

**PATTERN OF PRACTICE AND CHALLENGES EXPERIENCED BY  
TRADITIONAL BIRTH ATTENDANTS IN IBADAN SOUTH EAST  
AND OLUYOLE LOCAL GOVERNMENT AREAS, NIGERIA**

**BY**

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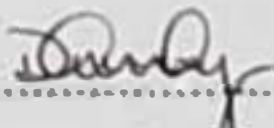
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## CERTIFICATION

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## DEDICATION

This research work is dedicated to the Glory of Almighty Allah for His mercy upon me; to the memory of my late father and mother, Alhaji Jimoh Bakare and Mrs. Surakatu Bakare.

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Wenifideen Oshubenga HMC02

## ABSTRACT

Trained Traditional Birth Attendants (TBAs) play important roles in promoting safe motherhood and reducing infant mortality rate in Nigerian communities. However, the challenges faced by practicing TBAs and their pattern of practice have not been adequately assessed. This study, aimed determining the pattern of practice and challenges faced by TBAs in Ibadan South East and Oluyole Local Government area (LGAs).

A cross-sectional survey of all the 172 TBAs who registered and practicing in Ibadan South East and Oluyole LGAs was conducted. Six Focus Group Discussions (FGDs), (2 for females and 1 for males in each LGA) were conducted among the TBAs. Four gender-sensitive In-depth Interviews (IDIs) were conducted for Community Health Extension Workers (CHEWs) who supervise them. In addition, a validated questionnaire was used to collect quantitative data from the TBAs. Content analysis was carried out for the qualitative data while the quantitative data were subjected to descriptive and Chi-square statistical analyses.

Participants' mean age was 44.7 ± 6.3 years, 92.4% were females and 86.2% had secondary education. More than half (58.8%) were trained by older family members, 24.4% were trained by government while 7.6% were trained in private hospitals. Respondents' supplementary jobs included petty trading (41.3%), auxiliary nursing (12.8%) and religious activities (10.9%). Almost all respondents (91.7%) encouraged pregnant women to attend ante-natal clinic and 89.0% referred high risk cases to formal health care facilities. Most respondents (87.9%) did not receive any form of support from the government. Some (30.8%) perceived the relationship between them and formal healthcare workers as not cordial. Many (51.7%) had never used the take-off antenatal and delivery kits given to them after their basic training. The universal precautions practised by some of the TBAs include: washing instruments in bleach (46.5%), use of sterile needle/equipment for each client (40.2%) and use of gloves during delivery (48.5%). A large proportion (89.5%) purchased their supplies from patent medicine vendors while few (9.5%) obtained their supplies from primary health care departments in their LGAs. About a third of the respondents practised appropriate record keeping. Gender (male 61.5%, female 31.8%) and levels of education (secondary school 27.5%, primary and informal 51%) were both significantly associated with good record keeping ( $p < 0.05$ ). Only 23.8% of the respondents educated community members on family planning and the importance of immunization. The challenges perceived by TBAs as revealed

by FGDs and IDIs include: little or no supervision, lack of monetary incentives from government, inadequate supplies of delivery materials, and lack of funding.

The traditional birth attendants were not sufficiently motivated to practice their profession in the two local government areas. There was poor record keeping among them and their inadequate adherence to universal precautions can put their clients at risk of infectious diseases. Regular supportive supervision and in-service training opportunities are needed to promote safe motherhood practices among them.

**Key word:** Traditional birth attendants, Safe delivery, Safe motherhood practices,  
Professional challenges.

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# CHAPTER ONE

## INTRODUCTION

1.0

### 1.1 Background of the Study

Traditional Birth Attendants (TBAs) constitute a major group of reproductive health care providers in the world today. It is estimated that between 60 and 80 percent of all deliveries in the developing countries occur outside modern health care facilities (WHO 1992), with a significant proportion of this attended by TBAs (Abioye-Kuteyi, Elias, Famulus, Fakunle, and Akinfolayan, 2001). In many rural communities in third world countries, TBAs even represent the only source of maternal health care services. Thus, the role of TBAs is critical in efforts to improve maternal health and reduce maternal mortality and morbidity in developing countries. With this in mind, there has been considerable focus on TBAs globally, especially in the last three decades (Abioye-Kuteyi et al., 2001). Among others, efforts have been directed towards training them in some principles of safe deliveries, and integrating them into Primary Health Care delivery system. By the early 1980s, approximately 82 per cent of developing countries had initiated training programmes for TBAs compared with 37 percent a decade earlier (Wanyu, Diom, Mitchell, Tih, Meyer 2007).

Since the dawn of history, man has been actively experimenting with a variety of available means to safeguard his health and promote the quality of life. In developing countries like Nigeria, the two forms of healthcare that permeate the healthcare system are the modern/orthodox and the traditional. Due to the popularity of the modern/orthodox healthcare system, one may be tempted to conclude that orthodox healthcare enjoys a higher patronage and supremacy over its traditional counterpart in most developing countries. However, the fact remains that effort to cope with the existing and enormous health problems in developing countries still lacks necessary corresponding facilities required to cope with such problems (Imogie, Agwuhike and Aluko, 2002).

Attendance at birth has been suggested to be essential in facilitating mother-child survival as the physiology of birth changed during human evolutionary history. "Midwife", an Anglo-Saxon term meaning "with woman", aptly describes the role that women have long assumed as birth attendants (Sage Encyclopaedia of Anthropology, 2005). A traditional birth attendant (TBA) also known as a traditional midwife (TM) is primary pregnancy and childbirth care

provider. Traditional birth attendants provide the majority of primary maternity care in developing countries, and may function within specific communities in developed countries.

Traditional birth attendants usually learn their trade through apprenticeship; although some may be wholly self-taught, they are not certified or licensed (Satishechandra, Naik, Wanlanutte, Mallapur 2009). Traditional midwives often provide health advice and education, and health care beyond the field of maternity. In many parts of the world, one of the criteria for taking the office of midwife is experience as a mother (Bisikn, 2008). Many traditional birth attendants that are consistent are older mothers; many are post-menopausal while many are also herbalists or other traditional healers. They often serve as a bridge between the community and the formal health system, sometimes accompanying women to health facilities (Satishechandra et al., 2009).

The focus of TBAs work is usually in assisting women during child delivery and in the immediate post-partum period. Frequently, their assistance also includes helping with household chores. Most traditional midwives travel to the pregnant woman's house to provide care; women may also travel to them to obtain care. Traditional midwives are usually assisted by the birthing woman's relatives. Many traditional midwives live in rural and often isolated communities (Dergsirtim and Goodburn, 2001). They may work at considerable distance from health facilities.

There have been considerable efforts placed on the education of TBAs in the last thirty years with little success. Most training programmes have focused on training the TBAs with little attention paid to the environment in which they work [National Primary Health Care Development Agency (NPCDA), 1997; Delano, Udo, Osanyin, Akinsoto, Anshodeinde, Adeniyi, Ogunluyi, Ladipo, and Oyelami, 1999]. Other issues must be addressed for Traditional Birth Attendants to be able to provide optimal care including integration of traditional healers into the formal health care system, conditions for referral, access to equipment, adequate transportation and other related issues (Sibley and Sipe, 2006).

In developing countries, Traditional Birth Attendants may sense increasing pressure to submit to regulation of their practice. Many may resolutely resist any type of certification or license, being content with their lay status and enjoying the simple, domestic nature of their vocation. Some may have conscientious objections to outside interference, believing that regulation may

place them as well as the families they serve in a compromised position regarding the physical, emotional, mental and spiritual well being of mother, child and the family unit (Saishechandra et al., 2009).

A common view is that midwifery is an ancient art that belongs to the community of women (Nahlen, 2000). Traditional Birth Attendants have their practice on the understanding that pregnancy and childbirth are natural processes and health care should be personalized to meet the needs of a woman and her family. While the practice of midwifery differs worldwide, most midwives provide prenatal care, assist the birth process, and offer emotional and psychological support to a woman and her family during the birth experience (Microsoft Encarta, 2009). Traditional midwives are likely to belong to certain subcultures or religious groups. Of the TBAs who are religious practitioners, a focus of their practice may well be to exclusively attend to the births of women of like faith (Nahlen, 2000).

Furthermore, certain families highly regard their privacy and view birth as such an intimate process that they may be hurt or humiliated in being billed by a midwife for the privilege of attending the birth of their child, thus the growing movement of unassisted childbirth. Among these families there is a need for the services of Traditional Birth Attendants who are willing and able to serve without demand for compensation. One way this may be accomplished is for believers in any given local government to provide a continuum of practical support, such as living arrangement to their community midwives (Sibley and Sipe, 2006). There is also the issue of emergency childbirth. Natural and man-made disasters from hurricanes or epidemics to terrorist attacks (real or synthetic) in highly populated cities have the potential of causing a demand for birth attendants that would overwhelm the medical establishment. In times like these, there would be no replacing the Traditional Birth Attendant. There is neither a replacement for a common knowledge of natural, home birth and women helping women in their local communities, which is where the TBA has its organic roots (Bisika, 2008).

