** trained traditional birth attendants complained that since the ban of community-based deliveries, the reception at the clinic by some health workers was negative and this had demoralised them from going there for any other services. This is evidenced by the following quotes:

> *Before the decision was made they would welcome us well when we referred a woman there but since then they don't consider us as partners. I remember one time I took a woman there who had delivered at home but was bleeding heavily so I was called to go there and I escorted her to the clinic. When I explained to the nurse, she started shouting at me asking why I delivered her when I knew I was not allowed. I tried to explain but she insisted that I delivered her and that I would bear the consequences if anything happened to the woman. So that scared me and now I don't go when people call me I just tell them to go to the clinic on their own* (30-year old tTBA).

> *I have gone to the clinic to take women there several times but never has the nurse asked me to conduct a delivery with her supervision. She just treats me like an ordinary woman when am there but earlier we were told we could deliver from the clinics* (58-year old tTBA).

4.6 Scenario Where No Delivery Services are Provided

The research findings reveal that despite the decision by government to stop community-based deliveries, some communities relied completely on trained traditional birth attendants for delivery services because the local clinics did not provide delivery services. A number of reasons for this situation ranged from understaffing to not having equipment for conducting deliveries despite the presence of trained staff. The scenario in Manyemunyemu community was described in a variety of ways by the respondents who said women had to walk to Muziya, Katapazi clinic or Zimba Mission Hospital to access delivery services:

> *I think government didn't consider us people in the rural areas when they made that decision. I say so because like at Manyemunyemu they built a clinic and brought only one nurse and they tell us no more home deliveries and yet their clinic doesn't also conduct deliveries. That is cruel to women who have to walk long distances to Zimba hospital or Katapazi clinic and have to spend money when they have a clinic nearby. It's not fair for women in Manyemunyemu. The government was supposed to first make sure all clinics are well equipped before making such a decision* (Respondent 1, FGD 2).

The respondents explained that the three places (Zimba, Muziya and Katapazi) were far from the community and the women had either to walk or spend money to access delivery services, a situation they described as unfair due to the fact that the local clinic could not provide those services. For some, they had to part away with personal property to raise money to use to pay either the transporters or for the services at the clinics they went to as they were charged by-pass fees before accessing the services. To some, the decision contributed to their poverty and underdevelopment as they had to pay for things like farming inputs when they had no cash to use. Some of them had this to say:

> *So if labour starts at awkward time especially at night and you have no money, you give household property even a bag of fertilizer to the owner of the vehicle because these places are far. When farming time comes you have a problem, no fertilizer and that means poor harvest and hunger in your home* (44-year old tTBA).

> *Zimba is over 16 kilometers, Muziya clinic about 12 kilometers and Katapazi about 14 kilometers. The problem with Muziya is that the road is very bad from here no vehicles go there unless you use an oxcart. The oxcarts are also hired. It's like we have wronged government here in Manyemunyemu and they are trying to punish us. We don't know. We are left with nowhere to go. If our clinic would start delivering we would breathe a bit. This is an old clinic older than Katapazi clinic but we don't know why this clinic is neglected. Yet it is a clinic known by government* (Respondent 1, FGD 3).

The key informants described the situation in Manyemunyemu area in their own words too and blamed government for the decision that seemed not to have taken into consideration the plight of these underserved people:

> *There the government didn't do a good job. People there are just wandering here and there. People feel unloved and uncared for by the government because the nurse is there but people go as far as Muziya or Zimba just to deliver and yet the clinic is there. So people there are wondering where government puts them. Let government quickly look into that issue so that people there are helped. That decision when the only clinic in the area doesn't provide the service they are talking about doesn't make sense and is merely a mockery* (Key Informant 1).

This scenario in this community made some respondents felt that the situation that prevailed was worse than before the decision was made. When asked to make a comparison of the situation before and after the decision to stop traditional birth attendants from conducting deliveries was made, one of them said it this way:

> *For me I think we can't even compare because we have not even experienced clinic deliveries here that government wants. We only know community-based deliveries and a few referral cases to far away hospitals and clinics. So we were better before the decision was made because we have not seen any good since the decision was made* (Respondent 2, FGD 3).

When asked of the best way to deal with the prevailing situation one key informant had this to say:

> *The only help that people had has been taken away from them. That means now women have to travel long distances to access delivery services. In town it is easier because there are a lot of clinics and hospitals but for rural communities people depend on a single clinic. Now the only clinic available doesn't give the required services and again government says women should not go to traditional birth attendants. We don't know what they want people to do in this area. In areas like these ones government shouldn't have stopped the trained traditional birth attendants before starting to conduct delivery services at the local clinic. More staffs were supposed to be taken there before that decision was made. Unless they tell us that the same government is not aware of the situation here. Given a chance I can tell government to let the trained traditional birth attendants continue with their work until the clinic there starts delivering women* (Key Informant 6).

When consulted on what they would feel on the decision that government made if the local clinic was able to provide delivery services, some respondents said they would have no problem with the decision because then they would have an alternative:

> *Then we have an alternative! We will have something to rely on. We will even encourage people to be going to the clinic for deliveries. That will be fine. Not where you stop people from what they are doing but you have no better option for*

> *them. Even now we encourage people but for real only those that are well-off manage to go to Zimba due to distance and costs (*56-year old tTBA).

From the results of the study it can be seen that community-based deliveries had persisted in Mukuni chiefdom despite full knowledge of the ban by government. Various reasons were given for this scenario ranging from lack of delivery services in some clinics, long distances to access the services, lack of health facilities in some communities to poor staff attitude at the health facilities. The ban produced both negative and positive effects on the community. Some negative effects among others included negative reception at clinics, looming disease outbreaks due to penalty fees, women going back to untrained TBAs and loss of respect and recognition from the community. Some positive effects include reduced criticism from the community especially when a complication arose, early detection and management of complications and enhanced community hygiene.

