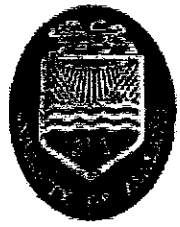

University of Malawi
KAMUZU COLLEGE OF NURSING

CONTRIBUTING FACTORS TO MATERNAL COMPLICATIONS DURING LABOUR AND DELIVERY AT TRADITIONAL BIRTH ATTENDANTS (TBAs) IN NKHOTAKOTA

A Research Dissertation Submitted to the Faculty Of Nursing in Partial Fulfillment for the Bachelor of Science in Community Health Nursing

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30TH NOVEMBER, 2008

DECLARATION

I hereby declare that this dissertation is a result of my own effort and hard work and that it has not been presented for any other degree.

Name of Candidate: Violet Seven

Signature: ..... Date: 27th November, 2008

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Signature: ..... Date: 27/11/2008

DEDICATION

This dissertation is dedicated to my beloved daughter Kumbirai Banda for her perseverance during the two years of my study without motherly care and love while I was pursuing my Bachelor of Science Degree at Kamuzu College of Nursing. Your understanding, patience and endurance can not be taken for granted. May the almighty God continue to bless you.

ACKNOWLEDGEMENT

I would like to thank the Almighty God for keeping me health and guiding me throughout the time I was writing this dissertation. Without which this work would have been a failure.

I sincerely express my heartfelt gratitude to my research supervisor, Mr. P. Mandalazi for the untiring commitment, ability to guide others, support, encouragement and constructive comments throughout the period of developing this research dissertation. His input greatly contributed to the success of this work.

I am indebted to the participants of this study without whose cooperation this study would have not been successful.

ABSTRACT

This study aimed at exploring contributing factors to maternal complications during labour and delivery at TBAs in Nkhotakota. Maternal complications are one of the causes of maternal death in Malawi.

The study employed a qualitative research design. The setting was Nkhotakota District Hospital and TBAs clinics. The sites were chosen to represent other TBAs clinics and the hospital as a referral site for complicated maternal cases.

Purposive sampling was used. A total of fifteen participants were recruited in the study of which ten were women who developed complications at TBAs and five were trained and practicing TBAs. Semi structured questionnaires were used to collect data. Data was analysed manually using content analysis.

The findings of the study have revealed that maternal complications at TBAs is a result of an interplay of several factors such as delay in decision making both by TBAs and husbands of clients, unsafe practices during labour and delivery, dirty environment, poverty and long distance to reach the health facility. It is therefore important to address the challenges met by TBAs and weaknesses of TBAs considering that the access to acceptable, professional, modern health care services for all pregnant women is still not met and the fact that TBAs represent the only source available for maternity care to many developing country women including Malawi.

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LIST OF ABBREVIATIONS

ANC	-	Antenatal Care
APH	-	Antepartum Haemorrhage
BEmOC	-	Basic Emergency Obstetric Care
BP	-	Blood Pressure
BR	-	Breech
CEmOC	-	Comprehensive Emergency Obstetric Care
CHAM	-	Christian Health Association of Malawi
CM	-	Centimeter
DHO	-	District Health Officer
DHS	-	Demographic Health Survey
EmOC	-	Emergency Obstetric Care
FP	-	Family Planning
HMIS	-	Health Management Information System
IEC	-	Information Education Communication
MCH	-	Maternal and Child Health
MDG	-	Millennium Development Goal
MDHS	-	Malawi Demographic and Health Survey
MMR	-	Maternal Mortality Rate
MNH	-	Maternal and Neonatal Health
MOH	-	Ministry of Health
PPH	-	Postpartum Haemorrhage
RHS	-	Reproductive Health Services
SMI	-	Safe Motherhood Initiative
TA	-	Traditional Authority
TBA	-	Traditional Birth Attendant
UN	-	United Nations
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children's Fund

USAID	-	United States Agency for International Development
WHO	-	World Health Organization
WRA	-	White Ribbon Alliance

1.0 INTRODUCTION

Across most of industrialised world, a woman's pregnancy typically is a period of great joy and elation usually culminates in the celebration of a cherished new life. Pregnancy is normal, healthy state, which most women aspire to at some stage in their lives. Yet for hundreds of millions of women, particularly those in developing countries, pregnancy presents great perils and risks of death and disability, often evoking substantial fear and even despair (MOH, 2007).

Of the 210 million women that become pregnant every year world-wide, 30 million (15%) result in serious health problems and even life-long disabilities for the mothers-to-be which lead to death in over 500,000 of them. Over 99% of these deaths occur in developing countries including Malawi. And for far too many other women, pregnancy complications lead not only to their death but also to the death of their newborn children (UNFPA, WHO, UNICEF, 2005).

Lashman, (2005), states that "many women who survive childbirth are seriously injured or disabled. Many face long-term disabilities such as uterine prolapsed, incontinence, infertility and obstetric fistula which profoundly and negatively affect the quality of their own and their families' lives". Overall at least 40 percent of women in developing countries experience complications, illness or permanent disability during pregnancy, childbirth or the six weeks after delivery and 15 percent of women develop potentially life threatening problems.

This enormous human toll of death and suffering is unacceptable and unnecessary. Women dying in childbirth or suffering pregnancy-related illness is not only tragic, but it is also a violation of their human rights to life and health. The right to health care increases the likelihood that they survive pregnancy and childbirth. The tragedy and opportunity is that most of these deaths can be prevented with cost effective health care services available in the country (WHO, UNICEF, UNFPA, 2005).

Nearly all formal health care services in Malawi are provided by three main agencies, which are: the Ministry of health provides about 60%, the Christian health Association of Malawi (CHAM) provides 37%. Other provider namely private practitioners, commercial companies, Army and Police provide 2% of health services (MOH, 2007).

In Malawi because the health care resources are unevenly and inadequately distributed. Only 46 % of the population has access to formal health facility within a 5 km radius, and only 20% of the population lives within 25km of a hospital (Essential Health Package document, 2004). Access to reproductive health services is worse in the rural areas as there is a particularly significant misdistribution of health personnel, which favours urban areas, and the secondary and tertiary levels of care (MOH, 2003).Therefore with these circumstances, pregnant women opt for TBAs for assistance during pregnancy, labour and delivery.

1.1 BACKGROUND

Nkhotakota district in the central region of Malawi is one of the districts where TBAs exist. Nkhotakota is predominantly rural. It shares boundaries with Salima District to the south, Kasungu District to the west, Mzimba and Nkhatabay Districts to the northeast and lake Malawi, which borders with Mozambique to the east.

Nkhotakota district has a projected population of 310,909 of whom 71,510 are women of child bearing age that is between 15-49 years (Nkhotakota District Hospital HIMS 2007).

Health delivery system includes government, Christian Churches Association of Malawi (CHAM), privately owned facilities, traditional healers and TBAs. 92% of the total population live in the rural areas where 90% of the mothers deliver their children in the villages assisted by TBAs, most of whom have inadequate training. The remaining percentages (8%) of mothers are assisted by health personnel under Nkhotakota District Hospital and Saint Anne's Hospitals.

Nkhotakota District and Saint Anne's hospitals have health centres which are sparsely distributed and not adequate to serve the rural population. People still have to walk about 30 kilometres to the nearest health centre. Many areas are also impassable during rainy season making it impossible for pregnant women, patients and health personnel to reach (World Medical Fund, 2006). Nkhotakota is also one of the five districts with less than the recommended number of Comprehensive Emergency Obstetric Care (CEmOC) facilities per 500,000 populations (UNICEF, WHO, UNFPA 2005). Currently the district has only two CEmOC facilities, one of which is a paying CHAM hospital where most rural women can't afford to access services. There are only two Basic Emergency Obstetric Care (BEmOC) in the district which is inadequate for the population.