In Nigeria, like many developing countries, the rationale for focusing on the training of community-based health workers, particularly TBAs and Volunteer Health workers (VHW) in the late 1970s includes the low coverage of formal health care and services (Isenatunbe, 1990). The coverage situation has not improved significantly over the years. As the health manpower and facilities conducted in 1991 showed, Nigeria had a total of 24,467 health facilities spread over 4,474 communities. For a country with about 101,011 communities, this

represents coverage of 14.3% (FNMI 1992). According to World Health Statistics 2009, the ratio of nurse-midwives per 10,000 population is as low as 17. In the rural areas, the health indices are particularly poor with only 30% of the people having access to health services within a 4 kilometre compared to 75% of urban people (Hergstrom and Crossburn 2001).

The maternal mortality ratio in the rural areas virtually triples that of urban dwellers. With this health scenario, considerable focus on the health of the rural people is necessary. As the TBAs play critical role in these communities, they have come under increasing attention of health researchers (Isenatumba, 1990). Traditional Birth Attendants are not a homogenous group in terms of practice and beliefs as these are influenced greatly by the social belief of their societies. This is not unexpected, as pregnancy and childbirth practices in all traditional societies are firmly rooted in the cultural milieu and surrounded with a variety of mystical beliefs and cultural practices.

## 1.2 Statement of the Problem

In Nigeria, with an estimated population of over 140 million and not less than 65% of this number live in the rural areas, the number of health professionals responsible for delivering orthodox healthcare is largely inadequate (Inogie et al., 2002). Yet, over 75% of Nigerian orthodox medical and paramedical personnel are concentrated in urban areas that have the large majority of modern health facilities to the detriment of the teeming rural dwellers. Many rural Nigerians, therefore, have not been exposed to the benefits of modern changes in orthodox healthcare system. Consequently, traditional healthcare system is the principal system used in most rural communities in Nigeria (Wairaven and Weeks 1999).

Since most people in the rural area do not have access to modern health care facilities as seen in the urban, it is pertinent to improve the healthcare facilities they have access to.

Some Traditional Birth Attendants are also found in the urban area and are highly patronized, which may be due to socio-economic problem of the people patronizing them. Meaning that there is a need to improve the practices of Traditional Birth Attendants which will culminate into reduction in maternal mortality and morbidity.

The study was therefore carried out to assess the practice and challenges experienced by Traditional Birth Attendants with a view of correcting their bad practices and proffering solution to their challenges.

### 1.3 Justification

One of the millennium development goals (MDGs) is reduction of maternal mortality and morbidity. It has also been observed and acknowledges that the practices of Traditional Birth Attendants (TBAs) contribute to maternal mortality and morbidity by playing crucial roles in providing antenatal services and assisting women in delivering their babies in most rural areas and also in urban. This is particularly important in medically underserved communities where primary or secondary health care services are not available. Hence, the problems and challenges associated with the practice of TBAs need urgent attention. This study assessed the challenges experienced by the TBAs with a view to using findings to suggest ways of improving their practices and reduction of attrition rates. The study of this nature is relevant in order to achieve this aspect of MDGs.

### 1.4 General Objective

The general objective of this study was to assess the pattern of practice and challenges experienced by the Traditional Birth Attendants in Ibadan South East and Oluyole Local Government Areas of Oyo State.

### 1.5 Specific Objectives

The specific objectives were to:

1. Document the demographic characteristics of trained TBAs in Ibadan South East and Oluyole Local Government Areas.
2. Document types of training that the TBAs have received;
3. Assess the pattern of practice of trained TBAs;
4. Document challenges experienced by the TBAs and;
5. Document the enabling environment put in place by the government for their function.

### 1.6 Research Questions

1. What are the characteristics of the traditional birth attendants in Ibadan South East and Oluyole I.GAs in Ibadan, Oyo State?
2. What is the nature of training that the traditional birth attendants have been exposed to?



3. What is the pattern of practice of trained TBAs as compared with the job description and set standards?
4. What are the challenges affecting the practice of the TBAs?
5. What are the measures put in place by the government in enhancing the operations of the traditional birth attendants?

### 1.7 Research Hypotheses

Two null hypotheses were tested by the study, these are:

- H<sub>01</sub> There is no association between good record keeping practices and demographic variables of the respondents.
- H<sub>02</sub> There is no association between kits use and demographic variables of the respondents.

### 1.8 Limitation of Study

The investigation relied absolutely on reported practices of the respondents. There was no way of ascertaining whether the respondents' claims were true or false. Also, the use of observational techniques in documenting the practice of TBAs would have been more objective. This could not be used because of the difficulty in ascertaining the actual time of conduct of deliveries by the TBAs.

## 1.9 Operational Definition of Terms

AIDS	Acquired Immune Deficiency Syndrome
FMOH	Federal Ministry of Health
HIV	Human Immune Deficiency Virus
IMR	Infant Mortality Rate
NIH	National Institute of Health
NPCDA	National Primary Health Care Development Agency
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendants
UNAIDS	United Nations Programme on HIV/AIDS
UNCED	United Nation Conference on Environment and Development
UNDP	United Nation Development Programme
UNFPA	United Nation Fund for Population Activities
USAID	United Nation Agency for International Development
WHARC	Women's Health and Action Research Centre
WHO	World Health Organisation
UNEP	United Nation Environment Programme

## CHAPTER TWO

### LITERATURE REVIEW

2.0

#### 2.1 Evolution of Health System in Nigeria

The healthcare system in Nigeria evolved over a period of time. The system has undergone some changes which may be grouped into different periods of national development viz: Pre-colonial, Colonial and Post-independence era; National Development Plans I, II, III, IV, V; National Health Policy (1988 and revised 2004); and, by the end of the 1990s, the health systems had virtually collapsed. Few people could afford annual check-ups, medicines or user fees at hospitals. One result was the resurgence of infectious diseases such as malaria, tuberculosis and cholera. The three pillars on which PHC (Primary Health Care) strategy for the achievement of "Health for All (HFA)" goal stands are inter-sectorial collaboration, active community involvement and use of appropriate technology. The organization of this health sector relates closely with other sectors on a holistic and mutual basis. This principle was fully upheld in the revised National Health Policy and Health Plan as roles of other sectors were given prominence. It states that:

*"Federal, State and Local Government shall support in a coordinated manner a three-tier system of health care. Essential features of the system shall be its comprehensive nature, multi-sectorial inputs, community involvement and collaboration with non-governmental providers of health care."*

The adoption of this historic document under the able leadership of Late Professor Olikoye Ransome-Kuti, the then Honorable Minister of Health, was informed by the poor state of health of the people and the negative impact on other sectors of the economy. The situation then was characterized by high mortality rates from common preventable diseases, high crude birth rate, and low life expectancy at birth - 50 years. This National Health Policy guideline was adopted in October 1988. This is with a view to achieving the goal of health for all using the primary health care approach as their main strategy. The period 1985 through 1993 witnessed a purposeful direction as significant improvement was observed in the health sector. Also, many programmes have been initiated by various organizations/agencies including the World Health Organization (WHO) for training of TBAs between 1970s and 1990s. The rationale for such programmes has been the assumption that TBAs are present at most home deliveries and can be trained to avoid harmful delivery and postnatal practices as it relates to Millennium Development Goals 4 and 5 (Bello, Ambe, Yahaya, and Omotayo, 2011).

## 2.2 Who are the Traditional Birth Attendants?

A traditional birth attendant (TBA) has been defined by World Health Organisation as a person who assists mothers during childbirth and initially acquired her skill by delivering babies herself or through apprenticeship to other TBAs (WHO, 1992). The Nigeria TBAs conform to this international definition. Having acquired their training informally within the traditional health system, TBAs practise within the social milieu of their communities and are not employed within the formal healthcare system (Abioye-Kuteyi, Elias, Familusi, Fakunle, and Akinfolayan, 2001).

The focus of their work is usually assisting women during childbirth delivery and in the immediate post-partum period. Frequently their assistance also includes helping with household chores. Most traditional birth attendants travel to the pregnant woman's house to provide care. Women may also travel to them to obtain care. Many TBAs live in rural and often isolated communities. They may work at considerable distance from health facilities. Also there is a sharp distinction made in international literature and discourse between "professional midwives" and "traditional birth attendants" (TBAs). Health authorities tend to accept this distinction, while anthropologists tend to reject or contest it, examining the social roles of definitions as tools of power to determine insiders and outsiders.

The World Health Organization (WHO) in 1992 distinguished trained TBAs as having "received a short course of training through the modern health care sector to upgrade their skills." WHO suggests that TBAs are stop-gap measures until more "qualified" personnel are available (<http://www.davis-flloyd.com/userfiles/midwifery.pdf>. Accessed on September, 2010). TBAs work and live among their people, usually in rural or peri-urban communities. Most TBAs regard their health care services as a calling, rather than profession per se. TBAs, in Nigeria, do not receive salaries from government or the community. Most of them also do not present formal bills or charges to their clients for services rendered; however, members of the community are known to reward their services in kind and or cash. In return for their services, communities are known to have dedicated some period of time to work on the farm of TBAs.

In general, many TBAs have other occupations, usually farming or trading. There are however indications in certain quarters that some TBAs are no longer satisfied with the "voluntary" nature of their services. Similar reports have also emanated from some works conducted in

other parts of the world (Wanyu et al., 2007). Thus, the issue of how to remunerate TBAs and Volunteer Health Workers are increasingly being discussed. Already, field experience shows that some TBAs now charge some fees from their clients.

Most TBAs undertake deliveries of their clients in rooms located within their compounds and purposely set apart for deliveries (delivery rooms). A few of them also attend to deliveries in the houses of their clients. Some are known to make rounds from one house to the other to see their clients (Wairaven and Weeks 1999). They also work with little or no supervision from the formal health system. Although designated supervisors and structure exist in some states, the problem of funding of supervisory activities and logistics, including transportation facilities, constitutes formidable impediments.

