UNIVERSITY OF MALAWI
KAMUZU COLLEGE OF NURSING

AN EXPLORATION OF ATTITUDES AND PERCEPTIONS OF TRADITIONAL BIRTH ATTENDANTS ON THEIR NEW ROLES

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LILONGWE

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"If I have seen further than others it is by standing on the shoulders of giants"

Isaac Newton

DECLARATION

I declare that this proposal is entirely the result of my effort. It has never been presented or published anywhere for the purpose of attaining an academic award of any kind.

Student: Hilda Jere Mwale

Signature: .....

Date: 25th Nov 2009

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DEDICATION

To my parents for their prayers, support and encouragement which made my academic life easier. I dedicate this work to my husband, Eric and my children Paul, Cathy and Comfort whose love, patience and understanding made the completion of this work a success.

Those women whose deaths make up maternal mortality statistics are mothers, sisters and wives. Their loss is deeply felt by those around them. This is dedicated to the memory of such women.

This work is also dedicated to those individuals and groups who are working towards improving maternal and neonatal health in Malawi.

ACKNOWLEDGEMENT

For this work to be compiled successfully it took the efforts of some people who instilled in me the desire to work hard and achieve what I have here. Those who are not mentioned by name, their contribution is known and treasured. I am indebted to the role played by Mr.A.N.K Simwaka, my research supervisor who was very supportive in form of advice and guidance throughout my work on the dissertation.

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My profound gratitude to all my colleagues for their emotional support and innovative ideas which have in one way or another contributed to this work, and of course the Alpha and Omega who "in all things works together for the good of those who love Him." All this would have come to nothing without God.

ABSTRACT

This study is a qualitative study whose purpose was to explore the attitudes and perceptions of TBAs on their new roles. This study was conducted at Ekwendeni. Convenience sampling was used to select the participants from a population of 90 TBAs who were trained by Ekwendeni Mission Hospital. A sample size of 23 TBAs was used. Data was collected using three Focus Group Discussions. Data analysis was done manually using Collaizi's method of content analysis. The study revealed that TBAs have knowledge of the changes in their role but have different views on the reasons for such changes. The study also found that despite having knowledge of the changes some TBAs still continue conducting deliveries. This study has concluded that there is minimal compliance to the TBAs changed roles. There is need for policy makers to revisit the policy and find other strategies of gradually replacing TBAs with Skilled attendants.

LIST OF ABBREVIATIONS

KCN : Kamuzu College of Nursing

MDG : Millennium Development Goals

MOH : Ministry of Health

SEARO : South East Asia Regional Office

TBA : Traditional Birth Attendants

UNFPA : United Nations Population Funds

UNICEF : United Nations Children's Emergency Funds

OPERATIONAL DEFINITIONS

Maternal Mortality: The death of a woman from pregnancy related causes, when pregnant or within 42 days of termination of pregnancy.

Skilled Attendants: People with midwifery skills (Doctors, nurses, midwives) who have been trained to proficiency in the skills necessary to manage normal deliveries, and diagnose, manage or refer complications.

Traditional Birth Attendants: Traditional midwives who have received short course training through modern health sector to upgrade their skills.

CHAPTER ONE: INTRODUCTON

1.0 Introduction and Background

Midwifery is a service based on a body of knowledge which is responsive to the changing needs of women. It takes place within a context of teamwork which is holistic by nature, combining an understanding of social, emotional, cultural and physical aspects of women's reproductive health needs. Pregnancy and childbirth are normal physiological events in the lives of a majority of women. Childbirth is a social and personal experience as well as an obstetric event and for most women a satisfactory outcome involves more than delivery of a healthy baby.

The midwife is the prime care provider in ensuring optimum physical and psychological wellbeing during the woman's pregnancy childbirth and early parenthood. Although the midwife is the prime care provider of midwifery services, the contribution of others in the health care is recognized. One such group of care givers is the traditional birth attendants. Traditional birth attendants are traditional, independent, non-formally trained and community based providers of care during pregnancy, labour and postnatal period (Van Leberghe, 2005). A TBA initially acquires skills by delivering babies herself or through apprenticeship to other traditional birth attendants. A trained TBA is one who has received short course training through the modern health sector to upgrade her skills.

When TBA training started in early 1970s, the aim was to improve obstetric services thereby improve maternal and neonatal mortality since TBAs already existed and were accessible and culturally acceptable. It was even hoped that they conduct antenatal clinics and be integrated into the health system. By 1992, A WHO/UNFPA/UNICEF joint statement emphasized that if TBAs are to make real contribution to safe motherhood, they must be integrated into the modern health system through training, supervision and technical support. While WHO continued to encourage TBA training, evidence emerged that this had little impact on maternal mortality. It may improve knowledge and attitudes but a small decrease in maternal mortality (Van Leberghe, 2005). By 1996, WHO started to turn focus away from TBAs, to emphasise the necessity of skilled attendance at birth.

In recent years, the role of TBAs has become obscured in the debate around prevention of maternal mortality. It became clear that the most effective measure to reduce maternal mortality is providing skilled care by skilled attendants. TBAs are not included in the definition of skilled attendants. The ineffectiveness of the risk assessment approach also puts the idea of using TBAs questionable. The risk assessment approach was introduced in the late 1970s in which health providers classified pregnant women as high (those who had greater chances of developing complications) and low risk (those who had less chance of developing complication) (WHO/SEARO, 2002). A thorough review of data from around the world showed that risk assessment does not predict who will and who will not have an obstetric emergency, as such all pregnancies are at risk. This means that TBAs who attended to pregnant women who are in low risk category can no longer conduct deliveries. This is why the Ministry of Health through Reproductive Health Unit had to redefine the role of TBAs from being actively involved in deliveries to that of being advocates and counselors in maternal and neonatal health (MOH, 2007). They will also act as a link between the community and the health facility. They can only conduct deliveries in unavoidable circumstances where a woman comes while in second stage of labour.

From a variety of literature, discussions and general observation, global maternal mortality statistics reflect a widening gap between the developed and developing world. For each woman who dies in developed world 99 will die in developing countries (WHO/SEARO 2002).Pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries. Malawi like many developing countries experience complications of pregnancy and childbirth as the leading cause of death and disability among women of reproductive age (MOH, 2007). Data shows that by choice or out of necessity 60% of births in developing countries occur outside a health institution and 45% assisted by TBAs, family members or without assistance at all (Fortney and Smith 1999). Health professionals who work to improve health care in developing countries generally acknowledge that addressing multiple causes of maternal and newborn mortality and morbidity must be a top priority. For millions of women who lack access to skilled care during pregnancy and childbirth, the

special joy is often overshadowed by the life threatening risks both mother and child face. Too often the miracle of new life is transformed into a painful struggle for survival.

During the United Nations General Assembly in September 2000, Malawi was one of the countries that signed the Millennium Declaration. This declaration outlines the eight Millennium Development Goals (MDGs) which countries must achieve by 2015. Goal number five aims to improve maternal health and reduce maternal mortality by ¾ between 1990 and 2015. To reach the MDGs countries need to provide the best possible care during pregnancy and child birth by strengthening health systems and services (Malawi MDG report 2008).