1.2 STATEMENT OF THE PROBLEM

It is clear that TBAs remain the major providers of maternity care in Malawi attending up to 26% of all births (MDHS, 2004). However evidence from the region and the experiences within the country has shown that TBAs are not effective in improving maternal and neonatal health outcomes.

Despite the efforts by the Government through Nkhotakota District Hospital and Saint Anne's Mission Hospital in promoting and supporting the TBAs through training, supervision and provision of resources, the district is still facing a challenge of increased maternal complications that lead to life-long disabilities and deaths of women who have been attended and referred to the hospital by TBAs.

In view of the above, the research was conducted to find out the contributing factors of maternal complications during pregnancy, labour and delivery at TBAs.

1.3 SIGNIFICANCE OF THE STUDY

The findings of the study will help the District Health Management Team health care providers and other stakeholders to develop strategies that would improve the health of women during pregnancy, labour and delivery. The study results will also improve TBAs'

skills and knowledge and the health of the women they attend especially in the rural areas. Shortcomings that may be found will be rectified while strong areas will be reinforced. The study findings can lead to better changes that will accelerate the reduction of maternal and neonatal morbidity and mortality with the aim of achieving the fourth and fifth UN Millennium Goals.

Policy makers and the general public will also benefit from the results of the study because knowledge of the contributing factors of maternal complications at TBAs will assist them to identify appropriate strategies for reducing the rate of maternal complications that lead to maternal deaths or life-long disabilities.

1.4 OBJECTIVES

BROAD OBJECTIVES

To explore factors that contribute to maternal complications during labour and delivery at TBAs.

SPECIFIC OBJECTIVES

1. To determine the level of knowledge of pregnant and postnatal mothers on maternal complications.
2. To find out associated factors with maternal complications.
3. To describe the perception of pregnant and postnatal women on TBA program.
4. To assess the effectiveness of the referral system from TBAs to the hospital.
5. To assess the knowledge of TBAs on danger signs of pregnancy and delivery of TBAs.

1.5 OPERATIONAL DEFINITIONS

Complication: It is a concurrent condition or disease, or an accident or second disease arising in the course of primary disease and adding to its severity.

Labour: It is the process whereby a viable foetus, placenta and membranes are expelled from the uterus, into the pelvic or birth canal and through the vaginal orifice.

Maternal mortality: Is the death of a woman while pregnant or within 42 days of termination of the pregnancy; irrespective of the duration and site of the pregnancy from causes related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Safe Motherhood: Is a woman's ability to have a safe and healthy pregnancy and delivery.

Skilled attendant: Refers exclusively to people with midwifery skills who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer obstetric complications.

2.0 LITERATURE REVIEW

Literature review shows that a number of surveys regarding TBAs have been done. Despite being perceived by many as beneficial to pregnant women there are also challenges in the programme.

According to a study done by the American College of Nurse Midwives to determine the difference between trained and untrained TBAs in terms of knowledge, attitudes, behaviours and impact on maternal and perinatal mortality, the study found significant improvements in TBA knowledge, attitudes, behaviour and advice and on the behaviour of women cared for or living in areas served by trained TBAs (White Ribbon Alliance/India, 2002). Similar findings were found by a cross-sectional study which was carried out in Mkuranga District of Tanzania with the aim of comparing the ability of trained and untrained traditional birth attendants (TBAs) in identifying women with danger signs for developing complications during pregnancy and childbirth as well as their referral practices. Study findings revealed that trained TBAs were more knowledgeable on danger signs during pregnancy and childbirth and were more likely to refer women with complication to a health facility, compared to untrained TBAs (Hussein, 2005).

In line with the above findings a study done by Jokhio on intervention involving traditional birth attendants (TBAs) to reduce perinatal and maternal mortality in Pakistan found that training TBAs and integrating them into an improved health care system were achievable and effective in reducing perinatal mortality (Jokhio, 2005). This agrees with the study done in Nepal, to evaluate the National TBA Training program which found that women who utilised services of trained TBAs in comparison to those who used an untrained person, had adopted better maternity care practices. (Sibley, 2002).

However studies done on the effectiveness of TBA training programs showed that reductions in maternal mortality occurred only in areas where the TBAs had skilled backup support. The studies found that the majority of the programs were in-effective because TBAs did not have sufficient literacy or general knowledge when they started their training.

Without supervision and backup support, they tended to slide back into old ways and were not able to prevent death when life-threatening complications arose during childbirth (Smith, 1999).

According to the study which was conducted to assess the role of traditional birth attendants (TBAs) in modern health care delivery in Edo State, Nigeria, it revealed that respondents believe that TBA can play meaningful roles in family planning, screening of high-risk pregnant mothers, fertility/infertility treatment and maternal and child care services. Rural dwellers prefer to use the services of TBAs, as compared to their urban counterparts. Reasons for the preference included TBAs availability, accessibility, cheap services and rural dwellers faith in the efficacy of their services. (African Journal of Reproductive Health 2002; 6 (2): 94-100).Similarly the RAMOS study that focused on maternal mortality found that TBAs were able to articulate some of the danger signs and they were referring more women during labour and delivery. TBAs were aware that some traditional practices were discouraged because they could be dangerous. Women in the local communities acknowledge the risk of going to an untrained TBA (Honduras, 1997).

This conquers with a study of deliveries at referral hospitals which was found that women referred by TBAs were appropriately referred. Of the 56% women referred by TBAs had a complication. 20% had a caesarean section, 28% had a poor perinatal outcome either mortality or morbidity (Honduras, 1997).

According to the study that was conducted in Zambia by Maimbolwa, et al on cultural childbirth practices and beliefs in Zambia, it was found that those who considered themselves TBAs advised childbearing women on appropriate cultural childbirth practices and assisted with deliveries at home. They also advised women on the use of traditional medicine, for example to widen the birth canal and to precipitate labour. If something went wrong during labour, they relied on traditional beliefs and witchcraft to explain the mishap and expected the woman in labour to confess her purported bad behaviour (Blackwell Synergy – J Adv Nurs, 43 (3) 263-74).This agrees with the Traditional Birth Attendants (TBAs) survey done in Swaziland which found that some TBAs carry out procedures which

are considered to be potentially harmful. Nearly 30% of TBAs have administered herbs, 45% attend to abnormal deliveries (breech and multiple pregnancies), 26.7% re-use their cord cutting tools and in the case of haemorrhage 23.4% do manual procedures within reproductive tract of delivering women (Lech, 2005).These findings were opposed by a survey on the characteristics, attitudes and practices of TBAs which was conducted in Danfa rural area in Ghana. The study found that TBAs usually gave correct or neutral advice and most recognised the benefits of rapid referral to hospitals for serious problems. The TBAs were supportive of family planning and very interested in improving their skills (Bull World health Organ. 1976).

In Malawi, according to the survey that was conducted by the national Statistics Office, Zomba, it was found that the role of TBAs in delivery assistance had increased from 23 to 26 percent. These results indicated that in rural areas 29 percent of the births were assisted by TBAs. (MDHS, 2004).