CHAPTER FIVE

DISCUSSION OF FINDINGS

The study explored trained traditional birth attendants' perspectives on governments' decision to stop community-based deliveries in Kazungula district of Southern province. In particular, the study sought to understand views over the decision and their new roles. It also sought to understand the experiences of trained traditional birth attendants since the stopping of community-based deliveries affected them directly and entailed stopping of their community-based delivery services. It also sought to know the effects of the decision in rural communities including those that did not have health facility-based delivery services.

The findings of the study are discussed under the following themes: Persistence of community-based deliveries, Non-adherence by trained traditional birth attendants to the policy ban, effects of the ban and current scenario where delivery services are not provided.

5.1 Persistence of Community-based Deliveries

Considering research objective number one "*to ascertain the persistence of community-based deliveries,"* findings from this study revealed that community-based deliveries in Mukuni Chiefdom had persisted despite the full knowledge of the policy ban by government of all community-based deliveries. This therefore means that women did not merely decide to deliver from the community but were compelled by a number of circumstances most of them beyond their control. This also meant that there were no instruments put in place to ensure that this policy was adhered to. The findings in this study corresponded to the findings in the Zambia Demographic and Health Survey (2013/14) which stipulated the reasons for not delivering at a health facility similar to those found in the study. Reasons listed in the ZDHS report included long distances, no lack of transport, short labour interval, high costs, facility not opened and poor quality service, lack of female health providers at facility, not customary and not necessary. The reasons not highlighted in the ZDHS report which were found in this study include, some clinics not providing delivery services despite having trained personnel due to lack of delivery equipment, and poor transition method from community-based deliveries to

institutional deliveries where people were not informed properly on the decision and as such engaged in passive resistance. There was no equipping of all rural health facilities with enough staff and equipment and building more facilities as close to the communities as possible.

The ZDHS (2013/14) report did not also highlight the perspectives and experiences of trained traditional birth attendants and women at large since the decision was made in 2010 and yet this was crucial to the success of any decision meant for the community. Failure to recognise the importance of local knowledge, feelings and experiences hence not incorporating them in the new systems meant to improve the health of people, was responsible for the poor performance of most policies that were in themselves well intended. Some studies done locally and abroad agree to this assumption (Phiri, 2006; Maimbolwa, 2004). Shiferaw (2013) discovered that 78 per cent of deliveries were done by TBAs and that women still preferred the services of the TBAs even when trained staffs were present in some communities. Generally, especially in Africa skilled delivery was still a farfetched reality since most countries had no access to proper medical facilities and services (Titaley, 2010). The ban of community-based deliveries had to increased poverty as families had to spend a lot of money for transport and food to distant health facilities and made to pay penalty fees once they failed to deliver from health facilities. Mammo (1990) equally agreed with this sentiment and said development efforts that were applied by scrapping off the old system and introducing completely new ones without appropriate continuity from the past have contributed to Africa's poverty and underdevelopment. This can be seen in the poor transition method from community-based deliveries to institutional-based deliveries without considering the local appropriateness of the decision.

5.2 Non-adherence by the Trained Traditional Birth Attendants to the Policy Ban

In reference to research objective number two, "*to ascertain the adherence of trained traditional birth attendants to the policy ban*", the findings from this study show that trained traditional birth attendants in Mukuni Chiefdom of Kazungula district did not comply with the policy directive to stop conducting community-based deliveries. To

them the decision to stop them from their work was a way of looking down on their traditional knowledge and experiences. This view was shared by other studies that revealed that even if modern midwifery wanted to incorporate traditional birth attendants in the health care system, modern midwifery wanted nothing to do or learn from traditional expertise (Staugard Ed, 1998; Gaskin, 1978). It shows a non-porous relationship between the two systems where modern midwifery assumes superiority over traditional knowledge. This is in agreement with the postcolonial criticism where eurocentrism appears to be the universal standard of best culture and practice hence anything to be deemed quality had to have elements of universality (Tyson, 2006). As a result of what Tyson (2006) called 'othering' of traditional expertise, the trained traditional birth attendants seem to have engaged in passive resistance to the policy ban as it looked down on their knowledge and experiences as not being knowledge at all (Phiri, 2006). The emphasis placed on increasing facility based deliveries at the expense of community-based deliveries led women and families to believe that child bearing had become highly medicalised hence dehumanized (Bohren, 2014). A study by David-Floyd (2001) in agreement with Bohrens' study, referred to this as a techno-medical model of childbirth where the women were separated from their natural environment and family.

The failure to recognise local and indigenous knowledge and expertise that shape the way people view and understand their conditions may be responsible for poor performance of well-intended policies like this one. Policies and decisions should include situating knowledge systems in their historical space and counteracting the legacy of imperialism and colonialism in postcolonial age by including indigenous knowledge system. Alvesson (2013) agreed with this assertion and advocated for the need to accommodate the wishes and traditional practices of the people they save. This was in tandem with the findings of this study where tTBAs felt looked down upon their knowledge that they held on for a long time even before they were trained by the health care system. Byrne (2011) added his voice and said there was need to review strategies for maximising the respective strengths of TBAs and SBAs for the benefit of the community. This calls for multi-directional borrowing and lending of knowledge across systems for effective project and policy success (Begele 2005).