The goal of improving maternal health is measured by two indicators namely; proportion of births attended by skilled personnel and maternal mortality ratio. Malawi's maternal mortality ratio has been steadily decreasing since 2000. In 2000 the maternal mortality ratio was 1,120 per 100,000 live births, in 2004 it was 984 per 100,000 live births and in 2006 it was 807 per 100,000(Malawi MDG report 2008).Although antenatal coverage was 97%, deliveries by skilled attendants in 1992 was 55% , in 2000 it was 62% and in 2006 it was 62%(Malawi MDG report 2008).The figures above indicate that not all mothers deliver at health facilities where there's skilled attendance at birth, others deliver at home or at traditional birth attendants. This therefore means that, in order to achieve 100% skilled attendance at birth there is need to understand the behaviour of TBAs in order to help them to change their mind set. The challenge lies in the ability to accelerate life saving behaviour change among TBAs. To do this it must be clear what their attitudes and perceptions are on their new role.

1.1 Problem Statement

Reduction of maternal mortality ratio continues to be a great challenge for Malawi. There is a common consensus about the importance of skilled attendance at delivery to reduce maternal mortality. Since TBAs are not skilled attendants they are required to send all mothers to deliver at the hospital. However, some TBAs are not complying with this requirement and a lot of women report to the hospital with complications after being

attended to by TBAs. Ekwendeni Mission Hospital receives patients with obstetric complications originating from TBA (personal experience). There's need to understand the TBAs behaviour by studying their attitudes and perceptions on their new role so that there's collaboration in reducing maternal mortality.

1.2 Significance of the Study

The study is important because it will provide information on how TBAs perceive their new role of referring all pregnant women to the hospital. By studying their perceptions more information will be obtained that will explain why TBAs are not complying with the new policy. The challenges that will be identified during the study will help to find ways of ensuring that all pregnant women are attended to by a skilled attendant, thereby helping in achievement of Millennium Development Goal number five which has percentage of women attended by skilled personnel as one of the key indicators. This study will also help to find ways on effective working relationship between TBAs and health personnel.

1.3 Objectives of the study

1.3.1 Broad Objective

To develop knowledge on the attitudes and perceptions of TBAs on their new roles.

1.3.2 Specific Objectives

1. To find out the TBAs knowledge on reasons for not conducting deliveries at home.
2. To explore reasons for TBAs non compliance to the changes in their roles.
3. To identify challenges that TBAs face in performing their new roles.
4. To explore other roles which TBAs can play in promoting maternal and neonatal health.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Traditional Birth Attendants are found in many societies. They are often part of the local community, culture and traditions and continue to have high societal standing in many places, exerting considerable influence on the local health practices. TBAs are part of the birthing process throughout the developing world, assisting in the birth of a substantial proportion of the world's newborns. This has led to a number of studies being done to find out information pertaining to TBA practices. This section reviews such information as it relates to this study.

2.1 TBAs Impact on maternal mortality

With specific focus on the trends of maternal mortality ratio it would be commonly consented that there's no significant impact from TBAs on maternal mortality. This is supported by a study done by Snibley and Snipe (2006) who state that there's no compelling evidence that training TBAs reduces maternal mortality and that there are modest associations between TBA training and maternal mortality but evidence remain insignificant and cost effectiveness of TBA training still remains an issue. Bergstrom and Goodman (2001) in a study to assess the role of TBAs in reduction of maternal mortality state that "throughout history TBAs have been the main human resource for women during childbirth." Their role varies across cultures and at different times. There's little doubt that they have a significant role when it comes to cultural competence, consolation, empathy and psychological support at birth. However recent analyses have come to the conclusion that the impact of TBAs on maternal mortality is low. Since their impact is low, it supports the establishment of new policy on their new roles but the study does not site the attitudes or perceptions of TBAs on new roles. A study done by Bisika (2003) found that most of the people rely on TBAs, although the quality of their services is poor due to illiteracy, their ailing age, lack of supervision and lack of supplies and equipment. The study also found that there was high awareness among TBAs about what they are supposed to do but their actual practice did not reflect what they are told by the formal

health system. Bisika recommended that TBAs need to be empowered to comply with requirements. In order to empower them one needs to understand their attitudes and perceptions on their role.

Although WHO has discouraged reliance on TBAs to improve maternal and neonatal services, some societies still rely on TBAs. This is shown in a recent report by a non-governmental organization in Bangladesh. The study by Huda and Zaffrula (2009) indicated significant reduction in maternal mortality due to involvement of TBAs. In Bangladesh only 10% of deliveries occur in government hospitals and clinics where negligence and inhuman treatment are common. Eighty percent of deliveries are attended by TBAs. In their experience, more maternal mortality occurred at public health centers due to absenteeism of doctors and other skilled workers even when TBAs referred in time. They further argue that it is not the fault of TBAs that maternal mortality in developing countries is not declining fast enough. The real problem is the absence of professionals or inadequate facilities at government hospitals as well as, to some extent, delay in taking decisions by family concerned and difficulties in arranging transport. Huda and Zafrulla suggested that instead of excluding TBAs from providing maternity care they may be considered as resource persons who could be involved in other health care programs, hence the new roles of TBAs.

2.2 Role of Traditional Birth Attendants

Traditional Birth Attendants generally hold a position of respect and influence within their communities. They are uniquely equipped to inform and assist women and their families in preparing for birth. This being the case, absenting their role at delivery does not mean complete exclusion from participating in health care issues, they can still play a significant role in improving maternal and neonatal health. Several studies have been done to identify what other roles the TBAs can play.

A study by Nyanzi and Manneh (2007) on TBAs in rural Gambia found that TBAs have a multiplicity of roles in their community. They act as general health providers, village leaders and elders and they also engage in political, economic, cultural, gender, health

and well being of the society. They concluded that TBAs are important for social and welfare not mere health practitioners. This means that if they are able to perform these roles, they can still continue to contribute to the wellbeing of mothers. Aluko, Ogwubike and Imogie(2002) also supports that TBAs can play meaningful roles in family planning and child care. Fortney and Smith (1999) observed that although TBAs cannot substitute for skilled providers, they can contribute to the survival of mothers and newborns by facilitating access to needed information, clinical services and support. They can also be involved in community education and mobilization. They can convey vital information to families and communities in a culturally appropriate way that will help families to understand how to recognize danger signs in pregnancy. In a study in Kenya, Kibaru (2006) states that it is important for health workers to work together with TBAs encouraging them to refer pregnant women to health facilities in time. They can also become involved in activities such as contraceptive distribution.

2.3 Summary

With reference from various literatures, it can be concluded that, although TBAs are important resource, their activities do not match with the changing needs of society. At the moment the major challenge is reducing maternal mortality (MDG5) by using skilled personnel. This means that TBAs should be entrusted with other roles which can also contribute to the reduction of maternal mortality. As can be seen from the studies, emphasis has been on the role of TBAs in reduction of maternal mortality, very little has been done to study the attitudes and perceptions of TBAs on their new roles.

CHAPTER THREE

3.0 CONCEPTUAL FRAMEWORK

Conceptual frameworks are structures that relate concepts together in a meaningful way (McEwen and Wills, 2000).In research, the conceptual framework serves as a guide or a map to systematically identify a logical, precisely define relationships between variables. It also provides clear description of variables, suggesting ways or methods to conduct the study and guiding the interpretation, evaluation and integration of study findings (Wood and Haber, 1986).