CONCLUSION

The literature review reveals that TBAs have a big role to play in the reduction of maternal morbidity and mortality especially in the developing region by complementing the work the health workers are doing. The Safe Motherhood (SMH) training that the TBAs undergo prepares the TBA to take up the roles according to SMH. However, the training alone cannot contribute to the reduction of maternal death but the SMH need to consider issues like culture, resources, age of the TBA and case-load during training. To promote effectiveness during the practice issues to consider include supervision, resources, communication, and transport from the hospital during referral.

3.0 CONCEPTUAL FRAMEWORK

3.1 MEDELEIN LEININGER'S TRANSCULTURAL NURSING THEORY

Different cultures perceive, know, and practice care in different ways, yet there are some commonalities about care among all cultures of the world hence there are a lot of difference among people in health care seeking behaviour. Culture is the learned shared and transmitted knowledge of values, beliefs, norms and life ways of a particular group that guides an individual or group in their thinking, decisions, and actions in patterned ways. The values, beliefs and practices for culturally related care are shaped by and often embedded in the world view, language, religious (or spiritual), kinship (social), political (or legal), educational, economic, technological, ethnotistonical and environmental context of the culture (George, 2002).

The theory has been chosen for this study because it provides a framework for understanding different care patterns individuals or groups employ in meeting a particular health need. A lack of knowledge of the cultures has been identified as the missing link in understanding the variations needed in care of individuals or groups. The theory is built on the premise that the peoples of each culture only know and define the ways in which they experience and perceive their nursing care but also relate these experiences and perceptions to their general health beliefs and practices.

The culture of a people dictates their caring system. This affects the way people perceive their well being or health. This perception will direct the type of care systems people choose when in need of care. Such systems include folk, nursing and professional. Folk care systems are "culturally" learned and transmitted. Folk knowledge and skills are used to provide care. The theory has the following subsystems:

- **CULTURE CARE PRESERVATION**
  Also known as maintenance, it includes assistive, professional actions and decisions that help people of particular culture to retain and/or preserve relevant

care values so that they can maintain their wellbeing, recover from illness or face handicaps/or death.

- **CULTURE CARE ACCOMMODATION**

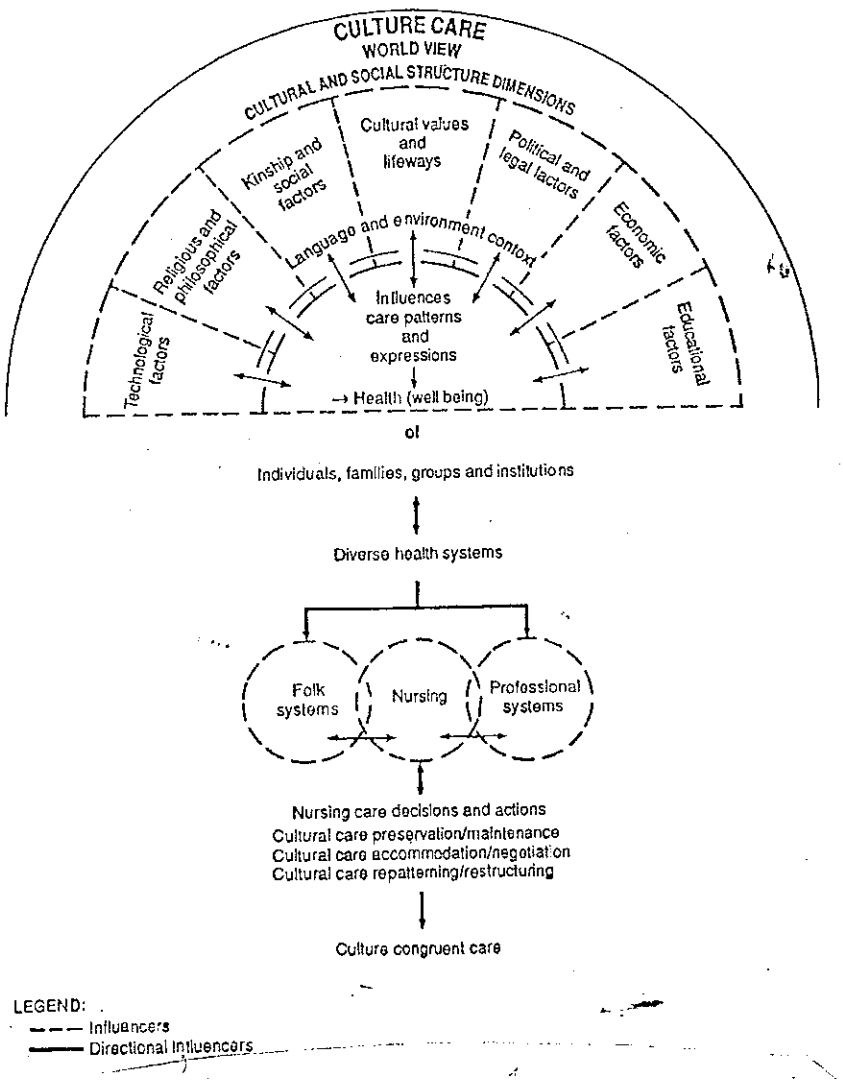
  Also known as negotiative or enabling professional actions and decisions that help people of designated culture adapt to or negotiate with others for a beneficial or satisfying health outcome with professional care providers.

- **CULTURE CARE REPATTERNING**

  Also known as restructuring requires the creative use of an extensive knowledge of the client's culture. It includes those assistive, supporting, facilitative or enabling professional actions and decisions that help clients reorder, change or greatly modify their life ways for new, different and beneficial health care problems.

3.2 THE TRANSCULTURAL THEORY MODEL

Also known as the Sunrise Model



3.3 APPLICATION OF THE THEORY TO THE STUDY

Understanding people's cultures will help us to understand why some people do certain things differently from others in relation to health care patterns. The only way to understand the people's cultures is through studying their knowledge, attitudes and practices regarding the various aspects of care, one of which is maternal and child care. The folk care systems (TBAs) attitudes and practices if studies will reflect the values and beliefs that are behind their care patterns. When clients from the folk care systems come to the professional care systems, the nurses will be in a better position to know cultural practices clients have encountered at folk care systems (TBAs).

The knowledge, attitudes of the folk care systems gained from research study is supposed to be assessed in the light of the professional knowledge of the professional care systems. Information gained from such an assessment will direct the nursing decisions and actions when working with the Folk care systems (TBAs).

A study of the folk care systems (TBAs) may reveal some health care patterns which are harmful to the health of individuals. For example, they may have a belief that prolonged second stage is a result of woman's mishap during pregnancy as a result a woman is delayed to seek emergency obstetric care. While maintaining respect for the culture, the folk care systems should be persuading to change for new ideas or be encouraged to adopt new ideas. For example early referral of women, with complications during labour, childbirth and postnatal. This is known as cultural care repatterning. If the study of contributing factors of maternal complications at the folk care systems TBAs) will reveal some care patterns, beliefs and values that are beneficial in promoting health then their practice may be encouraged. This is known as cultural care maintenance.

The knowledge and practices of the folk systems revealed through research studies can be used in coming up with recommendations on how the professional systems can be supportive, assistive, facilitative and enabling of the folk care systems. Such

recommendations may include support through supervision and provision of the necessary equipment and drugs, intensifying TBA trainings and refresher courses.

Cultural care presentation, accommodation and re patterning can be done through trainings of the folk care providers (TBAs). The trainings should as much as possible aim at making the TBAs change their practice and make them strong enough to encompass new ideas, whilst affirming them in their existing knowledge and experience. This is congruent with the WHO policy on TBA practice. The policy states that the TBAs should not be entirely absorbed into modern systems, but harmful traditional practices and rituals must be stopped. TBAs must be allowed to continue their good practice (Bradley, 1987).