5.3 Effects of the Ban and Current Scenario where No Clinic-based Delivery Services are Offered

Referring to the third and fourth research objectives: *"to understand from the point of view of the social actors the effects of the ban and to describe the current scenario where delivery services are not available,"* the study findings showed that the decision by government to stop community-based deliveries yielded both negative and positive results on the community in Mukuni Chiefdom. However, it can be noted from the findings that there were more negatives experienced than the positives. The findings revealed that trained traditional birth attendants and the community were not satisfied with the decision let alone the services available in their communities. The effects and current scenario could best be discussed jointly using the modified health service coverage and evaluation model sometimes called the Tanahashi Model (Tanahashi, 1978) that looks at the five As: *availability, accessibility, acceptability, affordability and appropriateness* of health services.

Availability

People can only utilise the health service where certain resources like manpower (staff), facilities (clinics), drugs and equipment (delivery kits) are available. The availability of these resources determines the capacity of the service which in turn reflects the amount of services that a community will receive. The study on the contrary revealed that in some communities the health facilities were not there (Libala) and in some where the facilities were available, delivery services were not provided due to lack of trained staff and equipment (Manyemunyemu). With the ban of community-based deliveries it is clear from the study that the only available help in the community was taken away without a replacement. Even the ZDHS (2013/14) showed that the staffing levels in the health institutions were still very low especially in rural areas. In communities where the facilities were missing and where the services were not available, it follows then that the communities had no access to the required services and this added an extra burden on the already under-served community by banning community-based deliveries. This meant that since community-based deliveries were banned, the women had to seek delivery

services in distant places since the available trained traditional birth attendants were stopped. This reduced the number of women with access to holistic maternal care. A study done in Ethiopia by Owolabi (2014) contrary to the decision to ban TBAs supported the need for training TBAs to be involved in the provision of pregnancy care owing to the fact that TBAs were already frequently used by women and that the alternative options were lacking in most developing countries. One would then assume from many studies that for decades to come the traditional birth attendants will continue to have a substantial influence and role to play in the health practices and life habits of rural populations even when modern health services are made available to them (Joseph, 2011).

Accessibility

The availability of a facility (clinic) and/or service does not always guarantee its utilisation unless it is situated within reasonable reach of the people who should benefit there from. Accessibility is therefore a needed requisite for satisfactory service provision. This study revealed that most women had opted to continue delivering within the community despite the ban due to long distances they had to cover just to access delivery services. In some areas (Manyemunyemu) the only seemingly near facilities were situated 16km away (Zimba hospital) 14km away (Katapazi clinic) and 12km away (Muziya clinic) which reduced the accessibility of the facilities and the services offered. Women accessed delivery services within their communities from trained traditional birth attendants and the stopping of their services reduced greatly the accessibility of maternal services in this chiefdom. The study showed that some women delivered on their way to the clinics, a sign that the facilities were not within easy reach and transport was a problem. This is similar to the findings of the ZDHS (2013/14) which showed that access to health facilities especially in rural areas was still a challenge. The meaning of these findings is that, although the policy directive was well intended, it only focused on one performance indicator; the ultimate reduction of maternal rates which they claimed that the training of traditional birth attendants did not contribute to (Leedam, 1985).

Other equally important aspects of accessibility to the needed health services were not considered before the ban and this has created a strain of the community. According to the WHO (1992), the training of traditional birth attendants was considered as an interim measure until all women had access to professional and modern health care services. Vansintejan (1988) agreed that due to limited facilities and inadequate trained manpower most communities had no access to proper medical facilities and services. Before this could be achieved (more health facilities and personnel) in the Zambian context as evidenced from this study, training was stopped and the services of TBAs stopped.

Acceptability

Accessing a service doesn't always translate into accepting it. Once the service is available and accessible by the community it needs to be acceptable otherwise people will still not utilise it and may end up seeking alternative options. Acceptability of a service may be influenced by a number of factors such as religion, traditional beliefs and cultural appropriateness (male mid wives) and satisfaction with services provided (Tahanashi, 1978). This study showed that even where delivery services were available and accessible, some women did not accept a situation where they were still delivered by their own relatives and friends when they went to the clinic due to non-availability of trained staff. Apart from discouraging some from going to deliver from health institutions, those that managed to go there felt it was a waste of time and resources.

Poor staff attitude was reported as one of the deterrents of clinic deliveries where women were scolded and shouted at and as a result most of them continued to be delivered from home. A study by Vogel (2015) is in agreement with these findings where he found out that globally many women experienced mistreatment during labour and child birth in health facilities which prevented some women from attending facility-based deliveries. Some of them said they did not accept clinic deliveries because they were culturally and traditionally used to delivering from their homes hence didn't see the need for going to the clinic even after the ban. This statement is in agreement with the study done by Titaley (2010) who said health strategies involving TBAs were beneficial particularly in

remote areas where their services were highly utilised because they were traditionally and culturally appropriate.

It is also clear from the study that the communities were not well informed of the reasons that led to the ban as a result they could not accept what they didn't understand and didn't conform to their traditionally acceptable methods. As long as peoples' perceptions were negative on a decision they were not likely to accept the service it supported. Lungu (2010) agreed with this argument. It is evident from the scenario prevailing that communities still accepted trained traditional birth attendants and were still considered important at community level.

A study done in Botswana by Anderson (1992) showed similar findings where she revealed that traditional birth attendants possessed a rich culture that informed childbirth at local level hence considered vital at community level. What this means was that any decision that was perceived to undermine local culture and tradition is bound to face resistance, rejection and failure.

Affordability

The health service coverage and evaluation model asserts that even when the health `service is available, accessible and acceptable, its effective utilisation depends equally on how affordable it is to the community. If the cost of the service in terms of transport costs and requirements for the baby are too high the service will not be utilised. The findings of this study revealed that women had to cover long distances to reach the health facility which was costly for them. Even if the delivery services were said to be free from governments' point of view, the findings showed that they were not cost free as women were made to spend money due to the many things demanded at the clinic in terms of baby requirements. These included among others jik, baby blankets, shawls, "*chitenge*" materials and cash just in case an emergency arose. Most women could not afford these items in terms of the quality of the items demanded at the clinic hence some opted to deliver from their homes. As if that was not enough, when they delivered from home they

were made to pay penalty fees up to K100 and not given postnatal services including under-five cards which they complained was too high for the local people and blamed the ban of community-based deliveries for the unnecessary cost. As a result of not getting health services unless penalty fees were paid, the study found out that most children were not immunised in time which posed a threat of disease outbreaks.