This study used Sister Callista Roy's Adaptation Theory. In this theory, Roy defines human beings as holistic adaptive systems, continuously responding to a number of environmental stimuli (Fitzpatrick and Whall, 1996).A stimulus is an entity that provokes a response and that serves as a point of interaction between the person and the environment. According to Roy, both internal and external factors are identified as stimuli and these include:

(a) **Focal stimuli**: Those things which immediately affect people and demand the highest awareness from them.

(b) **Contextual stimuli**: All other stimuli of human being's internal or external worlds that can be identified as having a positive or negative influence on the situation.

(c) **Residual**: These are beliefs, attitudes and traits of an individual developed from the past but affecting the current response.(see fig 1)

The environment either threatens or enhances the individual's ability to adapt. For human beings life is never the same, it is constantly changing and presenting new challenges. The person has the ability to make new responses to the changing conditions. As the environment changes the person has to grow, to develop and to enhance the meaning of life for everyone (Andrew and Roy as cited in Alligood and Tomey, 2006). From Roy's perspective, human behaviour represents adaptation to the

environment or organismic changes. Adaptation is therefore a process of responding effectively to changes in the environment in order to maintain homeostasis or integrity.

A person has four modes of adaptation and these are physiological, role function, self concept and interdependence. The physiological mode is associated with the person's physiological needs. Self concept relates to the basic needs for mental and spiritual integrity, beliefs and feelings about oneself. The self concept is formed both from internal perceptions and from perceptions of others. The self concept changes over time and guides ones actions.

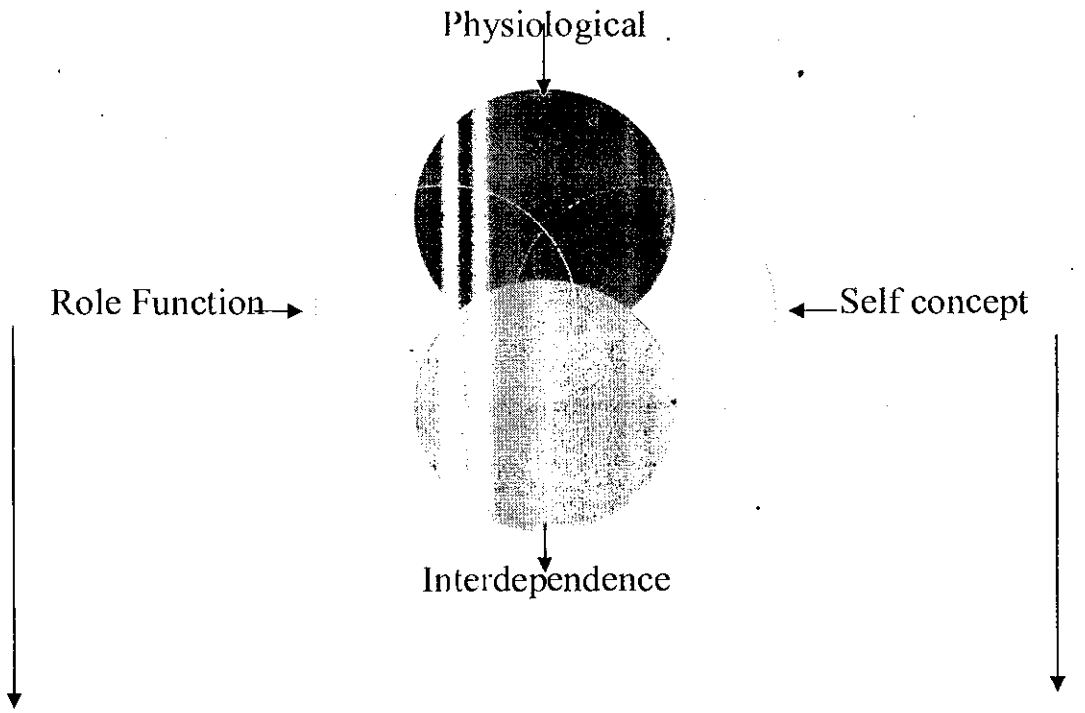
The role function mode consists of a set of expectations of how a person in a particular position will behave in relation to a person who holds another position. These roles are divided into; primary roles (gender, age) secondary roles, which are relatively permanent or may be chosen for example, teacher, spouse, or TBA. Tertiary roles are temporary and chosen such as committee member. It is often a sudden change in secondary roles which lead to difficulties. The need underlying the role function mode is social integrity, that is, knowing who one is in relation to others so that one can act appropriately (George, 2002).

The interdependence mode involves a fine balance between dependence on others and independence. Dependence is demonstrated by a need for affiliation with others for their care, support and approval. Independence is demonstrated by the ability to achieve, make decisions and initiate actions by oneself. The need underlying the interdependence mode is relational integrity or security in nurturing relationships. The mode focuses on the giving and receiving love, respect and values. (Fitzpatrick and Whall, 1996)

Within Roy's Adaptation model, adaptation is viewed as both a state and a process. As a process it involves systematic series of action directed towards the goal of adaptation, thus promoting integrity and affecting health positively. An individual can

use one or more of the adaptation modes in order to respond to changes that occur. Roy's adaptation model provides an effective framework for addressing adaptive needs of individuals, families and groups.

Fig 1. **PERSON AS AN ADAPTIVE SYSTEM IN ROY' MODEL**



External and Internal

Focal

Contextual

Residual

Adapted from Fitzpatrick and Whall (1996)

3.1 Application of the model to the study

Nursing is concerned with the person as a total being in interaction with the changing environment. Nursing's holistic approach looks at processes for maintaining wellbeing and high level function. The focus is on positive adaptation. In this study the problem is that some TBAs have adapted positively to the changes in their role while others have ineffective adaptation since they are still conducting deliveries even after changes in policy.

The primary concern is on the behaviour that is ineffective, therefore to determine the factors that influence the behaviour it is important to study the internal and external forces which will include circumstances, conditions or changes which challenge the TBAs to adapt. Adaptation promotes integrity and integrity is health thus adaptation leads to health (Fitzpatrick and Whall, 1996). If TBAs are able to adapt to the new policy, they will be able to refer all clients to the hospital thereby promoting skilled attendance at birth and improving maternal and neonatal health.

One of the adaptive modes in Roy's model is self concept. Self concept is central to the person's behaviour because it consists of the person's beliefs, feelings about himself or herself at any given time. One of the components of self concept is personal self which includes self consistency, self ideal and moral-ethical-spiritual self. Self ideal represents what the person expects to be and do (George, 2002). If TBAs perceive themselves in relation to what they used to do before then they will not adapt, but if they perceive themselves in relation to what they are supposed to do at this time, they'll be able to comply with the changes and this will lead to positive responses and promotion of health.

Another mode of adaptation according to Roy is role function mode. For individuals this mode focuses on the roles of an individual in society. The need underlying the role function mode in groups is role clarity. There's need for members to understand and commit to fulfilling expected responsibilities (Roy and Andrew as cited in Fitzpatrick and Whall 1996). Likewise, while society may expect TBAs to continue their previous role, it

is the responsibility of the TBAs to understand and commit themselves to the role which will be for the benefit of the majority.

The health care providers and the community are interdependent. The health personnel depend on TBAs to ensure that all women who come to them for delivery are sent to the hospital. The TBAs also depend on the health personnel to ensure that conditions are favourable for TBAs to perform their role effectively. Adaptive responses are those that positively affect health and the aim is to promote the health of human beings by promoting positive responses to change which directly affect health.