### 2.3 Traditional Birth Attendants and Skilled Health Workers

The term "skilled health worker" refers to an accredited health professional such as a midwife, doctor or nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (World Health Organization, 2004). Traditional birth attendants (TBAs) either trained or not, are excluded from the category of skilled health workers. In this context, the term TBA refers to traditional, independent (of the health system), non-formally trained and community based providers of care during pregnancy, childbirth and the postnatal period (World Health Organization, 2004).

Although the definition is quite specific, the use of it in measuring the proportion of births attended by a skilled health worker has been problematic. Many countries where maternal mortality is a big public health problem have also limitations in the availability of qualified health personnel. Country programmes strive to increase the proportion of births attended by a skilled health worker by providing training to and employing different cadres of personnel to participate in deliveries. The content of such training, however, usually is not standardized across countries and limited information is available on the exact components of such training. For maintaining comparability of individual country figures, the cadres apart from doctors, nurses, midwives and auxiliary midwives reported in surveys are not included in the category of "skilled health worker" unless information existed in relation to the training of such a cadre.

The most recent estimates of maternal mortality developed by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Fund for Population Activities (UNFPA) and The World Bank in collaboration with scientists from academia, show that at least half a million women have died due to pregnancy-related causes in 2005 (WHO, 1992). The estimates for the first time analyzed the changes in maternal deaths between 1990 and 2005, demonstrating slow and uneven progress towards achievement of the first target (to reduce maternal mortality ratio by three quarters, between 1990 and 2015) of the fifth Millennium Development Goal (MDG).

Overall, the global decline in maternal mortality ratio was 5.1%, and the annual decline was less than 1%. It is estimated that an annual decline of 5.5% in global maternal mortality ratios between 1990 and 2015 is required to achieve the target. Important gains have been made in some world regions such as Eastern Asia where the highest annual decline was seen (4.2%), and Northern Africa (3.0%), South-Eastern Asia (2.6%) and Latin America and the Caribbean (2.0%). However, maternal mortality ratio declined annually on an average of only 0.1% in sub-Saharan Africa between 1990 and 2005 (WHO, 2004).

It is recognized that in addition to a range of interventions before, during and after pregnancy, ensuring that all births are attended by a skilled health worker is a key strategy to reduce maternal deaths. On the basis of historical and observational evidence on the association between having a skilled health worker at delivery and reduced maternal mortality (Luk, Han, and Asuquo, 1999), the proportion of births attended by a skilled health worker, was selected as a proxy measure to monitor the progress towards the MDG 5 target of reducing maternal mortality. It was agreed at the special session of the United Nations General Assembly in 1999, which was held for the five-year follow-up to the International Conference on Population and Development (ICPD), that globally 80%, 85% and 90% of all births should be assisted by skilled attendants by 2005, 2010 and 2015 respectively (WHO, 1992).

As in many sub-Saharan African countries, the availability and quality of maternal health care is often inadequate in Nigeria. Only one-third of Nigerian women have skilled birth attendants when they deliver, in part because obstacles such as poverty, health workers' negative attitudes toward patients, and policies prohibiting relatives from being in the labour room discourage women from delivering at public hospitals. As a result, many women rely on

traditional birth attendants, who allow them to obtain social, emotional and other forms of support from family members or friends (Morhason-Bello 2008).

Orimadegun, Akinbami, Tongo, and Okereke (2008) compared the effects of out-of-hospital birth on early neonatal morbidity and outcome among referred newborns in South-West Nigeria. Their findings show that of the 511 admitted in the early neonatal period, 61.8% and 38.2% were delivered outside and inside the hospital setting, respectively. Babies were delivered at religious or "mission" house (16.7%), house of residence (38.0%), traditional birth attendants' homes (8.1%), and on the way to the hospital (6.9%). Births outside the hospital significantly increased as the birth order increased. They concluded that out-of-hospital births had greater risk of morbidity than hospital births. There is need to retain and monitor the activities of birth attendants and midwives involved in births outside the hospitals closer than it is presently done.

#### 2.4 The Role of Traditional Birth Attendants in Service Delivery

Imogie et al. (2002) assess the role of traditional birth attendants (TBAs) in modern health care delivery in Edo State, Nigeria. A total of 391 respondents comprising 18 TBAs, 309 childbearing mothers and 34 medical and para-medical professionals constituted the study sample. The results revealed that respondents believed that TBAs could 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 with their urban counterparts. Reasons for the preference included TBAs' availability, accessibility, cheap services and rural dwellers' faith in the efficacy of their services. It concluded that there is the need to restructure the training of TBAs as well as to fully integrate their services into the Nigerian orthodox healthcare delivery system especially as they affect rural settings (Abioye-Kuteyi et al., 2001).

However, in a work carried out in Ibadan by Taiwo, Oshkeyi, Lawoyin, and David, (2007), maternal deaths are blamed on healthcare workers not being skilled enough, financial barriers, failure to use family planning, emergency, antenatal and delivery care services. Factors associated with knowledge and attitude to preventing maternal mortality were also discussed. It was gathered that the fear of spiritual attack by the wicked people had been shown to promote the use of religious mission homes and the services of TBAs and herbalists (unskilled workers) for antenatal care and delivery. Many informal practitioners actually combine

traditional and orthodox care to get the different forms of assurance that each offers (Opaneye, 1998; Etuk et al., 1999).

## 2.5 Training of Traditional Birth Attendants in Nigeria and other African Countries

The potential role of TBAs in maternity care and safe motherhood began to be recognized in Nigeria in the 1970s (Maternal and Child Health Policy, 1991). Consequently, the re-training of TBAs was identified as an important strategy in efforts to increase women's access to maternity services and to reduce the high rate of maternal and perinatal mortality in Nigeria (Akpala, 1994). Since then several bilateral and multilateral donor organizations in collaboration with governments have been providing funding for TBA re-training programmes throughout the country (Akpala, 1994). However, in spite of these efforts, very little success has been achieved in Nigeria in the area of safe motherhood and perinatal health (Maternal and Child Health Policy, 1991).

Most traditional birth attendants are illiterate, and this may be a major constraint in training them to provide high quality care. Studies in the Gambia found that many trained attendants carried out some activities successfully, but there are some deficiencies in the care that they provide mainly due to their use of traditional practices or their inadequate knowledge (Menendez, Todd, Alonso, Francis, Lulat, and Ceesay, 1994). Continuing education and supervision of attendants are vital and should include training about infection control. In a survey conducted for the evaluation of training among 60 traditional birth attendants and midwives in the catchment area for the government hospital in the city of Ibadan, Nigeria (including 41 villages) by Matthews et al (1995), the findings indicate a high level of illiteracy and low levels of training by a health professional (13%). Religious beliefs and unsafe practices were identified as obstacles to proper treatment of obstetric emergencies. A programme was developed for the training of traditional birth attendants (TBAs) about safe childbirth practices and risk identification through pictures. The training was adapted to local conditions and beliefs. Birth cards were developed for use in reporting pregnancy history, month of initiation of prenatal care, immunization, and maternal and birth outcomes.

Analysis of record keeping revealed difficulties. TBAs were unfamiliar with month signs for the months of the year, and older users had sight and hearing deficits. Another pictograph card was developed which showed the record of 14 high risk complications. Twelve educational sessions were used to explain the high-risk record card. The outcome of this training was an



increase in rapport between midwives and birth attendants (even those not participating in the education project), and between TBAs and hospital staff, who had previously held negative attitudes toward TBAs. After seven months and the completion of training, 110 of the TBAs in the project were surveyed. Findings showed that 70% were able to recognize all 11 of the symbols of complications. The evaluation confirmed the importance of integrating TBAs into the health system (Isenalanibe, 1990).

Also, in another study conducted by Abioye-Kuteyi and others (2001) in Atakumosa West Local Government Area (LGA), Osun state in Nigeria. All 26 traditional birth attendants (TBAs) and their 109 clients in 15 settlements were interviewed to assess TBA training, practices and utilization. The study shows that about 51% of those studied had no designated room for deliveries; twenty-one (80.8%) did not consider any pregnant woman to be at high risk; three (11.5%) perform intravaginal examinations during labour, only a few recognized complications and twelve (46.2%) never referred patients. Despite these deficiencies, TBAs continue to practise in appreciable numbers and their services continue to be on demand in the communities under study. They later concluded that low socio-economic status, illiteracy, poor awareness of modern maternal health (MCH) facilities, personalized care, strong family influence and easy access to TBA services were strong factors promoting traditional midwifery in the LGA.

Sogunro (1987) in a survey conducted among 150 Traditional Birth Attendants (TBA) living in the peri-urban slum area of Ibadan to determine "demographic characteristics as well as knowledge about midwifery practices prior to introducing a training programme", shows that there were areas where the introduction of simple methods of aseptic technique, change in some nutritional practices and increased knowledge on the benefits of immunization might improve the outcome for mothers and infants living in traditional societies in Nigeria. The findings serve as a guide for the development of content of TBA training programme.