The findings also showed that there was an extra cost for lodging at the relatives' shelter as they awaited the delivery of women escorted. This amounted to a high cost of running two separate homes. Compared to the health facility-based deliveries, community-based deliveries were preferred as the trained traditional birth attendants were readily available within the community hence easily accessible, culturally acceptable and affordable as women were not required to pay anything for transport or buy a lot of things. Even where trained personnel were present, women sometimes preferred trained traditional birth attendants because of their availability and cultural appropriateness.

This means that even when delivery services were offered in some communities, some women delayed to make decisions to go for those services at community level due to high costs which would still affect maternal mortality levels negatively. This was in conformity with the three delays model in a study done in Zambia by Hazemba and Siziya (2010).

Appropriateness

The appropriateness of the services include the trust measures of the community towards the service in terms of how much the community was engaged in deciding what they deemed right and correct in their cultural context.

It is clear from the findings in this study that the community was not involved in the decision making process and worse still not communicated to effectively over the decision and the reasoning behind it. The decision though plausible from the biomedical point of view seemed not to be culturally appropriate especially for rural communities

like Mukuni chiefdom. Traditional leaders (*bana bedyango*) and trained traditional birth attendants equally felt disrespected for failure by government to not only involve them in the process of decision making but also informing them officially over the decision and the reasons for it. Government initially recognised the need to incorporate traditional birth attendants and engaged them in the health care system (Kruske and Barclay, 2004) which meant community empowerment and participation and yet the training on its own did not address access, costs, or acceptability of referrals by women or their families (Leedam, 1985).

Some studies done agree with this view on the availability, accessibility, cultural acceptability and appropriateness of trained traditional birth attendants (Fortney, 1997, Hazemba and Siziya 2010, UNICEF 1997). This means that there is nothing you can achieve for the community without their involvement and participation in all processes of the decision meant to benefit them.

5.4 Strengths of the Study

Notwithstanding the identified limitations, the study is recognizable for its strengths:
Firstly, the study has outlined the perspectives of the trained traditional birth attendants in the area of policy prohibition and has shown real life issues which are beyond measurement.

Secondly, the study is rich in its methodology and describes a step by step process of how things were done and future researchers can follow the path to arrive at similar findings in a similar setup. The study employed three methods of data collection namely focus group discussions, in-depth interviews and key informant interviews. Observations were done in all the three approaches of participants' gestures and facial expressions. This gave the study a high degree of triangulation at data collection level on which the strength of qualitative research depends.

Thirdly, the study is among the first if not the only one of its kind since the policy promulgation which shows the dynamics of community participation and empowerment which are powerful in qualitative research. Therefore, the findings probably could be generalisable to similar settings in rural areas of the country and provide useful insights that can inform policy and practice to improve maternal and child health.

5.5 Limitations of the Study

Like most studies, this study had its own limitations inherent in the methodology.
Firstly, generalisability of the findings of this study posed a critical problem. The study was conducted in one setting with a small sample of respondents taken from three health facilities of Kazungula district yet the district has more than twenty-two health facilities. The findings may therefore not be representative of other settings. Similar studies are therefore warranted in other settings for comparability of research findings.

Secondly, the study only looked at the perspectives of community members which do not give a full picture of the situation on the ground. There is need to triangulate the findings by looking at a larger source of information by getting the perspectives of health workers, men and common women who are equally important stakeholders.

Over and above, this study generated insights based on a small sample size in one setting. There is need for other studies using larger sample sizes and quantitative research methods in a diversity of settings to be done to determine the representativeness of these findings.

CHAPTER SIX

CONCLUSION

This study aimed at eliciting perspectives targeted at understanding the social life of trained traditional birth attendants after the ban and has shown policy failure and non-involvement of communities in decision making. The decision to stop community-based deliveries was made based on biased empirical evidence that was not locally appropriate especially for the rural communities with poor staffing levels. One would then question a holistic ban and earlier decisions hypothesising lack of valid evidence based studies. From the health promotion point of view, the policy ban did not incorporate the four tenets of health promotion being *community participation, community partnerships, community empowerment, equity and justice.* Failure to take note of these important health promotional tenets may lead to dissatisfaction and consequent passive resistance from the community despite the well intended decisions meant to benefit the community.

Implications to Governments' Decision Making Process

The findings will help government in the planning process to incorporate all stakeholders for successful policy implementation and set up instruments to ensure the policies meant for the community are followed and adhered to. The study will also help Kazungula district health management team to plan on improving their service provision to best serve the underserved communities and formulate health promotional messages that are evidence based.

Implications to Nursing and Midwifery Practice

The study has shown that the assessment of the health services provided to the community using the five 'As' *availability, accessibility, acceptability, affordability and appropriateness* works well in understanding satisfaction by the community and to help improve services provided. More importantly the themes that emerged from this study can be used as variables for further quantitative research and add further to the body of knowledge. This will help nursing and midwifery training to incorporate the perspectives of the people for whom their services are intended.

Implications to Public Health Research

The study used easy to follow steps in the methodology which will help future researchers to replicate similar studies in similar settings to enrich knowledge on the perspectives of other stakeholders like health workers, men, government officials and women of reproductive age who were not part of this study. Therefore the study has created room for further studies. The study done in Chongwe recently calls for more public health research to assess the possibility of retraining TBAs and continue using them specifically in resource constrained rural areas.