CHAPTER FOUR
METHODOLOGY

4.0 Research Design

The research design used in this study is a descriptive design within a qualitative design. A qualitative design is an approach used to investigate phenomena typically in an in depth and holistic fashion, through the collection of rich narrative material (Polit and Beck, 2006). This design has been chosen because in the study there will be a lot of narrative data from which the researcher will be able to make judgments or identify problems.

4.1 Study population and setting

The study population was Traditional Birth Attendants around Ekwendeni Hospital catchments area. The hospital trained 90 TBAs and from this population a sample was taken for the study. The study the setting was Ekwendeni. This was chosen for convenience since it was where the researcher was resident and data was collected during the holidays. This setting was also chosen because it is a representation of the rural setting where most TBAs are found.

4.2 Sample size and sampling method

The study had a sample size of 23 TBAs who formed three focus groups. The initial plan was to have a sample of 30 TBAs but seven did not turn up. The sample size was chosen because it was adequate for conducting four focus group discussions. However; only three focus group discussions were conducted because of absence of other TBAs and also due to data saturation.

The sampling method used for the study was convenience sampling. The traditional birth attendants who were available at the time of data collection were used in focus group discussions.

4.3 Data Collection

In qualitative research, the researcher is actively involved in the process of data collection either by collecting data or by supervising data collectors. In this study data was collected through focus group discussions. Focus group discussions are carefully planned sessions designed to obtain information in a focused area in a setting that is permissive and non-threatening (Polit and Beck, 2008). It takes advantage of group dynamics for accessing rich information in an efficient manner.

This method was chosen because people feel more at ease expressing their views when they share a similar background with other group members. It also helped the researcher to obtain view points of many individuals in a short time. Focus group discussions also capitalize on the fact that members react to what is being said by others thereby potentially leading to richer or deeper expression of opinion which can be more easily expressed in the security of being in a crowd. The focus group discussions were done in three groups of 6-9 people. This was carried out at a pre arranged venue within the community. The researcher acted as a moderator by guiding the discussion using a discussion guide. This approach facilitated accuracy and validity of data obtained as it was the researcher who directly monitored data collection. Data was gathered using a tape recorder and note taking. The discussion lasted 1hour to 1 and a half hours.

4.4 Instrument

In this study the instrument that was used for data collection was a discussion guide. This guide included carefully planned questions which guided the moderator during the discussion. The questions included only those that were essential in order to allow for sufficient time for the discussion. Probe questions were included during the discussion to gain more specific and detailed information. The instrument was pre tested to ensure that it elicited the responses expected by the researcher. After the pilot study refinements to the instrument were made to allow the main study to progress efficiently.

4.5 Data analysis

Data analysis consists of classifying and grouping the individual pieces of data so that a broad pattern may be seen clearly. Qualitative data is in form of narrative material, therefore the methods to be used require creativity and hard working in order to discover patterns, themes, forms and qualities found in written notes and tape recordings. Qualitative data analysis is an active and interactive process which occurs concurrently with data collection (Burns and Grove, 2001). Data obtained in this study was analysed manually, using the Colaizzi's method of data analysis which consists of seven steps.

1. Reading and listening to recordings of participants' description of the area under study.
2. Extracting significant statements that pertain directly to the phenomenon.
3. Formulate meanings for these significant statements.
4. Categorise the formulated meanings into clusters of themes.
5. Integrate the findings into an exhaustive description of the area being studied.
6. Validate the exhaustive description by returning to some of the participants to ask them how it compares with their experiences.
7. Incorporate any changes offered by the participants into the final description(Polit and Beck,2006)

Data analysis was done immediately after each focus group session. This helped to decrease the potential for confusing different sessions with one another. Tapes from each focus group were transcribed word for word in order to capture the exact words or phrases. The researcher had to be completely familiar with those data by reading the narrative data and listening to recorded discussion over and over in order to comprehend and synthesize the data and make sense of the data and what was going on through recurring words or themes and phrases. The researcher put these pieces of data together in order to get a sense of what is typical with regard to the perceptions and attitudes of TBAs.

4.6 Ethical Consideration

In any research, ethical considerations are important as basic guiding principles especially when dealing with human beings because they provide a basis for moral

conduct in respect of human dignity, integrity and authority. The main principles involved are informed consent, right to self determination and privacy and confidentiality

Informed consent centers on the protection of autonomy of individuals including protection from harm. This requires that the process of informed consent must ensure that participants have adequate information regarding the research, are capable of comprehending the information and have power of free choice (Beauchamp and Childress, 2009).To ensure that the participants had ethical protection, they voluntarily agreed to participate and gave an informed consent to participate. Participants were told to choose to participate or not and to withdraw from the study anytime without penalty. Those who agreed to participate were given a consent form to sign (refer Appendix G).

To ensure privacy and confidentiality all data that was gathered during the study was accessible only by the researcher and the supervisor and in no way did the researcher disclose information in a manner traceable to any of the participants. To further ensure strict confidentiality of information obtained anonymity was implored where names of participants were not included in the findings. No names were used when reporting what was said by a participant during the focus group discussion. All discussion guides, tape records, and notes will be destroyed soon after the study.

The study went through the Kamuzu College of Nursing Research and Publication Committee (RPC) for ethical approval. Letters requesting for permission to conduct the study at the study settings were written (refer Appendix E) and institutional clearance was obtained through responsible personnel at the health facility (Refer Appendix F)

CHAPTER FIVE

PRESENTATION OF FINDINGS

This chapter presents the findings on attitudes and perceptions of Traditional Birth Attendants on their new roles. The results focus on the description of the sample, the findings and the major themes that emerged following content analysis which was used to analyse data.

5.0 Description of the sample

Three focus group discussions were conducted between 24th September and 3rd October 2009. The focus Group discussions were done at Dunduzu, Ekwaiweni and Enukweni with nine, six and eight participants respectively.

5.1 Demographic Data

The sample consisted of 23 participants from the villages around Ekwendeni hospital. From the data collected it was observed that participants were between ages 45-60 years. Out of the 23 participants 65% were married, 22% were widows while 13% were divorced. On level of education, 91% of the participants had gone through primary education while 9% had no schooling. All the participants (n=23) have been practicing traditional birth attendance for more than 10 years.

5.2 Knowledge

5.2.1 Current responsibilities of Traditional Birth Attendants

When participants were asked about what they do as traditional birth attendants at the moment, the results indicated that most TBAs are not actively involved in deliveries but play a counseling role. Several participants in the focus group discussions indicated that they refer pregnant women to the hospital and encourage them to attend antenatal clinics or go to the hospital waiting homes when the pregnancy is term as one participant from Dunduzu explained that

"What we do now is to encourage mothers to go to the hospital for antenatal clinic and to deliver at the hospital since we have been told not to conduct deliveries."

However it was found that some of the participants are still conducting deliveries routinely despite being told to stop. This shows that not all TBAs have stopped conducting deliveries. This may be so because some of the TBAs have been in practice for too long such that changing to new roles may take time as one of the participants said

"I know that we have been told to stop conducting deliveries, but my house is near the road and women who have failed to reach the hospital because labour is advanced, come to me since I am a child of God and the woman needs help, I assist."(FGD Enukweni)

All the participants in the three focus group discussions supported the fact that they were formally told by officials from Ministry of Health on the changes in their roles. Some participants however were unclear on the changes because the officials told them that they should not demolish the structures in which deliveries were conducted and should continue to keep their uniform so that they can help during emergency deliveries. They felt that the officials should have said it clearly that TBAs should stop conducting deliveries. This shows that although information was disseminated some aspects were not clear. Lack of clarity can cause loopholes for malpractice by TBAs.