4.0 METHODOLOGY

The section gives a brief account of how activities were conducted to achieve research objectives starting from study design through to the dissemination of research results.

4.1 RESEARCH DESIGN

For the purpose of this study a qualitative descriptive design was used. This design was appropriate because it provided an accurate portrayal or account of characteristics of a particular individual, situation or group. Descriptive studies are usually conducted when little is known about a phenomenon (Burns & Grove, 2001). This assisted to explore more about TBAs practice through participation experiences at TBAs clinics.

4.2 THE SETTING

The study was conducted at Nkhotakota District Hospital. The site was chosen because being a free Ministry of Health facility there was high chance of more complicated maternal cases referred there and the site was a convenient place for the researcher.

4.3 SAMPLING

The population that was studied were women who developed complications at TBAs clinics and were referred to the hospital. Practicing trained TBAs were also included in the study. Purposive sampling was done to obtain sample representatives of the population. This sampling was ideal for the study because it involved conscious selection by the researcher of certain subjects or elements to include in a study (burns & Grove, 2001).

4.4 SAMPLE SIZE

A total of fifteen participants were recruited in the study of which ten (10) were women assisted by TBAs and five (5) were trained and practicing TBAs.
Sample characteristics included the following:

- Marital status
- Education level

Of ten (10) women who developed complications at TBAs, nine (9) were married and their husbands were influential in decision making. Six (6) women were illiterate.
Of five (5) TBAs who were still practicing and recruited in the study, the majority, four (4) never attended school and only one (1) attended primary school.

4.5 DATA COLLECTION INSTRUMENT

A semi-structured questionnaire with open ended questions and probes was designed and used to collect data (B & C).Open ended questions were used to give the participant freedom of expression by allowing participant to respond to questions in their own words. A semi-structured questionnaire was formulated in line with the purpose of the study and the type of respondents recruited in the study. Each questionnaire comprised of a demographic section and a section of questions. The questions were developed in English then presented in Chichewa considering that most of the participants were illiterate and could not understand English.

4.6 PILOT STUDY

To ensure that the instrument would produce the same results across situations and with different participants (validity and reliability), questionnaire was pre-tested at Saint Anne's Hospital with two (2) women with complications from TBAs either during labour, childbirth and postnatal who did not participate in the actual study. The pilot study helped the researcher to know whether the subjects understood the questions.

Knowledge of the questions helped the researcher to alter numbering and sequencing of some questions as well as adding and modifying accordingly. Questions which were not clear were deleted or paraphrased. To ensure that the questionnaire measured what it intended to, the researcher's supervisor reviewed it to judge its suitability

4.7 DATA COLLECTION

A semi-structured questionnaire for women with complications and TBAs was used to collect data. Clarifying questions were also used to facilitate the expression. Conversational style was used throughout the interviews. The interviews were conducted at Nkhotakota District Hospital in labour, postnatal and gaenacology wards. Prior contacts were made to explain the purpose of the interview. This was done to create a relationship, which would promote trust. Participants were given a choice whether to accept or refuse to participate. In-depth interviews were used in this study to probe personal experiences and opinions. Each participant was interviewed separately in a room after getting consent. Data was collected by the researcher alone. Each interview took about 45 minutes. Hand written notes were taken soon after each question to record data.

4.8 DATA ANALYSIS

Data analysis was done manually through content analysis. Data analysis was done soon after data collection in terms of individual responses.

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4.9 ETHICAL CONSIDERATION.

A research proposal was submitted to Kamuzu College of Nursing Research and Publications Committee which approved the study. Upon approval, permission to conduct the study at Saint Anne's and Nkhotakota District Hospitals was sought and obtained from Saint Anne's Hospital Administrator and Nkhotakota District Health Officer. Upon acceptance of the study, the researcher went ahead with the study. To

ensure that participants made voluntary choice in their participation in the study, an informed consent was obtained either by signing the consent form or putting thumb paint for those who could not write it. An informed consent was obtained after explaining to the participants about the nature, purpose and procedure of the study (Appendix A).

The right of the participant to participate or to withdraw at any time was emphasised because coerhesion would mean violating the participants' rights but also could also affect the information given. To ensure confidentiality only the participant and the interviewer were at the site of the interview and no name was used instead code numbers were used. Participants were also explained that upon completion of data analysis, all the information collected will be kept by the researcher only and thereafter destroyed.

4.10 DISSEMINATION OF RESULTS

The study findings will be disseminated through formal meeting with Nkhotakota DHO and other stakeholders. The results of the study will also be made available at Kamuzu College of Nursing.

4.11 LIMITATION OF THE STUDY

The pilot study was done at Saint Anne's hospital .This was due to the influx of clients to new Nkhotakota District Hospital because of free maternity services. Therefore Saint Anne's was utilized for pilot study and Nkhotakota DHO for the actual study.

5.0 FINDINGS

This is a presentation of the findings of a qualitative study whose aim was to explore factors that contribute to maternal complications during labour and delivery at TBAs in Nkhotakota. The findings focus on the following categories that emerged from the study:

- Information on maternal complications.
- Perception on TBA program.
- Effectiveness of the referral system.
- Factors associated with maternal complications.

5.1 INFORMATION ON MATERNAL COMPLICATIONS

There are a lot of maternal complications women encounter during labour and delivery. Normally a pregnant or postnatal woman should know at least ten of these complications.

5.1.1 Level of Knowledge of Pregnant and Postnatal Women on Maternal Complications

One of the objectives of the study was to assess the level of knowledge of pregnant and postnatal women as regards to maternal complications. From the list of twelve complications the majority were able to mention only a few maternal complications. 70% pregnant and postnatal women interviewed had little knowledge of maternal complications. Presented below are few commonly mentioned maternal complications:

- Postpartum haemorrhage.
- Prolonged second stage of labour.
- Oedema of feet.

5.1.2 Level of Knowledge of TBAs on Maternal Complications

The other issue the study looked at was to assess the level of knowledge on danger signs amongst TBAs.When responding to this it showed that 60% of the TBAs had

adequate knowledge of maternal complications. When asked to explain the complications and the category of pregnant women to refer to the hospital, one TBA explained:

> *"At my clinic I don't handle a primgravida, malpresentation and women with history of any operation because the women are prone to have complications. Therefore I refer them to a health facility to continue with antenatal care and delivery".*

5.2 CLIENTS' PERCEPTION ON TBA PROGRAM

Another area that the study focused on was to establish opinions of pregnant and postnatal women (clients) on TBA programme. The clients perceived the programme differently.

Study findings indicated that 60% of the clients perceived TBA program as beneficial and helpful to pregnant women for the following reasons:

- TBAs are easily accessible
- TBAs' services are cheap and negotiable.
- Some TBAs use herbs (traditional medicine) to cast out bad spells. Because of this women are ensured to have a safe delivery. Traditional medicine is also used by some TBAs to facilitate labour and delivery, also to avoid vaginal and perineal tears.
- Good attitude.

According to the above reasons the study found that women walk very short distances to get to a TBA than a health facility. It was also indicated that women choose to deliver at the TBA because it is less expensive although it may cost their lives. The use of herbs (traditional medicine) to cast out bad spells ensures women to have a safe delivery at a TBA. Traditional medicine is also used by some TBAs to facilitate labour and delivery, also to avoid vaginal and perineal tears. Good attitude amongst TBAs

encouraged women to utilise their services because they don't shout at women nor say rude remarks.