Implications to Public or Community Health Nursing Practice

The findings from this study are critical in improving community health nursing practice in that it highlights the importance of community partnerships and involvement in the services provided for them. Even though the nursing care practice is highly reliant on biomedicine, there is need to incorporate aspects of local skills and knowledge in practice for the benefit of the community. There would literally be very little community health nursing practice can achieve for the community without the participation of communities themselves. There is a lot that modern community health nursing can learn from traditional birth attendants and the community at large and vice versa.

6.1 Recommendations

The following recommendations are therefore being made:

1. **Policy Formulation -** government policy makers ought to formulate policies informed by empirical evidence with low bias. This calls for more local systematic studies or randomised controlled trials (RTCs) to ascertain the contribution of trained traditional birth attendants to maternal and infant mortality.
2. **Policy Exemption -** based on this study, Kazungula district should be exempted from the ban otherwise the policy remains a mockery when staffing levels and health facility coverage remains consistently low.
3. **Infrastructure -** government should ensure more clinics are built as close to communities as possible and all clinics start providing delivery services to reduce the distances and cost of accessing these services elsewhere outside the communities.

4. **Equipment -** The Ministry of Health should provide delivery equipment to clinics that do not have and ensure they start providing holistic services as close to the communities as possible.
5. **Human Resource -** Government should deploy more health workers to rural clinics and provide proper incentives that will attract them to stay there and work with motivation.
6. **Community Participation -** Policy makers should ensure all stakeholders are involved in all stages of decision making and implementation otherwise there would be nothing from the community without their involvement. This improves ownership and sustainability of programmes at community level.
7. **Referral System -** Government and Kazungula district health office should strengthen the referral system from communities (SMAGs) to health facilities by improving the road networks in the communities and provision of transportation in terms of bicycles to trained traditional birth attendants and zonal vehicles for health facilities.
8. **Re-training of TBAs -** Policy makers in government and the Ministry of Health may need to formulate Primary Health Care (PHC) oriented Reproductive Health Policies that support the training of TBAs through task-shifting tailored on evidence-based modified curriculum in the interim period until there are sufficient skilled birth attendants to service the hardest-to reach rural settings of the country like Kazungula. This is evidenced from the positive results from Chongwe district.

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APPENDICES

Appendix 1

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF PUBLIC HEALTH

INFORMATION SHEET AND INFORMED CONSENT FORM

This information sheet is for members of Mukuni chiefdom who we are inviting to participate in a study on **"Trained Traditional Birth Attendants' Perspectives on Governments' Decision to Stop Community-based Deliveries in Kazungula District, Southern Province"**

Instructions

This form has two parts:

(i) Information Sheet (To share information concerning the study)
(ii) Certification of Consent (For signatures if you choose to participate).

Part I: Information sheet

Introduction

Dear participant,

My names are **Chilala Cheelo** a student at the University of Zambia undertaking a master's degree in Public Health. My research team and I are conducting a study in your area. The study is focusing on the views of trained traditional birth attendants on governments' decision to stop them from conducting community-based deliveries in Kazungula district. We invite you to take part in this study. This consent form may contain words that you do not understand. Please feel free to ask any questions as we go through the information and we will take time to explain.

Purpose of the study

In 2010, the government of the republic of Zambia stopped trained traditional birth attendants from conducting home deliveries. Since then, their roles have shifted to encouraging and escorting expectant mothers to deliver from health institutions in an effort to prevent and reduce maternal deaths. The aim of the study is to get views on the decision to stop community-based deliveries so that the district health office and the government can better plan interventions to increase hospital deliveries that have remained low despite the ban. We believe that you can help us get this information by telling us what you think about this decision.

Type of Research Intervention

The study will require your participation in a group discussion that will take 45 minutes to about an hour.

Participant selection

You are being invited to take part in the study because we feel that your experience as a trained traditional birth attendant or female traditional leader can contribute much to our understanding and knowledge on the delivery services offered.

Voluntary participation

Your participation in this study is entirely voluntary. Therefore, it is your free choice whether to take part or not.

Duration

The discussion will be held once and will take about one hour.

Risks

There is a risk that you may share some personal or confidential information or that you may feel uncomfortable talking about some topics. You do not have to answer any question or take part in any discussion if you feel the question(s) are too personal or if talking about them

makes you feel uncomfortable. However your participation in this study will not affect access to any services at your local health facility in any way. The discussion shall be recorded but if you are not comfortable I shall only take notes of what you say. After writing the report all recordings will be destroyed.

Benefits

The information given in this study though may not immediately benefit you, will help government and the district health office to plan better strategies to improve delivery services to meet the needs of the community.

Reimbursements

You will be provided with a transport refund not exceeding 30 ZMK.

Confidentiality

We assure you that we will not share any information about you to anyone outside the research team. All the information that we shall collect from you will be kept private. Instead of having your name, any information about you will have a number. Only the researchers will know your number and all information will be locked up. We also ask you or others in the group not to talk to people outside the group about what was said during group discussion. In other words, we will ask each of you to keep what we discuss as secret.

Sharing of Results

The information collected will not be shared with or given to anyone except among the research team and university of Zambia. The information will also be share with you in a community meeting with the chief when the study is completed.

Right to Refuse or Withdraw

You have the right to refuse to participate or to withdraw from the study at any time.

Who to Contact

If you have any questions, you may ask me now or later. If you wish to ask questions later, you may contact the principal investigator on the following address:

Chilala Cheelo

University of Zambia

School of Medicine

Department of Public Health

P.O Box 50110

Lusaka, Zambia

Email: chilala.cheelo@yahoo.com

Cell: 0965141130

OR

ERES Converge IRB

33 Joseph Mwila Road

Rhodes park

Lusaka, Zambia.