5.2.2 Reasons for change in TBA roles

When the researcher wanted to find out the reasons for change in TBA roles, participants cited several reasons why they were stopped from conducting deliveries. Some of the reasons cited by participants were:

- To protect them from contracting HIV since they do not have equipment to test blood.
- They do not stock Nevirapine to give to mothers and babies for prevention of mother to child transmission of HIV.
- They are unable to detect complications like anaemia, and malpresentation.

- A lot of women die in pregnancy as well as newborns because of TBAs since some of them were mismanaging women.

However some Traditional Birth Attendants felt that the government should not have stopped all of them but only those who were mismanaging patients as one woman lamented

"Some of us have never had a woman or baby die in our custody but as they say that, when one fish is rotten the rest are affected."(FGD Enukweni)

5.3 Compliance on changed roles

During the focus group discussions, several participants denied having heard or seen one of their colleagues still conducting deliveries from the time they were told to stop. However, one of the participants accepted that some TBAs are still conducting deliveries on humanitarian grounds because the pregnant woman comes on her own to seek the services of a traditional birth attendant. It was also revealed that most of the TBAs who are conducting deliveries are the untrained ones because they did not get first hand information to stop. Another major reason for non compliance was loss of income. Those TBAs who were receiving something from mothers for the services they rendered were likely to continue as expressed by one of the participants who said

"Our friends who were earning a living through deliveries are likely to continue because they can't find money to buy soap."(FGD Ekwaiweni)

5.4 Management of emergency deliveries and women in labour

Several participants in the focus group discussions responded that when a woman comes to them in labour they escort her to the hospital and in case she delivers on the way before reaching the hospital, they assist with the delivery and take the mother and the baby to the hospital for thorough examination. However one participant complained that they are not provided with protective wear like gloves. On the same issue some participants reported that they escort some women to the hospital while others go on their own depending on availability of transport and how busy the TBA is at that moment. It was revealed that not all TBAs attend to emergency deliveries, some are afraid to so

because when the information about the TBAs redefined roles came, the officials emphasized that no one should conduct deliveries as one participant from Dunduzu said:

"We were told that whoever conducts deliveries will be sent to police, so we are afraid, for example one of us here had to disappear from her home so that the pregnant woman who came to deliver could leave and go to the hospital, later on the woman delivered on her own; the TBA did not participate"(FGD Dunduzu)

One of the participants from Ekwaiweni said that she cannot conduct emergency deliveries because she heard on the radio that whoever conducts deliveries will be fined K5, 000 together with the guardian who brought the woman to the TBA. However, few participants reported that they have never encountered a situation requiring emergency delivery, but in the event that an emergency delivery occurs, they expressed willingness to assist the woman and report to the hospital that it was an emergency delivery.

5.5 Referral to the hospital

When asked about who initiates referral to the hospital, almost all participants in the three focus group discussions said that the decision to refer clients to the hospital rests with the TBA because the woman comes to the TBA with a decision that she will deliver at the TBA. It is up to the TBA to refer the woman to the hospital. Some participants added that they refer clients to the hospital in liaison with the guardians who take the responsibility of finding the means of transporting the mother to the hospital if the ambulance cannot be easily accessed. It was reported that the TBAs who own cell phones call for the ambulance or one of the guardians is sent on a bicycle to the hospital to call for an ambulance.

5.6 Other suggested roles of Traditional Birth Attendants

Several TBAs in the focus group discussions reported that there are other roles which they can do in improving maternal and neonatal care. The following are some of the roles mentioned by TBAs:

- Providing antenatal care services like palpation and listening to the fetal heart.
- Encouraging women to go to waiting homes and deliver at the hospital.
- Providing health education to women on birth preparedness.
- Attending antenatal and under five clinics so that they can learn new things which can help them to advise pregnant women accordingly.
- Educating mother-in laws and husbands of pregnant women on importance of hospital delivery since most decisions regarding place of delivery are made by these people.
- Joining other safe motherhood groups within the catchment area.

However one of the participants responded that there is no other role which they can play as TBAs because it is at the hospital where all necessary assistance can be given to pregnant women.

5.7 Challenges

Several participants complained that some pregnant women are very stubborn when TBAs tell them to go to the hospital for delivery or waiting; they wait until labour is advanced. This puts the women in great danger because the TBAs may not be able to identify or manage complications which may occur.

Another, participant expressed concern about pregnant women being told by health workers to stop going to antenatal clinic after four visits. Some of these women do not understand the message well as such they are afraid to go to the hospital if they have problems. Most of these women report to TBAs if they have problems and this may cause delays in treatment.

Most TBAs said one of the challenges they face is that of poverty because when they were conducting deliveries some used to get a little money from the women they attended

to. They were also getting some allowances through refresher courses, and seminars organised by the hospital, but now they are being sidelined by the hospital as one participant lamented

"Poverty is a big problem now because some of us do not have any source of income." *(FGD Emukweni)*

Another challenge that was reported by the TBAs was poor reception at the hospital. The participants complained that when they escort a pregnant woman to the hospital, sometimes the reception is not good, depending on individual nurses they find .They are shouted at as if they were keeping the woman deliberately as one of the participants complained

"We are not even allowed to give a report since we are told to stay outside the labour ward while the pregnant woman goes in."(FGD Dunduzu)

5.8 Suggestions for effective performance

In all the three focus group discussions most participants suggested that government or health facilities should involve them in other activities that help to improve maternal and neonatal health. Some participants also suggested that they still need additional knowledge so that they are better equipped in their educating role as such the health facility should include TBAs in seminars or workshops involving health leaders. One of the participants also suggested that they should be oriented on report writing about referrals sent to the hospital since previously they were given forms where they used to tick on appropriate place to indicate reason for referral.

CHAPTER SIX

DISCUSSION OF FINDINGS

This chapter presents a discussion of findings on attitudes and perceptions of Traditional Birth Attendants on their new. The discussion will focus on demographic data, Knowledge on current roles of TBAs, reactions to changes, Compliance to new roles, Referral to hospital, Suggested roles which TBAs can play and Perceived challenges. Conclusion and recommendation will be made at the end.

6.0 Demographic data

Demographic data indicates that most of the TBAs are within the age range 51-60. This means that most traditional birth attendants are old. This can be an advantage in information giving since old people are custodians of culture and people tend to listen much more to what their elders tell them than anyone else. This is supported by the use of *Agogos* in Save the Children projects whereby they are used to disseminate safe motherhood information to young mothers in their locality (personal experience). However this old age can also have a negative impact on the services they render to pregnant women. According to Bisika, (2003) one of the reasons for poor quality services by TBAs is their ailing age. Age may affect the way they comprehend information given to them. Furthermore, older people have deep rooted cultural and social perceptions. According to Ngoma and Himwiila,(2009), TBAs can help to discourage harmful cultural practices related to pregnancy and childbirth. However, cultural and social perceptions often lessen the effects of information given and TBAs may require continued interaction with the formal health system for change to become evident.