However, some respondents (40%) perceived the program as not beneficial basing on the following reasons:

- Delays clients' referral to a health facility.
- Some TBAs forced women to drink traditional medicine in order to facilitate delivery which was a harmful practice.
- TBAs are not health personnel as such they lack adequate and proper skills and knowledge to assist women effectively.

One woman had this to say:

> *"I don't regard the program as helpful because I nearly died at TBA because the TBA didn't want to refer me on time to the health facility. She was giving me traditional medicine to drink that never worked. I decided myself to come to the hospital after staying at the TBA for two days. Now I am here in the hospital alive but lost my baby and would have also lost my uterus which was almost ruptured."*

Clients complained that TBAs intentionally delay referring women before complications occur. This is because TBAs don't want to lose their pay and reputation for being failures.

5.3 FACTORS ASSOCIATED WITH MATERNAL COMPLICATIONS AT TBAs

One of the objectives was to find out factors associated with maternal complications at TBAs. Maternal complications at TBAs is a result of an interplay of several factors such as delay in decision making both by TBAs and husbands of clients, unsafe practices during labour and delivery, dirty environment, poverty, distance and transport problems to reach the health facility.

5.3.1 Decision Making

The women who developed complications at TBAs were a result of delayed access to basic or comprehensive emergency obstetric care. This was because the TBAs delayed to make proper decision of referring the woman earlier to the health facility. It was reported that the delay was intentional because the TBAs didn't want to lose their pay and reputation for being failures. But one TBA had this to say:

> *"Sometimes I delay because I can't predict the outcome or complication. This makes me to delay referring clients."*

Some women were delayed at the TBA because decision making was left to the husband, whether to take the client to the health facility or not depended on his financial status.

> *"In most places transport is a problem because there are a few people with cars and might not wish to travel at night as such husbands are involved not only to chase for transport but also to make a decision as to where the woman should go for assistance."*

5.3.2 Delivery Practices

Other areas observed to be contributing to maternal complications at TBAs are; use of traditional medicine, unhygienic places of delivery and poor infection prevention measures.

5.3.2.1 Traditional Medicine

Responding to a question on delivery practices, it was noted that most clients were given traditional medicine whether to drink or applied in the vaginal wall to facilitate labour and delivery. This was extremely dangerous because it could lead to ruptured uterus and puerperal sepsis. One TBA agreed to this and she explained:

"Women who deliver at my clinic don't experience vaginal nor perineal tears because I apply pounded traditional leaves (chewe) on vaginal wall and os to make it slippery and avoid tears."

However one client lamented that:

"I have lost my baby and lost my uterus which has been removed following a rupture because the TBA was giving me very bitter traditional medicine to drink. This was my first pregnancy; i will bear children no more children."

5.3.2.2 Delivery Place

Findings indicated that most delivering places (rooms) were not conducive to deliver babies. Four (4) out of five (5), (80%) of delivering houses were grass thatched with the floor smeared with soil. The floor was dusty. At one TBA, the woman who had already delivered a baby was found lying on a wet plastic paper on the floor with rough surface. Between the client's buttocks lied two old and dirty sticks. The floor was also wet with blood and liquor. The client and guardians acknowledged the delivering place being unhygienic.

5.3.2.3 Delivering Equipment and Supplies

The study results showed that the District and Saint Anne's hospitals stopped supplying TBAs with gloves and equipment used for delivery. This is inline with the new roles of TBAs that they should not conduct deliveries hence the cessation of supplies. One TBA who is still conducting 2 or more deliveries a day had this to say:

"I don't use gloves when conducting deliveries instead I use empty sugar bags thrown away by people. This is because the hospitals stopped supplying TBAs with gloves."

In case the TBA fails to find a plastic sugar bag outside her house, she failed to give an alternative. This may mean that the TBA could conduct deliveries with bare hands.

5.3.2.4 Hygienic Practices

Hand washing is indicated even before touching or examining clients and putting on gloves in order to remove transient flora from the skin surface which causes infection.

The study findings revealed that the majority of the TBAs do not wash their hands before assisting the women to deliver but after delivery.

> *"TBAs don't wash their hands until the child is born then would wash their hands."*

5.3.2.5. Vaginal Examination

Responding to a question about vaginal examination 80% of TBAs agreed to do vaginal examinations unnecessarily. The remaining 20% denied doing vaginal examinations. She explained:

> *"When a woman comes for delivery i just show her a place to lie down until the head of the baby becomes visible on the vulva then I assist her to deliver otherwise no examination is done prior to delivery."*

5.4 REFERRAL SYSTEM

Referral of patients was one area that the study focused on to find out how the existing system was working. This is a process of transferring a sick person from one care provider to another, from home to health facility, such as from TBAs to health facility. This involves communication and transportation of clients to the next level of health care delivery system. Feedback is also an integral part of the referral system.

5.4.1 Referral to Hospital

Responding to questions of transportation of clients to the health facility, findings indicate that 80% of TBAs had bicycle ambulances used to ease transport problems

when referring a client. The bicycle ambulances are used to transfer clients from the TBAs home to the nearest health facilities.

However the provision of bicycle ambulances has not reduced transport time from home to the health facility. This is due to long distances and poor road infrastructure in most areas. The health facility should be within 5km radius from the community but most respondents in the study pointed out the problem of transport and long distances to find a health facility about 10-20 km.

Out of 100% of clients who were admitted at the hospital, 40% were not referred to the hospital by TBAs, but went to the hospital on their own accord. These were three mothers (30%) who had delivered at TBAs and one mother (10%) was still labouring (not yet delivered).

> *"I have come to the hospital on my own not referred by the TBA although I complained of severe abdominal pains post delivery."*

However, all (60%) of clients who were referred by TBAs had referral letters although the information on it was inadequate.

5.4.2 Feedback from the Health Facility

The results indicated that all (100%) TBAs don't get feedback from the hospital regarding the clients which were referred by them. TBAs usually get feedback from clients themselves or their relatives upon asking but not a written document from the hospital. TBAs expressed concern over lack of feedback from the hospital.

> *"We don't get feedback from the health facilities, we learn what has happened at the hospital from clients' relatives or the clients otherwise no written document is sent back to us. Unless the referred client dies, then we are followed up."*

5.4.3 Communication

All of the TBAs don't have cell phones or ground phones for communication with the health facilities when they need an ambulance to refer clients. They send clients relatives or TBAs sons to deliver message and call for an ambulance. Sometimes they use patients' cell phones for communication.

5.5 IMPACT OF TBAs NEW ROLES ON MATERNAL HEALTH

In an effort to improve maternal health through the reduction of maternal death by the year 2015, towards the achievement of UN Millennium Goals, the government of Malawi has developed policy documents one of which has redefined roles of TBAs.That is TBAs are not supposed to conduct deliveries in normal but only in un avoidable circumstances.

During the study it was found that the following problems that TBAs meet with their new roles contributed to maternal complications:

- Loss of Income Generating Activity
- Lack of Supplies

Following a delivery a TBA is paid for the service rendered but with their new roles, it was noted that TBAs have lost a source of income. They complained of decreased number of deliveries conducted at their homes since the implementation of their new roles. This has led to some TBAs to hold clients at their clinics for fear of losing pay until after a complication develops.

TBAs also expressed concern about lack of supplies especially gloves because the District and Saint Anne's Hospitals stopped supplying them with gloves.