Email: eresconverge@yahoo.co.uk

Phone +260 955155633/4

Appendix 2

INFORMATION SHEET (CHITONGA)

CHIPEPA CHIJISI MAKANI

MUTWE WAMAKANI: MEZEZO YABAMAKAINTU BAKAIYA KUTUMBUSYA MUMINZI KUKULESEGWA KUTUMBUSYA MUMINZI ANFULUMENDE MUCILIKITI CA KAZUNGULA (SOUTHERN PROVINCE)

CAKUSANGUNA

Mwaanzigwa!

Zina lyangu ndime **Chilala Cheelo,** ndili mwana wacikolo kucikolo cipati. Ndila mubalila cipepa cakulipa kutola lubazu muciiyo eci calo cisandulula ciiyo cimulomba kutola lubazu. Ndalomba, mulinvwe kwanguluka kubuzya mibuzyo ili yonse kamutana zumina kutola lubazu. Inga mwabuzya mibuzyo naa mwasala kale kutola lubazu.

MUZEZO WACIIYO EECI

Ndiyanda kuziba mizezo yabamakaintu bakaiya kutumbusya kwendelana aku lesya milimo yabo muminzi anfulumende.

MBOKWENDELEZYEGWA

mwabuzigwa kwaamba kuti munjile mulwiiyo olu akaambo kakuti ndiyandula bantu bakala mucooko muno bakonzya kundipa twaambo tukonzya kundi gwasya kuti ndi cikonzye kuubeleka oyo mulimo alimwi ndimwe wabaabo. Kuti naamwazumina kunjila mumubandi oyu, mulabuzigwa mibuzyo iijatikizya cooko cino abubelesi bwanu amizezo yanu. Ikuvwiila mibuzyo eyi cilatutolella iwoola lyomwe. Tuyakuzuminizyanya kucita eci kubusena nkomuyanda. Ikuvwiila kwenu kuya kulekodwa akaambo kakuti ndiyanda kuti kufumbwa ciindi inga ndajokelela kumubandi kutegwa ndibe amubandi usuumene. Balike bantu bakasalwa kuba muciibeela cangu baya kuba alubazu mu makani aku lekoda. Kumamanino alwiiyo olu, ndiyojoka alimwi tuyakwaabane ncetikajane.

ZILIJAZYO NA AKUTALIVWA KABOTU

Taakwe zilijazyo kumubili zikonzya kucitika akaambo ka kulwiiyo olu. Nokuba kuti, inga na mwalivwa bubi ikuvuuwa imwi mibuzyo. Ingamwakaka imwi mibuzyo, njomutayandi kuvuuwa antela mibuzyo itamuvwisi kabotu. Ingamwauleshya mubandi oyu kufumbwa ciindi. Ikwingula antela kutolalubazu mulwiiyo olu taluko leta pezi munzila imwi antela mukuyandaula buumi muzibbadela zya nfulumende.

BULUMBU

kwinyina bulumbu kulindinwe nyolike akaambo kakutola lubazu mulwiiyo olu. Kubamuciiyo oku takukonzyi kucinca mbomu tambula kusilikwa kuzwa ku cooko cilanga buumi naa Ministry of Health zibelesegwa mu Zambia, pesi ciyojanika kuzwa kuciiyo eeci inga cakugwasya cooko mumazuba akumbele alimwi akusumpula nseba zyabamakaintu mucooko.

INZILA ZIMBI ZYA KUTOLA LUBAZU

Iinga mwa sala na kutola lubazu muciyo eci nokuba kutatola lubazu muciiyo eci. Naa mwasala kutola lubazu muciiyo tamwelede kukala kusikila mama nino a ciiyo. Inga mwasala kuleka ciiyo kufumbwa ciindi pele takwe nocikonzya kumunyonganya. Naa mwasala kutatola lubazu muciiyo, muyo bikilwa manu kucibbadela ca nfulumende kufumbwa koonse nkomuya kujanika nokuba kufumbwa cimbi kwamana kunyina nomuti kanyongane munzila ili yonse.

IMAKANI AMASESEKE

Mwatambwa kutola lubazu muciiyo eci. Na mwazumina kutola lubazu mu ciiyo eci ndila mubuzya mibuzyo ijatikizya ciyo eeci. Kutegwa zintu zibe zya maseseke, mazina enu tati kambwe naa kulembwa acipepa. Mulapegwa inambala kutegwa kakwina kuziba kuti ndinywe bani mwapa mizezo eyo. Takwee uyoziba zina lyenu muciiyo. Pele ibantu abo balo bali muciiyo eci mbababayo kuba amakani aya. Ndakumana a ciiyo eci, zyoonse zili mukalekoda aka naa kufumbwa makani aati bwezegwe ayo nyononwa.

KULIPA

Kutola lubazu muciiyo eci nkwa kulipa kumanina. Mulizumizigilwe kucileka kufumbwa ciindi kakunyina kulisalazya. Naa mwayanda kucileka akati kati ka ciiyo, kufumba twambo

tomwaamba tuya kuba twa ma seseke alimwi tatu kapegwi kumuntu umbi kuti amucise naa kumunyonganya. Eci tacika munyonganyi mukutola lubazu kumbele amazuba.

BAKUTUMINA

Naa muyanda kwambaula a muntu kujatikizya ciiyo eci nkambo mwayeya kuti timwa bambwa kabotu, naa mujisi mibuzyo iguma ciiyo eci, inga mwatumina;

Bapati baciiyo: Chilala Cheelo

Kusaina: ______________________________

Bakutumina:

Chilala Cheelo
University of Zambia,
School of Medicine
Department of Public Health
Box 50110, Lusaka
Tel: 0965141130

ERES CONVERGE RB
33 Joseph Mwila Road
Rhodes Park
Lusaka
Tel: 0955 155633/4
0966 765503

Appendix 3

Consent form (Certificate of Consent)

I have been invited to participate in a research on “trained traditional birth attendants’ perspectives on government decision to stop community-based delivery in Kazungula district, southern province”.