The results also indicate that most TBAs were literate as most of them were able to read and write. The ability to apply knowledge is enhanced sometimes with increased education. Since these TBAs only had primary education it means that they did not have a sound educational background which is a prerequisite to the application of knowledge to practice. Although they have been told of the changes in their roles, putting this into practice may be a great challenge because of their low educational background.

Data also indicates that most TBAs have been in practice for a long time. This indicates that they have a lot of experience in maternal and neonatal health issues. Their experience can be beneficial because TBAs live in the community and are aware of the health problems the community faces; therefore they can be instrumental in helping out to solve such problems. However, their long time practice can lead to resistance to change or poor adaptation because they may perceive themselves as "midwives" and continue to conduct deliveries because of the deep rooted knowledge they had before undergoing training.

6.1 TBA current roles

From the data gathered there was a clear indication that most TBAs had knowledge about some of their current roles since several of them reiterated what they were told by officials from Ministry of Health (MOH). However there are still some who cling to their previous role of conducting deliveries because they feel that it is still their responsibility to help deliver pregnant women even after being told of the changes. This is supported by findings from Ministry of Health (2007) in an assessment of future roles of TBAs, it was found that TBAs do not always practice what they had been taught, a lot of them will use herbs and hold on to patients without referring in time. It is from such TBAs that pregnant women can develop complications. Saravanan (2008) in her study to examine the influence of biomedical frameworks of knowledge on local birthing practices supports this by saying that medical or nursing knowledge can be successfully disseminated but at local level some TBAs follow the instruction and sometimes do not, preferring to adapt to local perceptions and preferences of the community.

One of the conditions that could challenge TBAs to adapt to the changes is their self concept. Self concept is central to the person's behaviour because it consists of the person's belief and feelings about him or her at any given time. TBAs who are conducting deliveries routinely may perceive themselves as the only true answer to maternal and neonatal services. However, there is a strong belief that maternal and neonatal mortality can be brought down by increasing skilled attendance at delivery.

Data also shows that even though the TBAs have knowledge on their current roles, one role is not very clear to the TBAs. The TBAs indicated that they were a bit skeptical about the role of conducting deliveries only in unavoidable circumstances. This is so because they were threatened that they would be arrested if they conduct any delivery. This, coupled with lack of protective wear, has put them in a quandary as to whether they should conduct deliveries in emergencies. Lack of emergency care at community level can put pregnant women at risk of developing complications during delivery. Some TBAs also said that this role can be a loophole for other TBAs to continue conducting routine deliveries on the pretext of helping in emergencies. It is therefore possible that mothers can develop complications in the hands of these TBAs. This is supported by findings of MOH,(2007) that there are some good and bad TBAs, irrespective of what government decided, TBAs will always be there and practicing.

6.2 Reaction to changes

Change is necessary for growth, although it often produces anxiety and fear. Even when planned, change can be threatening and a source of conflict (Sullivan and Decker, 2005). Judging from the results, it shows that TBAs are aware of the reasons for the changes in their role as outlined in the findings. However there were different views as regards the approach used by government to stop all of them from practicing. Some TBAs felt that only those who had been mismanaging women during labour and delivery should have been stopped because women in the villages have been denied of the care that was readily available to them. Eldis (2009) agrees that by cutting out community care, the poor lose what care they had and will wait longest for skilled care. This is supported in a report by Devraj, (2009) that TBAs should be empowered rather than phasing them out because they provide services by operating in areas far away from any centre where skilled birth attendant may be available. The report further argues that the best way is to develop alternative strategies that recognize the services and skills of TBAs and incorporate them into the health system in such a way that women in the rural areas are adequately covered. Balancing the development of both community and clinical care allows early success in reducing maternal and neonatal deaths, including for the poor at a relatively low cost. Change Project (2009) however differs with such ideas by saying that feelings

articulated above shows resistance to change even when the rationale for change, such as increasing skilled attendance at birth, is well understood.

Even when change is expected and valued a grief reaction still may occur. The traditional birth attendants who are resistant to change are more likely to continue conducting deliveries and complications of pregnancy and delivery are likely to occur. This means that there is poor adaptation in the role function mode. While society may expect TBAs to continue their previous role, it is the responsibility of TBAs to commit themselves to the roles which will be for the benefit of the majority.

6.3 Compliance to new roles

From the results most Traditional Birth Attendants are complying with some of the new roles like providing health education on birth preparedness, referring pregnant women to the hospital for delivery and encouraging women to attend antenatal clinics. Although this is so, there is still some poor adaptation to other roles like, management of emergency deliveries and referral to the hospital.

6.3.1 Management of emergency deliveries

The results indicated that most TBAs are unwilling to participate in emergency deliveries because of fear of arrest and paying a fine to the extent that they leave the labouring woman unattended in second stage of labour. This can have negative impact on the outcomes of such deliveries because if the TBA is in attendance she can recognize some of the complications like post partum haemorrhage and expedite referral unlike when the TBA is not available. Furthermore when complications occur and the woman goes to the hospital, the TBA can still be implicated even though she did not participate. This behaviour by TBAs breaks the link that should be there between the community and the health facility. A report by WHO (2002) supports the fact by citing that Malaysia has been able to reduce maternal mortality by fostering partnership between TBAs and health workers.

6.3.2 Referral to hospital

The study findings indicate that referral to the hospital is initiated by the TBAs. However there are some discrepancies on how labouring women are sent to the hospital. In their redefined roles, TBAs are supposed to accompany the labouring woman to the hospital. However this is not always the case as the TBA escorts the woman only if she is not busy and when transport is available. This can have implications because if the woman is not escorted to the hospital sometimes the woman can deliver on the way to the hospital without any assistance thereby predisposing the woman and the baby to infections and other complications. Non availability of transport can also cause delays in reaching the hospital especially when they have to rely on public transport or sending someone on a bicycle to call for an ambulance. Lack of referral services has always been a challenge to seeking skilled attendance. This is supported by Kibaru (2006) who says that most maternal and neonatal deaths are caused by delays in arranging transport from homes of TBAs to referral hospitals. Such delays end up complicating cases which TBAs could not manage. To ensure safe, effective practice in maternal and neonatal care there has to be an enabling environment where transport for women and babies requiring referral is available (WHO, 2002).

6.4 Suggested roles which TBAs can play

Since TBAs are highly regarded by their communities, it is critical that they still be encouraged and enabled to play a role in improving maternal and neonatal health. From the data gathered it is evident that the TBAs themselves feel that they can still play other roles after taking away their role at delivery. This is supported by Nyanzi and Manney (2009) in their study of TBAs in rural Gambia, in which they found that TBAs have a multiplicity of roles in their community. They are involved in cultural, religious, gender, health and wellbeing of their society. Maternal mortality can be influenced by religious, gender or cultural issues. Customs and beliefs can prevent women from understanding health issues and from seeking them out. These TBAs can help in addressing such issues because they live in the community. WHO, (2002) also asserts that TBAs are an important element in safe motherhood strategy and key partners for increasing the number of births at which a skilled attendant is present. They are also in an ideal position

to work with families and communities providing education on important messages for a healthy pregnancy and safe birth. WHO (2002) cautions that despite the role they can play, TBAs cannot replace skilled attendants. There will not be substantial reduction of maternal mortality if TBAs continue to conduct deliveries routinely.