> *"We have been advised to stop conducting deliveries but only in unavoidable circumstances, so what will I use to protect myself and the client in that unavoidable circumstance."*

Asked one of the TBA.

6.0 DISCUSSION

The research study has revealed various issues associated with maternal complications during labour and delivery at TBAs. This includes information on maternal complications, perception on TBA program and the effectiveness of the referral system. The challenges of TBAs new roles will also be discussed regarding to TBAs perception.

6.1 INFORMATION ON MATERNAL COMPLICATIONS

Normally both clients and TBAs should have adequate knowledge on maternal complications obtained during health education at ANC and trainings respectively.

The study results have revealed that knowledge on maternal complications is very high among the TBAs than pregnant and postnatal women interviewed. This shows that the majority (60%) of TBAs know their scope of practice although it was noted that TBAs don't have adequate and proper skills to examine women during labour and post delivery for identification of problems. As a result women are referred when the problem is advanced and the condition is bad. The high percentage of the uneducated TBAs explains why it has been almost impossible to change the traditional beliefs of the TBAs. The level of education is a basic factor which attributes to how an individual takes information and counselling and uses it.

The findings also showed that five out of ten clients were told about pregnancy complications and where to go when a complication develops during pregnancy and delivery. The commonly mentioned problem by clients was post-partum haemorrhage as one of the most complications women may face during childbirth. This concurs with the findings by MDHS (2004) which showed that 7% of respondents reported heavy bleeding as the most often problem post delivery.

In view of the above discussion it is apparent that illiteracy of TBAs contributes to the development of maternal complications. This is because although TBAs have adequate knowledge on maternal complications, they lack skills on examining clients during labour and after delivery to detect at risk clients for complications.

6.2 CLIENTS' PERCEPTION ON TBA PROGRAM

The findings strongly indicate that the TBA program was regarded positively by most of the respondents in the study although it is risky. Clients viewed the program as helpful and beneficial to them. This is because TBAs are within reach in the villages and may be the only source of help for the mothers in the rural areas. This agrees with the study results by Umar, etal, 2007 who found that TBAs are a natural choice for most women because they live within their communities.

TBAs are the only affordable source of help in rural areas because of very low economic status of most people. Consistent with the report by WHO (1992) which states that "TBA program is acclaimed as beneficial in rural areas because services of skilled professional health care providers are not available and TBAs may be the only source of help".

According to the above discussion it indicates that TBA program is highly regarded by many people. This can contribute to the development of maternal complications because women have on choice but to seek assistance from a TBA although it is risking their lives.

6.3 FACTORS ASSOCIATED WITH MATERNAL COMPLICATIONS AT TBAs

The study findings have revealed that interplay of the following factors contribute to maternal complications at TBAs:

6.3.1 Decision Making

From the study findings it is apparent that men are instrumental in the decision making process. This is because the decision made would have financial implications. Therefore to choose a place of delivery depends on his financial status. This process delays referral of clients to emergency obstetrics care and contributes to the development of maternal complications at TBAs. This agrees with Chinombo who reported that delay in referral and transport problem account for another 15% of maternal deaths outside the hospital (Chinombo, 2006). In line with this, Matinga (1999) stated that in Malawi forty eight (48%) of women and thirty (30%) of men are functionally illiterate and eighty percent (80%) of rural women can neither read nor write, this has greatly affected the decision making of both men and women and any risk may arise is associated with witchcraft which only a traditional healer or a TBA can overcome.

In view of the above discussion it is clear that decision making contributes to delay of referral of women which leads to the development of maternal complications at TBAs.

6.3.2 Use of traditional Medicine

The study results showed that the majority of TBAs (60%) use traditional medicine to facilitate labour and delivery also to avoid vaginal tears. This concurs with the study results by MOH (2007) which revealed that both trained and untrained TBAs use herbs to initiate and accelerate labour. This is a harmful practice because it can cause the uterus to rupture as the contractions will be forceful and strong throughout labour. This concurs with Maine (1992) who stated that "there is no doubt that in some areas TBAs cause increase in maternal morbidity and mortality through unsafe practices such as vaginal examinations and use of traditional drugs because these harmful practices can cause puerperal sepsis".

Clients may also be delayed at TBA hoping that the herbs will work until after developing a complication then the clients are referred to a health facility. These are not only unnecessary delays of going to hospital and be given the right intervention but also

introducing infection to the mother and baby (Kawerama, 2007).It was also reported by MOH (2006) that harmful social and cultural beliefs and practices contribute to the high maternal mortality ratio in the country.

According to the findings four out of five (80%) TBAs were illiterate. This could be one of the influencing factors TBAs to use traditional medicine as it is in line with the description of a TBA that she usually has no formal education as a result, beliefs influences are very strong influence in her practice (Cannon, 1995). Kachule (2004) also stated that "the high percentage of the uneducated TBAs explains why it has been almost impossible to change the traditional beliefs of the TBAs. Level of education is a basic factor which attributes to how an individual takes information and counselling and uses it."

Illiterate women (clients) are also at risk of developing maternal complications because an illiterate woman is less likely to have access to and use health services in general and maternal services in particular, including antenatal and delivery care. They are also less likely to recognise the complications of pregnancy and seek medical care and are more likely to use possibly harmful herbs.

6.3.3 Delivery Place

The results showed that four out of five (80%) of delivery rooms were grass thatched with soil smeared on the floor and walls. The environment puts women at risk of developing complications like puerperal sepsis. This is because dust favours multiplications of microorganisms and harbours microoganisms for a long time. Clients can easily get infected because they deliver on the floor with a mat and plastic paper only.

6.3.4 Delivering Materials

The study showed that TBAs are not supplied with gloves for infection prevention. This has led to one (20%) of TBAs who still conducts at least 2 deliveries per day to put on dirty sugar bags which people throw away in their rubbish pits. This is a harmful practice because the TBA is introducing infection in women's birth canal rather than protecting

them. No wonder three out of four (30%) clients admitted due to puerperal sepsis in the gynaecological ward were all from the same TBA. This practice is contrary to infection prevention measures which require use of a separate pair of gloves for each client (Tietjen, etal, 2000).

6.3.5 Hygienic Practices

Hand washing may be the single most important infection prevention procedure. Findings have shown that all TBAs (100%) don't wash hands before examining clients and putting on gloves but only after removing gloves. This is unhygienic because hand washing is indicated even before touching or examining clients and putting on gloves in order to remove transient flora from the skin surface which causes infection (Tietjen, et al, 2000).

6.3.6 Distance and Transport

The study showed that women have to walk very long distances to get to a health facility for childbirth. And when advised to await labour at the district and Saint Anne's hospitals they consider cost of transport, upkeep and hospital fees. With these circumstances women chose to deliver at the nearest TBA because it is less expensive although it may cost their lives.

It is also evident that women who developed complications had delayed to the medical and surgical interventions of emergency obstetrical care. This is because although TBAs recognise the need for referral, most experience transport problems because they stay distance away from the main road and the health facility and in the villages where there are few or no vehicles. This situation is worse at night because the vehicle owners are reluctant to travel at night.

The use of bicycle ambulances has slightly improved delays in referral of clients to health facilities because cycling is very difficult in areas which are hilly, sandy and with poor road infrastructure. As a result of poor transport and communication to the main

road or health facilities, clients are delayed at TBAs and later develop complications which is life threatening both to the mother and baby.