I have read the information above, or it has been read to me. I have had the opportunity to ask questions about it and any questions I had have been answered to my satisfaction. I therefore consent voluntarily to take part in this study.

Name of Participant:………………………………………………………………………..

Signature/Thumb Print of Participant:……………………………………………......

Date:…………………………………………………………………………………………

Witnesses

Name:….……………………………………………………………………………………

Signature/Thumb Print:…………………………………..

Date:

…………………………………………………………………………………………….

Appendix 4

CONSENT FORM (TONGA)

CHIPEPA CHAMBA KULIPA KUBANTU BABUZIGWA

TITLE: TRAINED TRADITIONAL BIRTH ATTENDANTS PERSPECTIVES ON GOVERNMENT'S DECISION TO STOP COMMUNITY-BASED DELIVERIES IN KAZUNGULA DISTRICT; SOUTHERN PROVINCE

Uyandaula: Chilala Cheelo

Eci ncakutondezya kuti memo………………………………………………. (zina utola lubazu) ano ndazumina kutola lubazu kumulimo oyu.

Ndazumina ku toola lubazu kumubandi ujatatikizya cooko kujana mizezo iguminizya kulesya kutumbukila muminzi abanfulumende mu Kazungula. Ndizi kuti mubandi oyu inga baubika mumapepa, pesi zina lyangu talika bikwi kulizyezyo nzyo batikajane.

Ndilizi kuti ndili libile kukaka kubikwa mumu bandi oyu. Alimwi ndilizi kuti ndili libide kucileka akati akugusya zina lya ngu kakwina kupegwa mulandu.

Ndapegwa lubazu lwa kubuzya kufumbwa mibuzyo njendiyanda, alimwi eyi mibuzya yavwiligwa mukukomana kwangu.

______________________	______________________	______________________
Kusaina utola lubazu	**Kusaina ulalngilila**	**Uyandula twaambo**

____

Mwezi

Bakutumina: Chilala Cheelo	ERES CONVERGE RB
University of Zambia,	33 Joseph Mwila Road
School of Medicine	Rhodes Park, Lusaka
Department of Public Health	
Box 50110, Lusaka	Tel: 0955 155633/4
-Tel: 0965141130	

Appendix 5

Focus Group Discussion Guide – (Total time 45-60 minutes)

I. Introduction (10 min)

Part 1

1. Thank the participants for coming
2. Explain the purpose of the study
3. Assure that the discussion will be kept confidential
4. Ask for their consent to participate and explain that their participation is voluntary
5. Give warm up questions to set the climate.
6. Date:…………………………ID No.:………………………
7. Place:……………………………………………………..
8. Language used during discussions:…………………………

Part 2

1. How do you understand government's decision to stop TBAs from conducting community-based deliveries?
2. What were your roles before the ban of community-based deliveries as a tTBAs?
3. How have your roles changed after the ban of community-based deliveries?
4. What are some of the good things you see with the ban of community-based deliveries?
5. What are some of the bad things that you experience as a result of the ban?
6. How do you compare your work before and after the ban?
7. Where do women deliver from currently? Have people stopped coming to you for deliveries? If not, why?
8. How are communities staying far from health facilities coping with the ban?
9. What is happening in communities without delivery services?

If there are no questions and concerns, we have come to the end of our discussion. Thank you very much for your time and participation.

Appendix 6

Focus Group Discussion Guide (Chitonga)

Mubandi Abama Kaintu Bakaiya Kutumbusya Muminzi

1. Sena mukutelela buti kulesya kutumbusya muminzi kwa bamakaintu bakaiya kutumbusya muminzi?
2. Milimo nzi imwi njimwakajisi infulumende kaitana lesya kutumbusizya muminzi?
3. Sena milimo yanu yakacincha buti kuzwa infulumende niyakamulesya kutumbusizya muminzi?
4. Mbubotu nzi mbomubwene ankambo kakulesya kutumbukila muminzi?
5. Mbubi nzi mbomubona buletwa ankambo kakulesya kutumbusya muminzi?
6. Muyelanya buti milimo yanu infulumende kaitana lesya achechino chindi kamulesedwe?
7. Sena nkokuli bamakaintu nkobatumbukila cino cindi? Sena bakaleka kubola kuli ndinwe kukutumbuka? Na tabalekede, muyeya kuti nkambonzi nchoba taleki?
8. Sena bamakaintu bakala kule azibbadela bakalanganya buti kambo kakwinka kukutumbukila kizibbadela?
9. Nchinzi chichitika mumasena mutakwe zibbadela zyakutumbukila (mbuli kumanyemunyemu)?

Ikuti na kunyina mibuzyo nanka kambo kamwi kakwaamba, twasika kumamanino amubandi wesu. Twalumba kucindi canu akutola lubazu.

Appendix 7

Key Informant Interview Guide – (Total Time 45-60min)

Part 1

1. Thank the participants for coming
2. Explain the purpose of the study
3. Ask for their consent to participate and explain that their participation is voluntary
4. Date:…………………………………………………………..
5. Place:…………………………………………………………..
6. Language used during discussions:…………………………
7. ID No.:……………………Interviewer:………………………
8. Profession of interviewee:……………………………………

Part 2

1. What are some of your roles as a female traditional leader?
2. Are you aware of the ban of community-based deliveries by government?
3. If so how do you understand the decision by government?
4. How are you helping your community to adhere to the ban by government?
5. In your view have communities stopped delivering from TBAs? If not, why do you think they haven't stopped?
6. What is your view on community deliveries by tTBAs before stopping them compared to their current roles?
7. How do you view this ban especially where delivery services are not available e.g. Manyemunyemu Clinic.
8. What is the current scenario in such places?
9. What do you think should be done to improve delivery services for your community?