Since the adoption of the Primary Health Care approach in Nigeria in 1979, the three tiers of government (Federal, States and Local) have accepted the idea of the need to integrate TBAs into the PHC system and have consequently initiated TBA training programme. Presently, trained TBAs exist in virtually all the local Government Areas of the country. Many international agencies including United Nations Fund for Population Activities (UNFPA), World Health Organization (WHO) and the United States Agency for International

Development (USAID) have technically and financially supported TBA training activities in Nigeria. These efforts have resulted in the existence of sizable number of trained TBAs in the country; however a significant proportion of practising TBAs remains untrained till date. Most of those who have received initial training have not been given refresher training, some after more than 5 years of the initial training (Oyejipo, 1997).

Key elements common to the TBA training programmes include principles of hygienic practices in delivery; and identification of high-risk cases and appropriate referrals. Although a training curriculum and manual exists nationally, there have been considerable differences in the TBA training programme of various states and organisations. A recent evaluation of TBA programme in three states (Abia, Ogun and Plateau), for example, showed differences in the conduct of refresher training for TBAs (Zoakah and Idoko, 1997). Various organisations are also known to have designed or adopted curriculum deemed appropriate for their own situation, for example St. Mary's Hospital, Urua Akpan and the CAC Church Training Centre, Ede (WHARC, 1998).

Various studies conducted in Nigeria have shown that TBAs' practices improved after training, and trained TBAs performed better than the untrained ones (Akpa, 1994; Matthews et al, 1995; Zoakah and Idoko, 1997). They observed higher hygienic standard, identified high-risk cases better and effect referrals quicker. Trained TBAs, in general, offer higher standard of maternal and prenatal care than untrained TBAs. Similar findings have also been reported from other parts of the world (Brennan, 1989). Brennan reported a fall in maternal mortality rate of over 50 per cent, and 40 per cent in communities where TBAs have been trained in Ikot Ekpene LGA of Akwa Ibom State. However, certain residual problems have been reported by some authors even after training. For instance, Larison, Sculipe, Ebrahimi and Abel (1987) reported that some trained TBAs even though duly identified high risk pregnancies, they still continued to manage the cases on their own instead of referring to health facilities. Thus, supervision of trained TBAs is essential to reinforce what was taught and ensure optimal practice.

Although TBAs have been trained since the late 1800s, important milestones over the last century illustrate the shifting policies towards TBA training as a global public-health strategy. Credit for the first formal training programme is usually given to a British missionary midwife, Miss M. F. Wolfe, working in Sudan in 1921 (Hening, 1994,

www.genesis.ac.uk/archive, accessed in December 2005). The Inter-Governmental Conference of Far Eastern countries, held in Bangkok in 1937, called for the integration of TBAs into rural health programmes. By 1952, the United Nations Children's and Emergency Fund (UNICEF) began to supply trained TBAs with delivery-kits. The goal of these early programmes was to improve peri-natal healthcare (Fleming, 1994). Nearly 20 years later, interest in primary healthcare and in traditional medicine in relation to primary healthcare had grown to the extent that the UNICEF and WHO sponsored a technical consultation on TBA training. By the time of the 1978 Alma Ata Declaration, the WHO was fully in support of training TBAs to extend the reach of primary healthcare services. At that time, the WHO recommended that trained TBAs work side-by-side in 'articulation' with the modern health system, so that the informal traditional and formal modern health systems could presumably co-exist without conflict.

Most TBAs initially acquire their training in the traditional way by serving informal apprenticeship with older and experienced TBAs. However, some TBAs are known to have undergone no such apprenticeship but reckon them to be gifted with ability for such services particularly after having undergone a number of deliveries of their own, and assisted others. The practices of TBAs sometimes pass along family lines, with a daughter taking after her mother. While an apprenticeship of an average of 5 years has been reported among some Yorubas (Makinde, Owa and Awoludebe 1995), apprenticeship of up to 5-20 years has been reported to be normal in some northern communities (Akpala, 1994). Some TBAs are known to have been trained within the church system. The Christ Apostolic Church is particularly well known in this regard, and has a training centre of its kind in Osun state (Good Women Association of Nigeria Faith Home). Other denominational groups such as Cherubim and Seraphim, Celestial Church and Apostolic Faith are also known to have raised TBAs through various mechanisms (Makinde, Owa and Awoludebe 1995).

In sub-Saharan Africa, about 3% of pregnant women have at least one antenatal visit and 12% are attended to by a professional healthcare worker at delivery. High quality maternity care is often unavailable. Home birth remains a strong preference and often is the only option (Wairaven and Weeks, 1999). Of the 22 countries surveyed in Africa, only in Botswana had a professional health care provider attended more than 75% of deliveries (UNAIDS International and US Department of Health, 1996). Between 60% and 90% of deliveries in

rural areas are assisted by traditional birth attendants (Wairaven and Weeks, 1999, Isenatunbe, 1990).

Over the past decades, traditional birth attendants in many regions have been trained in midwifery and basic hygiene as part of a safe motherhood initiative aimed at reducing maternal mortality (Wairaven and Weeks, 1999). Traditional birth attendants speak the local languages, allow traditional birthing practices, and often have the trust and respect of the community (Wairaven and Weeks 1999; Isenatunbe 1990). Although providing highly skilled medical attendants for all deliveries in poor communities remains a long-term goal, an intermediate solution is to identify, support, and train birth attendants who are already practising in local communities.

Ninety-nine percent of all maternal mortality is in the developing countries, with limited resources and shattered economics. It may take a long time for these countries to provide qualified doctors, nurses and back up structure to reduce high maternal mortality and other obstetric complications with very low cost and utilizing existing resources, hence the need to train more TBAs. In countries with very high maternal mortality rates, the highest priority should be assigned to improving emergency obstetric care; other interventions will include reduction of exposure to high-risk and unwanted pregnancies by the provision of family planning services, safe abortion, training and supervision of traditional birth attendants, and improvement of other aspects of maternal health services (Detels and McEwen, 2002; Beaglehole and Tanaku 2002).

In a study, Bergstrom and Goodhum (2001) found that trained TBAs were significantly more likely to practice hygienic delivery than untrained TBAs. This is supported by Bullerys (2002), that given the high proportion of rural births in Africa that are assisted by traditional birth attendants, and the growing prevalence of HIV infection in African countries, TBAs may have a role to play in preventing prenatal transmission of HIV. Also pregnant women preferentially consulted trained TBAs, and that mothers in progromine areas were more likely to take iron pills, seek immunizations, use oral dehydration solution, practise family planning and improve their families' diet.

The success of the WHO's encouragement can be measured by the rapid increase in the number of countries undertaking TBA training. For example, in 1972, only 20 countries had

TBA training programmes. It is now estimated that 85% of developing countries has some form of TBA training (Fleming, 1994). With the advent of the safe motherhood initiative and without evidence to show that the risk approach and trained TBAs can reduce maternal mortality, there has been a gradual waning of enthusiasm for TBAs. In 1992, the WHO emphasized that if TBAs were going to contribute to safe motherhood, they must be 'integrated' into the modern health system through training, supervision, and technical support (WHO 1992). However, by 1997, the WHO and many safe motherhood advocates turned from TBA training to promote skilled birth attendance for all (Fleming, 1994), most recently calling for a 'new' and 'expanded role' for TBAs, where TBAs act as 'link workers' to skilled birth attendants rather than as primary care providers (Tampol, 2005; UNFPA, 2004).

The broad goals of TBA training programmes are to reduce maternal and child mortality and morbidity and; to improve the reproductive health of women. The objectives include: enhancing the linkages between the modern health system and community, increasing the number of TBA-attended births, and improving the skills and stature of TBAs (WHO, 1992). Training programmes vary, however, in addressing these objectives. For example, individuals, non-governmental organizations, and missions have trained TBAs through the private sector and also through local, state and national government and, international agencies have trained them through the public sector. Training programmes may last from several days to several months and may include clinical practice at a health facility, follow-up supervision, and continuing education (Fortney and Smith, 1997).

The content of curricula of TBA training also varies. Most TBAs have been trained to upgrade their skills so as to be able to perform safe deliveries. Consistent with the emphasis on extending the reach of primary healthcare, many TBAs have also been trained to take on the expanded functions of prevention, screening, and referral (Fortney and Smith 1997; Sibley and Sipe 2004). Very few programmes have included content on initial response and stabilization of maternal and newborn complications (e.g. resuscitation of newborns or detection and management of sepsis), and content that would be very useful to those who are confronted with emergencies that might save lives.

Millennium Development Goal (MDG) 4 aims to reduce mortality of children aged less than five years, by two-thirds between 1990 and 2015. MDG 5 aims to reduce maternal mortality by three quarters during this timeframe. Policy regarding the best strategies to meet these goals, however, swings between community-based care and facility-based care, while safe

motherhood and child-survival advocates compete for limited resources (Freedman and Waldman 2005; WHO, 2005).

## 2.6 Reducing Maternal Mortality

It is well known that poor countries are also the ones with highest maternal mortality rates. In analogy to the link between poverty and infant mortality, the relation poverty-maternal mortality is also common in these countries. This being said, there are considerable differences, even among countries that carry similar burdens of poverty, and much of this seems related to constrained access to care (Kunst and Houweling, 2001).

It is obvious to many practitioners that professionalisation of delivery care is a key to reducing maternal mortality (Graham, Bell, and Bullough, 2001; Kowalewski and Jahn, 2001). Industrialized countries have halved their maternal mortality in the early 20th century through access to professional midwifery care at delivery, and further reduced it to current historical low through access to effective and safe hospital technology (Loudon, 1992). Table 2.1 is summarized for community interventions that reduce infant and maternal mortality.