The health providers and community leaders, in which TBAs fall, are interdependent. Interdependence involves a fine balance between dependence on others and independence. When there is interdependence, members of the team are respected and valued by the community. For this interdependence to work it must be based on mutual trust and respect.

6.5 Perceived challenges

The findings indicate that the change of TBA roles has come with challenges. One of the challenges was that some pregnant women are stubborn when they are told to go to the hospital for delivery instead they go to the TBA. Such women may prefer to go to the TBA because of the TBAs proximity to the women's homes, respectful attitudes of TBAs which is lacking in most health care facilities and their woman centered care. However problems can arise when TBAs delay in seeking skilled care for such women. Another possible reason for unwillingness to go to the hospital is that those women may not be aware of the deficiencies in TBAs' skills and the potential risk to both themselves and the baby (Safemotherhood, 2003). From the data, another challenge that came up was that of loss of income by the TBAs. Due to the changes in their roles TBAs do not have a source of income because most of them were relying on monetary or material support they used to get after conducting delivery. This loss of income may lead to TBAs continuing their previous role thereby putting pregnant women at risk of complications.

6.6 Limitations of the study

There were some limitations to the study that may have had an impact on the results. The study was done on a small scale as a result it cannot be generalized to Malawi as a whole, as it would not have a true representation of what is on the ground. Time was also a limitation for this study since studies that are part of an academic program have a time

frame attached. There was limited literature on the new roles of TBAs possibly due to the fact that it is a new policy and few studies on this policy have been conducted. Most studies were on the role of TBAs in safe motherhood or reduction in maternal mortality. The sample size of 23 was out of convenience in response to time constraints; a larger sample would have yielded more ideas on TBAs attitudes and perception on their new roles. The study would have yielded more information if in depth interviews were used in combination with focus group discussions because in focus groups social loafing can occurs, which means other participants may not express their views.

6.7 Implications of the study

The study findings have implications in the field of nursing education, nursing practice nursing management and nursing research.

6.7.1 Implications to Nursing Education

Nurses as educators are responsible for disseminating health information to the public and ensure that the community is aware of any new developments or changes. The information that is dissemination should be clear so that people who use that information are sure of what is expected of them at all times.

Nursing education must explicitly define the independent, dependent and interdependent roles of a nurse. The interdependent roles require that the nurse practice as a member of a team without undermining the roles of others. This team includes TBAs who cannot be completely excluded from the provision of maternal and neonatal health services.

Nursing education has a greater role to play in ensuring that a lot of midwives are trained so as to gradually replace TBAs with skilled personnel.

6.7.2 Implications to Nursing Practice

To practice as professionals, nurses must ensure that they respect the dignity of others. Nursing practice has a challenge of ensuring that those who participate in care of pregnant mothers and neonates, such as guardians and TBAs are respected. These are the

people that are closer to the women in the community and are the ones who can ensure that women are encouraged to deliver in the hospital. If such people are not respected they can't see the need to send clients to the hospital where treatment is inhuman. This will lead to more women preferring to go to TBAs and come to hospital only when there are complications.

Community based approaches need to be instituted so as to promote demand for maternal and neonatal health services and encourage healthy behaviours. Nursing practice must ensure that the existing TBAs do not work in isolation and should be part of a wider health system, in this way compliance to any policy changes will increase.

6.7.3 Implications to nursing management

The study findings presents challenges to nursing management for formulation of innovative strategies to increase number of skilled attendants who can be available whether a woman delivers at home or at a health facility. Policy changes should be clearly stipulated and communicated to the community concerned to avoid distortion or unclear expectations.

6.7.4 Implications to nursing research

Nursing research is challenged to explore exhaustive information on perceptions of TBAs on a larger scale so that generalization of the findings is possible. More must be known on the maternal and neonatal health seeking behaviours so that appropriate measures can be instituted to improve maternal and neonatal health. Research can also be done on utilization of TBAs as women companions in labour and delivery rooms to provide psychological and emotional support. Several research topics can be built from this one to explore exhaustive information on how best TBAs can be utilized after absenting their role in conducting deliveries.

6.8 Conclusion

The study sought to explore the attitudes and perceptions of TBAs on their new roles. The study has revealed that TBAs have knowledge of changes in their role but do not have a clear idea as to the significance of their roles in promoting maternal and neonatal health. This is due to the fact that the TBAs consider their major role in terms of delivering babies, absenting them from this role makes them less active. The study also revealed that some TBAs who continue to perform deliveries routinely do it on humanitarian grounds and because of lack of income since most of them depended on this as a source of income after attending to a woman. Another major reason revealed by the study is that some pregnant women insist on delivering at the TBA despite being told that TBAs have stopped conducting deliveries. The challenge is on improving skilled attendance at birth to prevent complications and utilizing TBAs effectively during transition from TBAs to increased skilled attendance for all women at birth.

6.9 Recommendations

- Health facility to conduct orientation workshop to explain details of the TBAs new roles and clear any misconceptions.

- Incorporate TBAs into other safe motherhood groupings in the community so that they do not feel neglected by the health system.

- Sensitisation of community leaders to disseminate messages to untrained TBAs who may still not have access to new information.

- Provision of small incentives to TBAs who bring mothers in a timely manner and find other ways of protecting TBAs income so that they have no reason not to refer a woman.

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6.11 LIST OF APPENDICES

Appendix A.

Focus Group Discussion Guide

Ensure that the environment is conducive for participants to discuss freely

Introduction: Researcher introduces herself to participants

Participants introduce themselves to the researcher, stating
age, marital status, level of education and years of practice.

Welcome remarks and introduction of the topic to discuss

QUESTIONS

1. What do you do as Traditional Birth Attendants at the moment?

2. Are you aware of any policy changes regarding TBAs roles? If yes, what are those changes?

3. Did you communicate these changes to other people concerned? If yes to who did you communicate.

4. What do you think are the reasons why government says you should not conduct deliveries?

5. Have you heard or seen any TBAs who are still conducting deliveries?

6. What do you think are the reasons why some TBAs are not complying with this new policy?

8. What do you do when a woman in labour comes to you?

9. Who decides on referral and arrangement of transport?

10. What other roles can you play in promoting maternal and neonatal health?

11. What problems or challenges do you face in your new role?

12. What do you think Government or health facilities should do to ensure your effective performance?

14. How is the reception when you take clients to the hospital?

Summarise all the main points arising from the discussion. Ask if there are any changes or additions to make.

Thank the group for actively participating in the discussion.

Appendix B

Timeline

Activity	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
Topic Identified										
Literature Review										
Proposal writing										
Submission of proposal										
Pre-testing										
Data Collection										
Data analysis										
Report Writing										
Binding of Dissertation and submission										

Appendix C.