If there are no questions or concerns, we have come to the end of our interview. Thank you very much for your time and participation.

Appendix 8

Key Informant Interview Guide (Chitonga)

Mubandi abana bedyango

1. Milimo nzi imwi njomujisi mbuli basololi bachikaintu muminzi?
2. Sena mulizi kuti infulumende yakalesya boonse bamakaintu kutumbukila muminzi?
3. Kuti na mulizi, mukutelela buti kulesya ooku nkuyaka chita infulumende?
4. Sena mugwasilizya buti bana maleya kuti bachilile malailile anfulumende aaya?
5. Mukuyeya kwanu, sena muyeya kuti bamakaintu bakaleka kutumbusyigwa abamakaintu batumbusyizya muminzi? Na peepe, ntwambonzi tupede kuti kaba chitubusyigwa muminzi?
6. Mukuyeya kwanu, inga mwailanganya buti milimo yabamakaintu batumbusya muminzi infulumende kaitana balesya kutumbusya muminzi kwelanyika amilimo yabo chino chindi?
7. Mukulanganya buti kulesya ooku kwanfulumende kapati mumasena atajisi zibbadela zyakutumbukila mbuli kumanyemunyemu?
8. Sena bamakaintu batumbuka buti mumasena aamusyobo ooyu?
9. Sena mukuyeya kwanu nchinzi chelede kucitwa kutegwa milimo yakutumbuka isumpuke mubulelo bwanu?

Ikuti na kunyina mibuzyo nanka kambo kamwi kakwaamba, twasika kumamanino amubandi wesu. Twalumba kucindi canu akutola lubazu.

Appendix 9

IN-DEPTH INTERVIEW GUIDE (ENGLISH)

ID No:…………….. Interviewer:……………………….. Date of Interview:…………………….

Age of tTBA:…………………...

1. How did you become a traditional birth attendant? (qualifications for TBA)
2. How long have you worked as trained traditional birth attendant?
3. Are you aware of the ban of community-based deliveries by government? (If yes, how did they know about the ban? Reasons for the ban)
4. Have you ever experienced a woman dying while giving birth (maternal death)?
5. What were your roles/duties as a tTBA before the ban of community-based deliveries?
6. What are your roles now and how do they differ from your previous roles?
7. How would you describe your experiences as a trained traditional birth attendant since the ban? (positive and negative experiences, relationship with the community)
8. How does conducting a delivery at the health facility differ from conducting community-based deliveries?
9. How are you currently working with the health facilities? (relationship with health workers)
10. Have women stopped coming to you for deliveries? If not why do you think they haven't? (probe for home deliveries, how they help adhere to the ban if at all)
11. What is the major challenge you have in your work currently?
12. How do communities that stay far from health facilities cope with the ban? (describe current practices/scenario)
13. How would you react if you were told to resume community-based deliveries?
14. What in your opinion should be done to improve delivery services in your community?

If you have no questions or comments we have come to the end of the discussion thank you for your time and participation.

Appendix 10

IN-DEPTH INTERVIEW GUIDE CHITONGA

ID No:…… Uyandaula:………………………….. Buzuba Bwamubandi:……………………….

Myaka ya TBA:…………………...

1. Sena mwaka salwa buti kuti kamutumbusya muminzi?
2. Mwabeleka myaka yongaye mumulimo wakutumbusya muminzi?
3. Sena mulizyi kuti infulumende yakalesya bamakaintu kutumbukila muminzi? (na mulizyi sena mwakazyiba buti? Twambonzi ntomuyeya twakapa kuti infulumende ilesye kutumbukila muminzi)
4. Sena mumulimo wanu kuli nimwakafwidwa mumama cindi cakutumbuka?
5. Sena mwaka jisi milimo nzi infulumende kaitana kulesya kutumbukila muminzi?
6. Ino kwacindi cino mujisi milimo nzi amana indene buti anjimwaka jisi kusanguna?
7. Mbubuti mbomunga mwasandulula ibubelesi bwanu buli mumama wakaiya kutumbusya mumunzi kuzwa infulumende niyakalesya kutumbukila muminzi? (bubotu a bubi mbomubwene, cilingwe abana buleya)
8. Sena mukuyeya kwanu ikutumbusya muminzi kwindene buti akutumbusya kucibbadela?
9. Sena cino cindi mubeleka buti a zibbadela kuguminizya mulimo wenu? (cilongwe a babelesi bacibbadela)
10. Sena bamakaintu bakaleka kubola kulindinwe kuzikutumbusigwa? Na pepe, muyeya kuti nkambonzi ncobataleki kuboola? (kuyandaula butumbusyi bwamuminzi, mbobagwasilizya infulumende kuzwidilizya muzezo oyu)
11. Sena mbuyumuyumu nzi mbomujisi mukubeleka mulimo wanu cino cindi?
12. Ino iminzi ikala kule azi bbadela ikalanganya buti kambo kakutumbukia kucibbadela kuleka muminzi? (ncinzi cicitika muminzi kwacindi cino itakwe zyi bbadela)
13. Sena inga mwalinvwa buti kuti mwambilwa kuti mutalike kutumbusya muminzi alimwi?
14. Mukuyeya ncinzi celede kucitwa kusumpula maumi abamakaintu mucooko cenu?

Ikuti na kunyina mibuzyo nanka kambo kamwi kakwaamba, twasika kumamanino amubandi wesu. Twalumba kucindi canu akutola lubazu.