**Table 2.1: Family and community interventions that reduce newborn mortality while improving maternal health.**

Family and community interventions that reduce newborn mortality while improving maternal health: what trained TBAs can do.		
Pregnancy	Labour, birth - 1 <sup>st</sup> 24 hours	Post natal > 24 hours
Universal	Universal	Universal
<p>Promote</p> <ul style="list-style-type: none"> <li>Antenatal care</li> <li>Tetanus toxoid</li> <li>Breastfeeding</li> <li>Care-seeking</li> <li>Quality clinical care (demand for)</li> </ul> <p>Situational IPT for malaria</p>	<p>Provide</p> <ul style="list-style-type: none"> <li>Safe delivery</li> <li>Hygiene/PMTCT</li> <li>Thermal care</li> <li>Clean cord care</li> <li>Resuscitation</li> <li>Breastfeeding</li> <li>Care-seeking</li> </ul>	<p>Promote</p> <ul style="list-style-type: none"> <li>Skin and cord hygiene</li> <li>Breastfeeding</li> <li>Care-seeking</li> <li>Extra</li> <li>Care of LBW babies</li> <li>Extra home-visits</li> </ul> <p>Provide</p> <ul style="list-style-type: none"> <li>ARI management</li> </ul>
<p>ARI=Acute respiratory infection. IPT-Intermittent presumptive treatment. LBW-Low birth weight. PMTCT=Prevention of maternal-to-child transmission of HIV</p>		

Adapted from Sibley & Sipe (2006)

## 2.7 Involving Traditional Birth Attendants in Preventing Perinatal Transmission of HIV

As global efforts to prevent perinatal transmission of HIV expand, traditional birth attendants could play a key role in implementing effective interventions in poor rural settings by offering services such as HIV testing and counselling and short courses of antiretroviral drugs (De Cock, Fowler, Mercier, De Vincenzi, Saba, and Hoff, 2000). Every year a million women infected with HIV deliver babies without professional help. In sub-Saharan Africa about 63% of pregnant women have at least one antenatal visit and 42% is attended by a professional healthcare worker at delivery (MACRO International and US Department of Health, 1996). However, high quality maternity care is often unavailable (Graham and Newell, 1999).

According to Walraven and Weeks (1999), birth delivery at home remains a strong preference and often is the only option. Of 22 countries surveyed in Africa, only in Botswana had a professional healthcare provider attended to more than 75% of deliveries (MACRO International and US Department of Health, 1996). Between 60% and 90% of deliveries in rural areas are assisted by traditional birth attendants (Walraven and Weeks, 1999).

Although providing highly skilled medical attendants for all deliveries in poor communities remains a long term goal, an intermediate solution is to identify, support, and train birth attendants who are already practising in local communities. For example, traditional birth attendants in rural Cameroon are selected by a village committee and, after specialized training for up to six weeks, they are given a certificate, instruction book, and delivery kit. Retention of birth attendants is high because they share cultural and health beliefs with the women and have strong ties with the community (Printer, 2001). The competence and skills of traditional birth attendants may vary widely across settings. As with professional midwives in geographically isolated clinics, traditional birth attendants require continuing education and supervision, and they need to be able to refer patients and help transport them to hospitals for second line care during delivery (De Bruwere, Tonglet, and Van Lerberghe, 1998).

The ability to prescribe short courses of antiretroviral therapy presupposes that the infrastructure for antenatal care is able to provide quality care, including HIV counselling and testing (Haggaley and Van Praag, 2000). While most pregnant women in poor settings attend antenatal clinics at least once before delivery, few of these women are offered and receive HIV counselling and testing. Practical obstacles such as travelling distances and fear of violence w



discrimination may also affect a woman's decision to get tested (Cartoux, Msellati, Meda Wellfens-Ekra, Mandelbrot, and Leroy, 1998). Rapid HIV testing services—strategies that provide an HIV test, its result, and counselling specific to the result during a single antenatal visit—seem to be effective and acceptable to pregnant women, and they can be expanded to include counselling of couples (Bakari Cartoux, Msellati, Meda Wellfens-Ekra, Mandelbrot, and Leroy, 2000; Painter, 2001). Programmes to prevent perinatal transmission of HIV aimed at women in rural areas will need a thorough preparation involving the community, dissemination of information on effective strategies for preventing perinatal transmission of HIV, training of community health workers, and strengthening of links between home care and available antenatal and maternity clinics.

Making facilities for HIV testing and counselling more widely available in poor settings undoubtedly remains one of the most important challenges in combating the HIV and AIDS epidemic in poor parts of the world. Traditional (or "trained") birth attendants could play a critical role by reaching pregnant women not currently receiving formal antenatal care and by assisting with delivery of primary services designed to prevent HIV transmission (De Brouwere et al., 1998). If rapid HIV testing could be made more widely available to pregnant women (for example, in primary healthcare centres and mobile clinics), trained birth attendants could oversee the provision of nevirapine to women infected with HIV who give birth at home and to their newborn infants. Traditional birth attendants could also counsel women and their partners on how to reduce the risk of HIV being transmitted to the child, focusing particularly on the postpartum period (Bakari et al., 2000).

To increase efforts to implement measures to reduce pediatric AIDS in areas with a high prevalence and in poor settings, research is urgently needed to assess how best to provide nevirapine in a single dose to women delivering at home and their neonates. In areas where the prevalence of HIV is high (for example, >20%) and HIV counselling and testing are not yet widely available, nevirapine might be offered, in the short term, to all mothers and newborns (Guay 1999; De Cock 2000; Marseille 1999 and Sinkala 2001). However, any potential long term risk from exposing large numbers of uninfected infants to nevirapine at birth has not yet been studied. With this approach, women and infants would be treated presumptively, and women and their partners could still be offered HIV testing after the baby is born. Such an approach has the potential to greatly simplify effective prevention of HIV transmission, while still maintaining the recognised benefits of HIV counselling and testing for the individual

woman and her community. Counselling and testing are critical to allowing women and their families to make informed decisions about breast feeding, reproductive health choices, and other interventions to prevent HIV transmission (De Cock et al., 2000)

### 2.7.1 Innovative Models for Prevention of Perinatal Transmission of HIV Involving Traditional Birth Attendants

Traditional birth attendants already offer preventive health services to pregnant women and their newborns in rural settings. In some areas where birth attendants have become part of the healthcare system, they are increasingly involved in providing cost-effective malaria prevention services to pregnant women in sub-Saharan Africa (Nahlen, 2000). Village workers in India have been trained to assess signs of neonatal sepsis, deliver prophylactic cotrimoxazole, and provide supportive neonatal care (Bang, Bang, Baitule, Reddy, and Deshmukh, 1999). In rural settings traditional birth attendants could take on several tasks critical to perinatal HIV prevention. In some settings it may be possible to train traditional birth attendants to provide confidential HIV counselling and testing them, perhaps using rapid oral fluid or whole blood testing.

Innovative models for prevention of perinatal transmission of HIV involving traditional birth attendants are needed to develop decentralized and home based intervention strategies appropriate to rural settings. Although these approaches would be developed to address local needs, taking into account different levels of community support, they could also be used in other rural settings where formal antenatal and maternity care services are severely limited. Pilot programmes could identify potential barriers, such as concerns about privacy and confidentiality, and could test solutions to address these concerns in the local context (Piot, Bartos, Ghys, Walker, and Schwartlander, 2001).

The present challenge is to translate the findings of research looking at perinatal transmission of HIV into deliverable public health programmes and to link these efforts to primary prevention of HIV infection in adults and the care of infected individuals. Local resistance and barriers to effective collaboration between traditional birth attendants and medically trained healthcare workers will have to be reduced if efforts to prevent perinatal transmission of HIV are to reach most of the rural population (Mandelblatt, Landreau-Mascara, Rakaczewicz, Herrebi, Henifa, and Hurgard, 2001). Recruiting professional midwives and doctors to work in

remote areas remains difficult, and, even if they are recruited, first line obstetric care will most likely still be delegated to TBAs (Nahlen, 2000).

## 2.8 Traditional Birth Attendants' Record Keeping Practices

Village health workers (VHWs) and Traditional Birth attendants (TBAs) provide health care services to the communities in which they live, improving access to health care as well as serving as an important link between the periphery (the communities) and the health sector. The data this category of workers generates about their communities will strengthen Primary health care management information system in Nigeria (Umar, Olumide, and Bawa, 2003).

In a study that was carried out to assess the knowledge, attitude and practices of VHWs and TBAs regarding record keeping in Ibarapa Central and Akinyele local government areas (LGAs) of Oyo State, Nigeria (Umar et al 2003), results showed that there were a total of 62 and 102 active VHWs/TBAs in Ibarapa Central and Akinyele LGAs respectively. Over two-thirds in both LGAs knew the uses of record keeping for monitoring and evaluation purposes and most of them felt that keeping records was easy. Sixty-one percent of the respondents in Ibarapa Central and 96% of those in Akinyele LGA reported keeping records of their health activities. Of those who kept records, two thirds in Ibarapa Central and almost all (96%) in Akinyele LGA reported forwarding the records they kept to the local government headquarters.

The type of record kept was mostly on patients' treatment and delivery. These were recorded in an exercise book. Most did not have the VHW/TBA record of work or the community profiles (wall charts) developed and recommended by the Federal Ministry of Health (FMOH) because they were not supplied. The factors associated with record keeping included duration as a VHW/TBA, previous training on record keeping, receiving feedback. Recommendations made included ensuring availability of materials and periodic training and re-training of the VHWs/TBAs by the LGAs, and regular provision of feedback by the National Primary Health Care Development Agency (NPHCDA).