Lack of transport may also contribute to the malpractice of some TBAs that has led to maternal death in the developing countries (MOH, 2007). Apart from long distance and unavailability of vehicles in the villages, some clients might not afford any available means of transport because of poverty. This agrees with the Malawi National Health Plan (MNHP) 1999-2004 which stated that Malawi was considered the 9th poorest country in the world and that 60% of people were living below the absolute poverty line. As a result women develop complications at TBAs because TBAs fail to refer some clients early to the health facility to prevent complications because it all depends on the financial position of the husband or the client herself.

6.4 REFERRAL SYSTEM

Referral is an integral part of comprehensive and continuous client care. It ensures that client's health needs will continue to be met as the client moves from one resource to another.

Findings have shown that TBAs refer clients mostly when complications have already occurred. This is because most TBAs keep on holding clients for fear of losing their pay and reputation. Transport problems and improper delay in decision making also contribute to delayed referral of clients. As a result clients are delayed to medical and surgical interventions which could have prevented the occurrence of the complication.

It is supposed that the health facilities respond to referral of the clients through the referral forms because this is an important part of the referral process. Findings have shown that TBAs don't' get feedback from the health facilities of the referred clients. This discourages TBAs to refer clients to the health facilities. To support this notion Booyens (2001) says that to operate effectively there must be a feedback to provide information on the status and performance of the systems. Pietroni (1996) also says

that if there is no response on referral process, the referral source may become discouraged and not send further referrals until a complication occurs.

The findings also showed that the majority of TBAs have bicycle ambulances to ease transport and communication problems during referral of clients to health facilities. This may indicate efficient referral system between the health facilities and TBAs although the impact is slight.

6.5 IMPACT OF TBAs NEW ROLES ON MATERNAL HEALTH

The newly revised Reproductive Health policy does not allow TBAs to conduct deliveries as a result TBAs encounter with the following problems which negatively affect the lives of pregnant and postnatal women:

6.5.1 Loss of Income Generating Activity

The findings showed that TBAs have lost a source of income. This is due to decreased number of deliveries they are conducting. As a result TBAs keep on holding those few clients who have come for delivery in order to get paid. This is harmful because the TBA might hold a client who requires emergency obstetric care.

6.5.2 Lack of Supplies

Findings revealed that TBAs stopped getting supplies especially gloves from the DHO and Saint Anne's hospitals. This has led to one of the TBAs putting on dirty sugar bags in order to protect herself. This is a harmful practice as the TBA is just introducing microorganisms into women's reproductive system that cause infection. For example puerperal sepsis.

6.6 CONCLUSION

In systems approach productivity is viewed as a function of the interplay of people, structure and environment. Similarly the findings of the study has revealed that maternal complications at TBAs is a result of an interplay of several factors such as delay in decision making both by TBAs and husbands of clients, unsafe practices during labour and delivery, dirty environment, poverty, long distance to reach the health facility and impact of new roles of TBAs. It is therefore important to address the challenges met by TBAs and weaknesses of TBAs considering that the access to acceptable, professional, modern health care services for all pregnant women is still not met and the fact that TBAs represent the only source available for maternity care to many developing country women including Malawi.

6.7 IMPLICATIONS OF THE STUDY

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

6.7.1 NURSING MANAGEMENT

The study findings have shown that nursing managers should lobby their respective district assemblies to upgrade health centre to BEmOC sites so that there is good coverage of Maternal and Neonatal Care in the districts. Nurse managers should be advocates for clients in terms of resource allocation both human and material resources in the health facilities especially in rural areas.

6.7.2 NURSING PRACTICE

As a practitioner it is important that nurses should be understanding and patient when handling referred cases from TBAs. This is because the study has revealed that women develop complications at TBAs because of factors beyond their control.

It is also important for practitioners to give feedback to TBAs on referred patient by them. This will help TBAs to improve their care.

6.7.3 Nursing Education

The results have indicated that some clients did not know what danger signs or complications of pregnancy. Therefore as educators nurses should include this in their health education talks in all health facilities including outreach clinics so that women should have adequate and proper information regarding Maternal and Neonatal health care.

Health education should be 'husband friendly' so that husband are encouraged to accompany their wives for antenatal care and acquire knowledge regarding Maternal and Neonatal Health Care.

Nurses as educators should conduct training of TBAs to orient both trained and untrained on their new role in Maternal and neonatal Health Care to ensure and maintain uniformity.

6.7.4 Nursing Research

Not much information on contributing factors to maternal complications has been revealed from the study. Therefore there is need to conduct a similar study on a larger scale so that the results should be generalised.

6.8 RECOMMENDATIONS

Basing on the findings the following recommendations have been made:

- The study has revealed that women suffer complications during labour and delivery at TBAs because of lack of skilled attendants due to inaccessible and inadequate health facilities mostly in the rural areas. Therefore it is recommended that the government should create more maternity units especially

Basic Emergency Obstetric Care sites in the rural areas to provide skilled care at delivery.

- In those areas where maternity services are offered by CHAM health facilities, the community opt for TBAs because they can't afford to pay for maternity services due to poverty. It is therefore recommended that the DHO should restart service agreement with CHAM health facilities in order to increase the utilisation of maternal health services in the district in order to prevent maternal complications.

- The study has revealed that the new roles of TBAs have a negative effect on maternal health because of the decreased number of clients or having no clients for delivery at TBAs. As a result some of the TBAs keep on holding the clients or delaying referral of clients for comprehensive emergency obstetric care for fear of losing their pay. It is therefore recommended that Nkhotakota DHO should establish a reward system for early and successful referrals by TBAs to encourage them to make timely referrals and not holding on to clients.

- The study also reveals that husbands' delay in decision making contribute to maternal complications at TBAs. It is therefore recommended that the DHO should make antenatal clinics "husband friendly" in order to allow men to accompany their wives for antenatal care in order to acquire knowledge on maternal health which includes birth preparedness and danger signs.

- The study has revealed that the DHO and Saint Anne's hospitals stopped supplying TBAs with gloves and this has led to one of the TBAs to use dirty plastic sugar bags which contaminates clients' birth canals. It is therefore recommended that the DHO and other stakeholders should restart supplying TBAs with gloves for infection prevention.

6.9 ISSUES FOR FURTHER STUDY

There are other areas that need further investigations and these are:

- To investigate factors that hinder men's participation in maternal health care.
- To determine perceptions of communities on new roles of TBAs.

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APPENDIX A

CONSENT FORM

Dear Participant,

My name is Violet Seven. I am a second year Bachelor of Science in Nursing student majoring in Community Health Nursing at the University of Malawi, Kamuzu College of Nursing. In partial fulfillment of the program, a research study is required. I am conducting a study to find out the contributing factors of maternal complications during labour and delivery at TBAs in Nkhotakota.

I will ask you questions using a questionnaire. You are assured of your right to privacy and confidentiality. All the response will be kept confidentially in sealed envelops and locked up in a drawer where only the researcher and the supervisor will have access.

No names will be used on the questionnaire instead code numbers will be used for anonymity. You have also freedom to choose to participate or not. If you choose to participate and later decide to withdraw from the interview, you are free to do so without any penalties.

You will not be exposed to any risk in participating in this study. After data analysis all the interview responses will be destroyed by burning. The interview will take an average of 30-35 minutes.

There might be direct or indirect benefits to you as a participant since the findings of the study will be used to improve TBAs skills and practice to be competent providers.

If you agree to participate in this study please sign below.

I have read and understood the above information and wish to participate in the study.

Date..... Signature of Participant:.....

Date: ..... Signature of Researcher: .....