Budget

Outlined below is the expenditure to be incurred during the research

ITEM	AMOUNT	
Stationery	K	T
4 reams of paper at K750.00 per ream	3, 000	00
4 pens at K25.00 each	100	00
4 pencils at K20.00 each.	80	00
1 Tape recorder at 2,500.00 each	2,500	00
10 audio tapes at K500.00 each	5,000	00
1 flash disk at K3,500.00	3,500	00
4 large envelops at K80.00 each	320	00
1 lever arch file at K450.00	450	00
10 batteries at K300	3,000	00
1 hard cover at K500.00 each	500	00
Sub total	**18,450**	**00**

Secretarial services

Photocopying focus group discussion guide at K10.00 per page

Binding 3 copies of dissertation at K130.00 per copy

Typing and printing 3 copies of dissertation at K3000.00 per copy

Typing and binding two copies of proposal at K2000.00 per copy

Subtotal **13,450 00**

Transport

Literature search K1, 500.00

Data collection K15, 000.00

Subtotal **K16, 500 00**

Lunch and refreshments

3 Lunch meals at K650 per meal

Soft drinks for 31 people at K1, 550.00

Subtotal **K3, 500.00**

Contingency

This is money set aside for any eventualities K8, 000.00

Grand total **K59, 900.00**

JUSTIFICATION FOR BUDGET

Stationery

Stationery will be used for printing and photocopying the research proposal, data collection instruments, letters for obtaining consent, and literature review. It will also be used for recording information during data collection. Stationery will account for 31% of the total amount.

Secretarial services

It is a requirement that the proposal and final report should be printed and bound. This will cost 22% of the total amount.

Transport

The researcher will travel from Kamuzu College of Nursing to reproductive health unit and to Ekwendeni for literature search as such funds will be needed. Some funds will be used during piloting and data collection. This will cost 28% of the total amount

Lunch and refreshments

During data collection the researcher will need meals and refreshments for participants. This will account for 5% of the total amount.

Contingency

This is included to carter for any price increase that may occur in the course of the study and any eventualities. This will account for 13% of the total amount.

APPENDIX D

University of Malawi
Kamuzu College of Nursing

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

TITLE: **ATTITUDE AND PERCEPTION OF TBAs ONTHEIR CHANGING ROLES AT EKWENDENI HOSPITAL**

INVESTIGATOR(S): *HILDA MWALE*

YEAR OF STUDY: MATURE ENTRY: BSc IN NURSING

REVIEW DATE: 22ND July 2009

DECISION OF THE COMMITTEE: *APPROVED,*

SIGNATURE:.....**DATE**.....23/11/09
DEAN OF POSTGRADUATE STUDIES AND RESEARCH

CC: supervisor: *MR SIMWAKA*

DECLARATION OF INVESTIGATOR(S)
I/We fully understand the conditions under which I am/we are authorized to carry out the above mentioned research and I/We guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/We will resubmit the proposal to the committee.

DATE...23/11/09.....**SIGNATURRE(S)**...Mwale.....

Appendix E.

University of Malawi,
Kamuzu College of Nursing,
P/Bag 1,
Lilongwe.

The Hospital Director
Ekwendeni Mission Hospital
P.O Box 19
Ekwendeni

Through: The Research Coordinator, KCN

Dear Sir,

REQUESTING FOR PERMISSION TO CONDUCT A STUDY ON ATTITUDES AND PERCEPTIONS OF TRADITIONAL BIRTH ATTENDANTS ON THEIR NEW ROLE

I am a student at Kamuzu College of Nursing doing a Bachelor of Science in Nursing. I am to conduct research study in partial fulfillment of my degree program. It is for this reason that I request for your permission that I conduct my study at in the area around your institution. This study will be conducted using focus group discussion.

The findings of the study will help to identify how best the health institution can work with traditional birth attendants in order to reduce maternal mortality.

I hope this request will meet your most expected consideration. Thanks in advance.

Yours faithfully,

Hilda Mwale.

APPENDIX F.

CHURCH OF CENTRAL AFRICA, PRESBYTERIAN
SYNOD OF LIVINGSTONIA

Copy

EKWENDENI HOSPITAL
P.O. Box 19
Ekwendeni
Malawi
Email: ekwehealth@sdnp.org.mw

Telephone: (265) 01 339 222/349/248
Fax: (265) 01 ~~333 059~~ 310059

EKH/MIS/01

Ref:

24th September, 2009

University of Malawi
Kamuzu College of Nursing
Private Bag 1
LILONGWE

Through: **The Research Coordinator, KCN**

Dear Mrs. Mwale

PERMISSION TO CONDUCT A STUDY ON ATTITUDES AND PERCEPTIONS OF TRADITIONAL BIRTH ATTENDANTS ON THEIR NEW ROLE AROUND EKWENDENI CATCHMENT AREA

I hereby give permission for Hilda Mwale to conduct a study on attitude of the TBA's in the Ekwendeni catchment area.

We are looking forward to the results.

Yours faithfully

Dr. Anneke Snoep
MEDICAL OFFICER

All communications should be addressed to the Medical Officer-in-Charge

Appendix G.

UNIVERSITY OF MALAWI

KAMUZU COLLEGE OF NURSING

INFORMED CONSENT

RESEARCH TITLE: **Changing role of TBAs: A study of attitudes And perceptions of TBAs on their new role round Ekwendeni catchment area**

My name is Hilda Jere Mwale. I am doing my final year in Bachelor of Science in Nursing Mature Entry at Kamuzu College of Nursing. As a requirement for my study, I am conducting a research study on the above topic. You have been chosen as one of the participants. To obtain information in this study, focus group discussions will be conducted. The study findings will help health workers to work effectively with TBAs in improving maternal and neonatal health. It is up to you to accept or refuse because participation in this study is voluntary. There are no risks associated with this study. Tape recording and note taking will be done during the discussions. Names will not be used, the information obtained will be kept confidential only accessible to myself and my supervisor. At any point in time within the discussions, you have the liberty to withdraw, however your participation will be greatly valued

Could you sign below if you agree to participate in this study

I.....agree to participate in the above study after being given full information about the study .I make this decision upon full consideration of all the issues that would be involved and declare this decision entirely my own.

....

Participant Researcher

Date.....

Kalata ya chizomelezgo

mutu wa kafukufuku

Kusintha kwa udindo wa wazamba: Kafukufuku wakukhumba kumanya maghanoghano gha wazamba pa udindo wawo wupysa

Zina lane ndine Hilda Mwale (Nyajere).Nkhulutizga masambiro ghane gha unesi ku sukulu ya Kamuzu koleji ndipo nili mu chaka cha umaliro. Ngeti lwande limoza la masambiro ghane, nkhwenera kuchita kafukufuku pa mutu uwo nasankha.Imwe mwasankhika kuwa yumoza wakuchita nawo kafukufuku uyu.

Kuti nisange uthenga wakwenerera pa kafukufuku uyu nkhwenera kuchita vidumbirano na awo wasankhika. Ivo visangikenge pa kafukufuku uyu viwovwirenge kuti wachipatala wagwire makora ntchito na wazamba pakukwezga umoyo wa wamama wa pathupi na wabonda.Vili kwa imwe kujipereka panyake kukana kuchita nawo kafukufuku uyu. Palije chakofya panyake uheni uliwose pakafukufuku uyu.Mazina kuti ghagwiliskikenge ntchito yayi pakufufuza uthenga uwu kweniso fundo zose izo zisangikenge namugwiriska ntchito ndine na asambizi wane.Muli na wanangwa kulekezga pa nthowa pala mwaona kuti mungakwaniska yayi kweni chingawa chakovwira kuti mutolepo lwande.

Pala mwazomera kuchita nawo kafukufuku sainani pasi apa:
Ine.....nazomera kuchita nawo kafukufuku uyu nati naphalirika na kuzomerezgana nazo fundo zose zakukhwaska kafukufuku uyu.Nasankha ndekha kwambula kuchichizgika na munthu waliyose.

Zina la uyo wakuchita kafukufuku.....

Zina la muzamba.....Dazi.....