## 2.9 The Concept of Healers in International Health Policy

The concept of traditional medical practitioners/traditional birth attendants/traditional midwife which can be "found in most societies" and "is part of the local community, culture, and traditions" came to prominence as part of the World Health Organization's emphasis on

primary health-care (PHC). Declaring the goal of "health for all in the year 2000" in 1978, WHO proposed the PHC model as a comprehensive strategy for achieving a more equitable provision of health care?

This watershed shift in health development policy advocated styles of community-based education and service delivery that would be closely tailored to the conditions, resources, and culture of particular countries.

*"The Conference considered primary health care to be essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. (WHO 1978: 16)"*

In accordance with this vision, the PHC policy supported programmes for training indigenous practitioners to serve as health auxiliaries. The aim was to solve the problem of health staffing levels by enlisting already trusted and experienced traditional medical practitioners in health initiatives.

## 2.10 Conceptual Framework

Conceptual frameworks relevant to the design and selected for review in this study are the theory of planned behaviour and the theory of reasoned action. Conceptual framework describes the relationship of a problem to the concepts in a model. Theory of planned behaviour and the theory of reasoned action models would be used in showing the linkages among a set of concepts believed to be related to this problem.

### 2.10.1 Theory of Planned Behaviour and Theory of Reasoned Action

The Theory of Planned Behaviour (TPB) and the associated Theory of Reasoned Action (TRA) explore the relationship between behaviour and beliefs, attitudes, and intentions. Both TPB and TRA assume behavioural intention is the most important determinant of behaviour. According to these models, behavioural intention is influenced by a person's attitude toward performing behaviour, and by beliefs about whether individuals who are important to the person approve or disapprove of the behaviour (subjective norm). The TPB and TRA assume

all other factors (e. g. culture, the environment) operate through the model's constructs, and do not independently explain the likelihood that a person will behave a certain way.

The TPB differs from TRA in that it includes one additional construct, *perceived behavioural control*; this construct has to do with people's beliefs that they can control a particular behaviour. Azjen and Driver (1991), as quoted in National Institute of Health (NIH) (2005), added this construct to account for situations in which people's behaviour, or behavioural intention, is influenced by factors beyond their control. They argued that people might try harder to perform behaviour if they feel they have a high degree of control over it. People's perception about controllability may have an important influence on behaviour.

According to this model, attitudes toward behaviour are shaped by beliefs about what is entailed in performing the behaviour and the outcomes of the behaviour. Beliefs about social standards and motivation to comply with those norms affect *subjective norms*. The presence or lack of things that will make it easier or harder to perform the behaviour affects the *perceived behavioural control*. Thus a causal chain of beliefs, attitudes, and intentions drive behaviour.

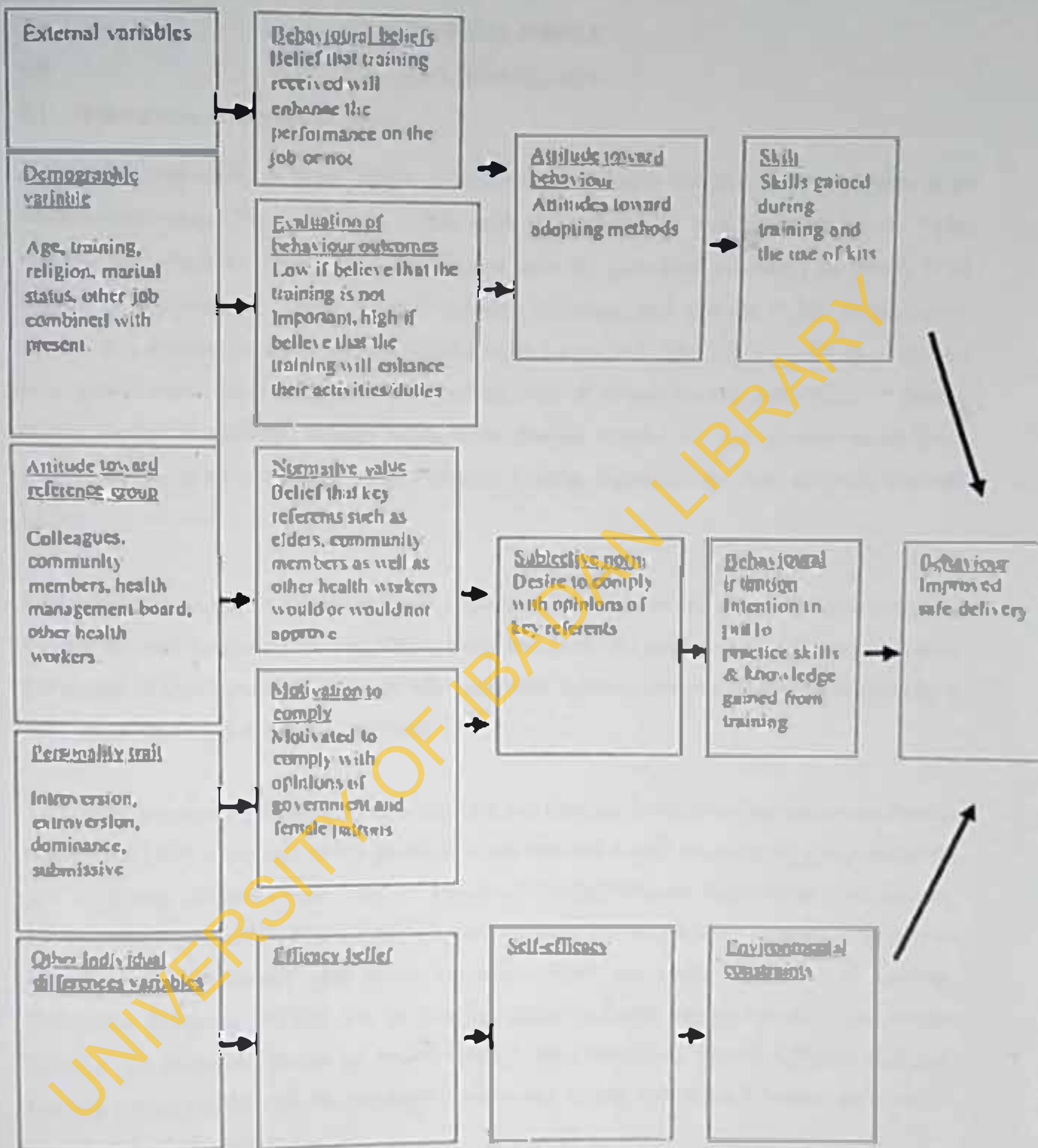


Figure 2.1: The theory of planned behaviour and the theory of reasoned action as applied to traditional birth attendants' practice

## CHAPTER THREE

### METHODOLOGY

#### 3.0

#### 3.1 Description of the Study Area

Ibadan, the largest city in West Africa, is located in the South-Western part of Nigeria at an altitude that ranges from 152m to 213m, with isolated ridges and peaks rising to 271m (Sridhar and Ojediran, 1983). It is also located near the grassland boundary of South-West Nigeria on longitude 3° 5' east of the Greenwich Meridian, and latitude 7° 23' North of the equator at a distance of about 145km North-East to Lagos city. The city is made up of eleven local government areas (LGAs) which include five in urban Ibadan metropolis – Ibadan North, Ibadan North-East, Ibadan North-West, Ibadan South-East and Ibadan South West LGAs and six in rural areas namely Akinyele, Lagelu, Egbeda, Ona-Ara, Oluyole and Ido LGAs.

Ibadan used to be the social, educational, commercial, industrial and administrative centre of the old Western Region (now Oyo, Ogun, Ondo and parts of Lagos and Edo States). It is now the capital of Oyo state and has direct link with many urban centres as well as rural areas by a network of roads, railways and air routes.

This study was carried out in Ibadan South East and Oluyole Local Government areas. Ibadan South-East LGA comprises of ten political wards and five health districts. The population of this LGA was 266,046 (male 130,577, female 135,469) (National Population Commission, 2006). Most of the inhabitants are traders, civil servants and small scale farmers. The people practise both Christianity and Islam. However, there are some adherents of African Traditional Religions (ATRs). The various categories of health workers in the LGA are as follows: one Medical Director of Health (MDH), six Community Health Officers (CHOs), fourteen nurses (midwives), twenty three Community Health Extension Workers and sixteen Environmental Health Officers.

Oluyole Local Government Area, the rural LGA, is one of the oldest local governments in Oyo State with its headquarters at Ibi Ayunre, a small town along Ijebu Ode/Ibadan road with a population of 202,725 (male 102,220 and female 100,505) (NPC, 2006). It shares boundaries with six local Governments (LGAs) in Oyo and Ogun states. It is bounded in the north by Ibadan South East/Ona-Ara LGAs, in the west by Ibadan South-West/Ido LGAs, and

in the south and east by Egbu Obalemi Odeda and Ijebu-North LGAs in Ogun State respectively. Oluyole Local Government was established in 1976 and was a much larger area until May 1989 when the present Ota-Ara Local Government was carved out of it. The Council occupies about 4,000 square kilometres of land.