APPENDIX B

QUESTIONNAIRE FOR A RESEARCH STUDY

To be addressed to women who have been referred from TBAs with maternal complications.

INTERVIWERS NAME: _____

CODE NUMBER: _____

DAY/MONTH/YEAR:

SECTION A

DEMOGRAPHIC DATA

1. How old are you?
   - 10 – 19 years ☐
   - 20 – 29 years ☐
   - 30 – 39 years ☐
   - 40 – 49 years ☐
2. What is your marital status?
   - Married ☐
   - Widowed ☐
   - Divorced ☐
   - Single ☐
3. How many children do you have?
   - None ☐
   - 1 – 4 ☐
   - 5 - 7 ☐
   - 8 – 10 ☐
   - >10 ☐

4. Which religion do you belong to?

Roman Catholic ☐
CCAP ☐
Anglican ☐
SDA ☐
Moslem ☐
Other (Specify) _____

_____

5. What is your tribe?

Chewa ☐
Tumbuka ☐
Yao ☐
Taonga ☐
Lomwe ☐
Other (Specify)_____

_____

6. Have you ever attended school?

Yes ☐
No ☐

7. How far did you go with your education?

None ☐
5 – 8 ☐
Secondary ☐
University ☐
Never ☐

8. What is your occupation?

Farmer ☐
Housewife ☐
Businesswoman ☐
Other (Specify) _____

9. What is your husband's occupation?

Farmer ☐

Housewife ☐

Businessman ☐

Other (Specify)_____

_____

SECTION B

MATERNAL AND CHILD HEALTH CARE

QUESTIONS

1. Did you see anyone for antenatal care for your pregnancy?

Yes ☐

No ☐

2. If yes, whom did you see?

Doctor/clinical officer ☐

Nurse/midwife ☐

Traditional Birth Attendant ☐

Other (specify)

3. How many times did you receive antenatal care during this pregnancy?

No of times ☐

4. During any of your antenatal care visits were you told about the danger signs of pregnancy complications?

Yes ☐

No ☐

Don't know ☐

5. If yes, what are the danger signs or symptoms during pregnancy indicating the need to seek medical care?

Fever	☐
Shortness of breath	☐
Excessive bleeding	☐
Convulsions	☐
Weakness	☐
Swelling of hands and feet	☐
Headache	☐
Severe abdominal pain	☐
Dizziness	☐
Excessive vomiting	☐
Blurred vision	☐
Less /no fetal movement	☐
Don't know	☐

Other (specify)_____

6. Were you told where to go if you had any of these complications?

Yes	☐
No	☐
Don't know	☐

7. As part of your antenatal care during this pregnancy, were any of the following done at least once?

	Yes	No
Were you weighed?	☐	☐
Was your blood pressure checked?	☐	☐
Did you give a urine sample?	☐	☐
Did you give blood sample?	☐	☐

8. After your child birth, did any health care provider or a traditional birth attendant check on your health?

Yes ☐

No ☐

9. If yes, how long after delivery did the first check take place?

Hours ☐

Days ☐

Weeks ☐

Don't know ☐

10. Why didn't you deliver in a health facility?

Cost too much ☐

Facility not open ☐

Too far/no transport ☐

Poor quality at facility ☐

No female provider at facility ☐

Husband/family did not allow ☐

Not necessary ☐

Not customary ☐

SECTION C

ACCESSIBILITY OF HEALTH FACILITY/TRADITIONAL BIRTH ATTENDANTS

1. Which is the closest place where a pregnant woman could give birth?

Hospital ☐

TBA ☐

2. How far from your home is the closest place where someone could give birth?

Less than 1 kilometer ☐

1-5 kilometers ☐

5-10 kilometers ☐

10-15 kilometers ☐

15 or more kilometers ☐

3. How long would it take you to reach there?

Less than 30 minutes ☐
30-60 minutes ☐
1-2 hours ☐
More than 2 hours ☐

4. How do you travel to the TBA?

Footling ☐
Bicycle ☐
Car ☐
Other (specify) _____

5. How do you travel to the health facility?

Footling ☐
Bicycle ☐
Car ☐
Other (specify) _____

SECTION D

CULTURAL PRACTICES AND BELIEFS

1. Do you have to inform anybody prior to going to the health facility or TBA?

Yes ☐ go to question 2.
No ☐

2. Whom do you inform when you want to go to the health facility or TBA?

Husband ☐
Grandmother ☐
Mother in-law ☐
Friend ☐
Uncle ☐
Others (Specify)_____

_____

3. Who decides for you to attend or not to attend the health facility or TBA?

Husband ☐

Grandmother ☐

Mother in-law ☐

Self ☐

Others (Specify)_____

_____

4. Are there any traditional beliefs for pregnancy, labor and delivery regarding you and the newborn?

Yes ☐ go to question 5.

No ☐

5. Which are the traditional beliefs?

_____

_____

6. What does your religion say about hospital services?

_____

_____

SECTION E

QUALITY OF TBA SERVICES

1. How do you perceive the TBA program?

_____

_____

2. Have you ever been attended by a TBA?

Yes ☐ go to question 3.

No ☐

3. What was the reason for utilizing a TBA during pregnancy, labor and delivery?

_____

_____

4. What kind of services were you given regarding pregnancy, labor and delivery the TBA?

	Yes	No
Checking height	☐	☐
Checking fetal size/presentation	☐	☐
Checking fetal condition	☐	☐
Checking for anemia	☐	☐
Asking past obstetric history	☐	☐
Vaginal examinations	☐	☐
Fundal pressure	☐	☐
Traditional medicine	☐	☐
Referral	☐	☐

Others (Specify)_____

_____

5. (a) Did you ever have maternal complications at TBA clinic?

Yes ☐ go to question (b)

No ☐

(b) When did you have maternal complications?

During labour ☐

During delivery ☐

After delivery ☐

(c) For how long did it take for you to be referred to the health facility?

Immediately ☐

1 – 2 hours ☐

3 – 4 hours ☐

5 – 6 hour ☐

>6 hours ☐

6. How did you travel to the health facility?

Footing ☐

Oxcart ☐

Bicycle ☐

Ambulance ☐

Stretcher ☐

7. What resources were available/used for conducting delivery?

_____

_____

8. What are the advantages of utilizing TBAs during labour and delivery?

_____

_____

_____

THANK YOU FOR PARTICIPATING

APPENDIX C

QUESTIONNAIRE FOR THE TRADITIONAL BIRTH ATTENDANTS

1. How old are you?

20-30 years ☐
30-40 years ☐
40-50 years ☐
50-60 years ☐
60-70 years ☐

2. Have you attended school?

Yes ☐
No ☐

3. How far did you go with your education?

1-4 ☐

5-8 ☐

Secondary ☐

4. Which clients are you supposed to handle at your clinic?

_____

_____

_____

5. What kind of antenatal services do you give here?

_____

_____

6. What interventions are performed to a woman in labor?

7. Can you explain the danger signs of pregnancy and labor?

8. Which pregnancy conditions warrant referral to a health facility?

9. What are the symptoms during childbirth indicating the need to refer the woman for immediate health care?

10. When would you refer the pregnant woman with past obstetric problems? For example previous scar(s) and post partum hemorrhage?

11. In case of transport problem for referral of a woman with obstetric complications, what would you do in order to prevent morbidity and mortality?

12. Do you get feedback from the hospital?

Yes ☐

No ☐

13. What challenges do you meet with the new roles of TBAs?_____

_____

_____

_____

THANK YOU FOR PARTICIPATING