Ibadan South-East and Oluyole LGAs consist of multi – ethnic nationalities predominantly dominated by the Yoruba. The Igbo, the Edo, the Urhobo, the Itsekiri, the Ijaw, the Hausa, the Fulani and foreigners who are from Europe, America, Asia and other parts of the world live within the LGA especially in the industrial area along Old Lagos Road by pass.

### **3.2 Study Design**

A descriptive survey which focused on the functionality and operations of all the registered and trained Traditional Birth Attendants (TBAs) in Ibadan South East and Oluyole LGAs in Oyo State was adopted for this study.

### **3.3 Study Population**

All 172 certified and practising TBAs who were trained under United Nations Fund for Population Activities (UNFPA), State Ministry of Health and Local Government Council between 2003 and 2006 in Ibadan South-East and Oluyole LGA were selected for this study.

### **3.4 Sampling Procedure**

A purposive sampling procedure was adopted to include all registered 172 TBAs who were trained and functioning in the LGA in this study.

### **3.5 Instruments for Data Collection**

Qualitative and quantitative methods were used to generate data for the study.

Qualitative method involved the use of focus group discussion (FGDs) and In-depth interview (IDI) to generate data among trained TBAs and women of child-bearing age within the communities where TBAs operated in the LGA. Four FGD sessions were conducted in four (4) sessions; two (2) sessions among TBAs with eight (8) persons in each session and two (2) sessions among women of child-bearing age with eight (8) persons in each session. IDI was conducted among health workers each in Oluyole and Ibadan South East LGAs of Oyo State



Quantitative data were gathered through the use of a researcher-administered questionnaire. The instrument comprised of four sections: section A contained items on demographic information of respondents, section B comprised issues relating to participants' knowledge and methods of training; section C comprised of items on TBAs' practices, competence and challenges, while section D focused on government policy on TBAs.

### 3.6 Data Collection Process

1. Visits were made to the leaders of the TBAs association for formal introduction and to discuss the purpose and details of the research with them. Here permission was sought to undertake the study and for their cooperation. Addresses of the TBAs were obtained from the leaders and these were traced to ascertain the authenticity of the address.
2. Recruitment and training of research assistants was carried out. The research assistants (RAs) were recruited based on recommendation from other researchers, educational qualifications and experiences in researches. The RAs were recommended based on their involvement in previous researches and after brief discussions, all were found to have at least secondary education with a few who were holders of first degree on various fields. Three are female and the other a male. Training curriculum comprised the following: introduction to the general and specific objectives, research questions of the study, interviewing skills, informed consent form, ways of establishing rapport with interviewee, appropriate questioning and listening skills, review of the FGD guide and questionnaire and how to administer them, and the research data collection process. The training lasted for two days.
3. Development of questionnaire and pre-test of instruments were also ensured. The English version was used for pre-testing among Community Health Workers (CHW) in Ijebu North East LGA for critique and further useful suggestions, while the translated version of the instrument was pre-tested among 30 TBAs in Sagamu LGA. This local government area has similar characteristics in terms of structure and function with the study areas. This was done to confirm the validity of the instrument.
4. Pre-test of FGD and IDI guides followed the above stage. As a general rule, research instruments are not to be used in the field survey without adequate pre-testing, this informed the reason why this pre-testing was given an adequate attention. All aspects of this instrument were pre-tested both in-house and among the study population including the question content, wording, sequence, form and layout, item comprehensibility and instructions.

5. FGD was held among TBAs and women of child-bearing age within the community served by the TBAs. This was to triangulate the responses for validity. In-depth interview was held among health workers in Oluyole LGA.
6. The administration of questionnaire was done by the researcher with the help of four (4) research assistants that were trained before the commencement of the study. Data collection was carried out within a period of two weeks. The study participants were interviewed in Yoruba language at a time considered convenient for them and at a place that ensured confidentiality. Data collected in Yoruba was later translated into English.

### 3.7 Validity of the Instruments

In order to ensure validity and reliability of the instruments and responses, some measures were taken such as review of instruments, pre-testing, back translation of questions from English into Yoruba and vice versa and, ethical considerations. Some Experts – a sociologist, a linguist, a medical statistician and a health education specialist were consulted to review the instruments for face and content validity. The instruments, first drawn in English were translated to Yoruba, because the study population comprised predominantly Yorubas who would prefer the FGDs and the interview conducted in their dialect. They were back translated into English by other experienced researchers from the department to ensure there was no information lost and also that the meaning of the questions was not distorted.

### 3.8 Reliability of the Instruments

Analysis of questionnaire pre-tested was done using Cronbach's alpha coefficient of the Statistical Package for Social Sciences (SPSS) in order to ascertain the psychometric properties of the instrument. The result of the correlation coefficient was 0.741 and it was taken as being reliable. Relevant corrections were effected before the commencement of the study.

### 3.9 Data Management

Efforts that were made to manage the data include:

1. The quality of information collected was checked by the researcher on daily basis. Problems discovered during data collection were resolved immediately.
2. Serial numbers were assigned to each of the each item of the questionnaire for easy identification and recall of any instrument with problems.
3. Administered questionnaire copies were edited and hand-coded by the researcher with the use of a coding guide that was developed.
4. The copies of administered questionnaire were stored in a place that would be safe from destruction by water or fire and where unauthorised persons will not have access to them.

### 3.10 Data Analysis

Data collected were entered on SPSS spread sheet for analysis. The findings were summarised and presented in tables and charts for better understanding. Also findings from the qualitative data were transcribed, presented and analysed using content analysis, where necessary, statements from respondents were stated verbatim without mentioning names. Quantitative data were subjected to descriptive and Chi-square statistical analyses.

### 3.11 Ethical Considerations

The recruitment of respondents was based on their permission. Verbal informed consent was sought in order to protect the right of the study participants. Participants were given the choice to give and withdraw their consent freely that is each participant was told to be free to withdraw from the study whenever they wanted to get out of the study.

Confidentiality of each participant was maintained during and after the collection of the data. Simple procedure was used for assigning code numbers to each participant and no name was used on the questionnaire forms.

## CHAPTER FOUR

### RESULTS

#### 4.0

#### 4.1 Demographic Characteristics

The socio-demographic characteristics of traditional birth attendants (TBAs) are presented in Table 4.1. One hundred and seventy two TBAs were studied with a mean age of 41.7 (6.3) years. Figure 4-1 shows the distribution of the respondents' education and 80% had secondary school education. The proportion within the 35 to 39 years age group was the highest (21.5%) followed by those in the 40-44 years age bracket (20.3%) and 45- 49 years (18.0%). Majority (92.1%) of the respondents were females, and all were of the Yoruba ethnic group. More than ninety per cent of respondents were in marital unions and 78.5% of these were in monogamous marriages. There were more (79.1%) Christians among the respondents and 80.2% had secondary education. The proportion of respondents who were involved in other jobs was 86.05%, 5.2% did not respond while the remaining respondents said no to other job, that is they did not involved in other jobs. Of those that said yes to other jobs, 52.03% were traders, 19.59% were clergy men, 14.86% were auxiliary nurses, 7.43% were into tailoring, 2.70% were involved in farming, 2.03% were herbalist/native doctors and the remaining respondents (1.35%) were civil servants.

#### 4.2 Knowledge Acquisition and Training Received by TBAs

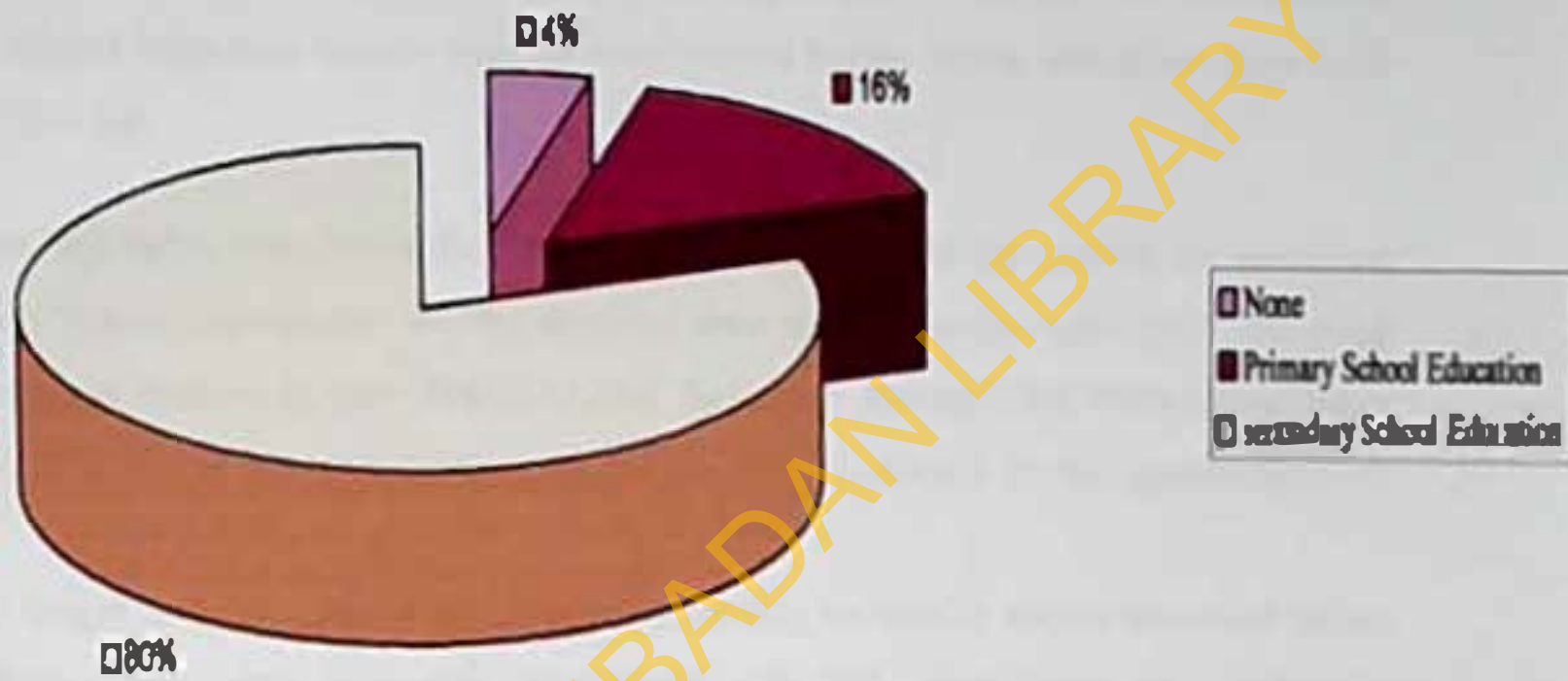
##### 4.2.1 Introduction of the Participants to the Job of TBAs

A large majority (91.1%) reported that they were introduced to the job by older family members. Those who were introduced to the job in response to an emergency situation were 2.9% and only 2% of the participants reported that they were introduced to the job because they were good at taking delivery of animals. According to the Community Health Extension Workers (CHEWs) interviewed during in-depth interview, any TBA that could be selected for training in the formal health sector must be a registered member of the Traditional Birth Attendants (TBA) association of Oyo State and must be active and practicing in a local government area. In addition to this, the TBA must possess at least primary school education.

**Table 4.1: Socio-demographic characteristics of respondents**

<i>Variable</i>	<i>Frequency</i>	<i>Percentage</i>
<b>Age(years)</b>		
30-34	26	15.1
35-39	37	21.5
40-44	35	20.3
45-49	31	18.0
50-54	21	12.2
55+	22	12.9
<b>Total</b>	<b>172</b>	<b>100</b>
<b>Gender</b>		
Female	159	92.4
Male	13	7.6
<b>Total</b>	<b>172</b>	<b>100</b>
<b>Marital status</b>		
Married	156	90.7
Never married	8	4.7
Widowed	6	3.5
Separated	1	0.6
Divorced	1	0.5
<b>Total</b>	<b>172</b>	<b>100</b>
<b>Family type</b>		
Monogamy	135	78.5
Polygamy	31	18.0
No response	6	3.5
<b>Total</b>	<b>172</b>	<b>100</b>
<b>Religion</b>		
Christianity	136	79.1
Islam	27	15.7
Others	9	5.2
<b>Total</b>	<b>172</b>	<b>100</b>

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**Figure 4.1: The distribution of educational status of respondents**

#### 4.2.2 Places, Years, Criteria and Topics Received During Training

Places where participants received training to become Traditional Birth Attendants are shown in the Table 4.2. More than half of the respondents (57%) were trained by private hospitals, 20% were trained by the ministry of health staff and those who were either trained by the University College Hospital Ibadan or mission house were of the same proportion each (4%). Of all the participants, almost all 162 (95.3%) indicated ever receiving training from the government. The participants at the FGD unanimously responded that the person must have at least primary school education receive training from formal health sector and then come back to practicing TBA job.

The Table also highlights years when the TBAs received training and the criteria for selection for the training. Many respondents (40.7%) received their training in the year 2003 followed by those who were trained in year 2005 (22.1%). Selection through the TBA association (60.5%) topped the list of selection criteria for the training conducted by the government as shown.

Issues mostly taught and discussed were educating pregnant women to attend antenatal clinic (ANC) (91.9%), identifying high risk pregnancies (90.7%), identifying and referring pregnancy related complications early (89%), taking aseptic deliveries (86.6%), promoting acceptable modern family planning methods (84.9%), discourage harmful traditional practices (84.9%), promoting early initiation of breastfeeding (79.7%), managing umbilical stump (79.1%), encouraging mothers to take their children to the clinic for immunisation (77.9%) and promoting nutrition and ORT use (76.2%) (Table 4.3). Ninety six percent of respondents found the training received useful.

Table 4.4 shows the areas indicated for further training. Many of the respondents (30.2%) reported that they needed training in modern delivery methods followed by 22.1% who mentioned knowledge on TBA activities and 19.7% who mentioned immunisation while the least (1.2%) were those that cited wound management. Other services rendered by the TBAs include circumcision (25.6%), family planning (15.7%), promotion of vaccination (12.8%) and umbilical cord care (14%). Others include promotion of immunisation (12.7%), wound treatment (11%), community education (10.5%) and reproductive health education (2.9%).

**Table 4.2: Place/year and reported criteria for selection for training**

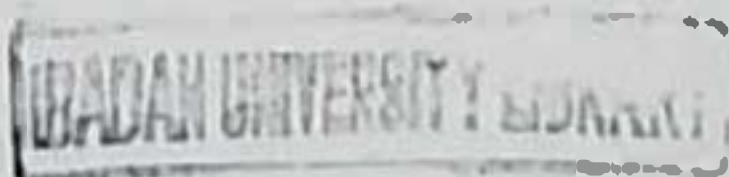
<i>Place of training</i>	<i>No</i>	<i>%</i>
Private hospital	98	57.0
Ministry of Health	35	20.0
University College Hospital (UCH)	7	4.0
Mission House	7	4.0
No response	25	15.0
<b>Total</b>	<b>172</b>	<b>100</b>
<i>Year of training</i>	<i>No</i>	<i>%</i>
1998-2003	104	61.0
2004-2009	56	32.0
No response	12	7.0
<b>Total</b>	<b>172</b>	<b>100</b>
<i>Selection criterion</i>	<i>No</i>	<i>%</i>
Selection through IBA association	101	60.5
Selected by government agents who conducted interviews	11	6.4
Selected based on educational background/previous certificate	6	3.6
Selection through the ministry of health	4	2.3
Attendance of previous training on delivery	2	1.2
No response	15	25.5
<b>Total</b>	<b>172</b>	<b>100</b>



**Table 4.3: Reported topics taught during the training**

<i>Topics taught</i>	<i>Agree</i>	<i>Disagree</i>	<i>Undecided</i>
Encouraging pregnant women to attend antenatal clinic	91.9	5.0	3.1
Identifying high risk pregnancies and referral	90.7	5.3	4.0
Identifying and referring pregnancy-related complication early	89.0	3.0	8.0
Taking delivery aseptically	86.6	6.2	7.2
Promoting acceptable modern family planning	85.9	7.4	7.7
Discouraging traditional practices harmful to newborns, girls and pregnant women	84.9	5.2	9.9
Promoting early initiation of breast feeding	79.7	12.9	7.4
Managing umbilical stumps	79.1	9.3	11.6
Encouraging mothers to take their children to the clinic for immunisation	77.9	14.0	8.1
Nutrition and use of oral rehydration therapy	76.2	12.5	11.3

*Multiple responses, data in percentages*



**Table 4.4: Reported areas for further training by respondents**

<i>Needed areas</i>	<i>N</i>	<i>%</i>
Modern delivery methods	52	30.2
Knowledge on TBA activities	38	22.1
Immunization	31	17.7
Capacity building	23	13.4
TBA and TBA related treatment methods	18	10.5
Family planning	5	2.9
Wound management	2	1.2
<b>Total</b>	<b>172</b>	<b>100</b>

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### 4.3 TBAs' Practices, Competences and Challenges

#### 4.3.1 TBAs' Practices

The percentage distribution of methods of recording births is shown in Figure 4.2. Highest number were those that used mental recollection (43.0%) followed by those who recorded in exercise books (33.4%) and by the participants who recorded them by entering as strokes on the wall (20.9%) while the least were those that used colour coded bottles (1.2%). Concerning kits, 54.1% had ever used the kit after training while 22.1% still had the kits given to them. Also, consumables in kits were mostly replenished by purchase from local market (89.5%), from donor agencies (4.1%) and local government in 4.1% of the cases and through the TBA Association (2.3%). As shown in Table 4.5, 30.3% soaked instruments in bleach after use against 69.7% that did not soak instrument in bleach. Also, 40.2% used sterile needle/equipment for each client and 44.4% reportedly used glove during delivery against 55.6% that did not use. Discussant at FGD gave the type of records kept to include number of live births, stillbirths, referred cases, and maternal death. In some cases, the CHEWs collected the record during their monthly meeting with TBAs at their LGAs.

With regards to the nature of the services rendered by the participants, most of the FGD participants cited delivery, child health care, health education, antenatal clinic and immunization. They also reported that most of their clients come from places outside Ibadan such as Aba Nla, Onikoko etc and also from within Ibadan. Concerning the charges for the services, most of the discussants in Ibadan South-East reportedly did not charge their clients. They added that in some cases they fed their clients after delivery. However, for those who charged fees, fees were in the range of five hundred naira to one thousand two hundred naira, as summarised by a female discussant who said that "at minimum we charge between N500 to N1,200". The fees charged were used to purchase materials needed by both mother and child. In Oluyole LGA, a male discussant said, "we receive N1,000 for delivery and from this we buy all the materials needed for both the mother and the new child. For normal treatment, we collect N500".

### 4.3.2 Respondents' Competence on TBA Job

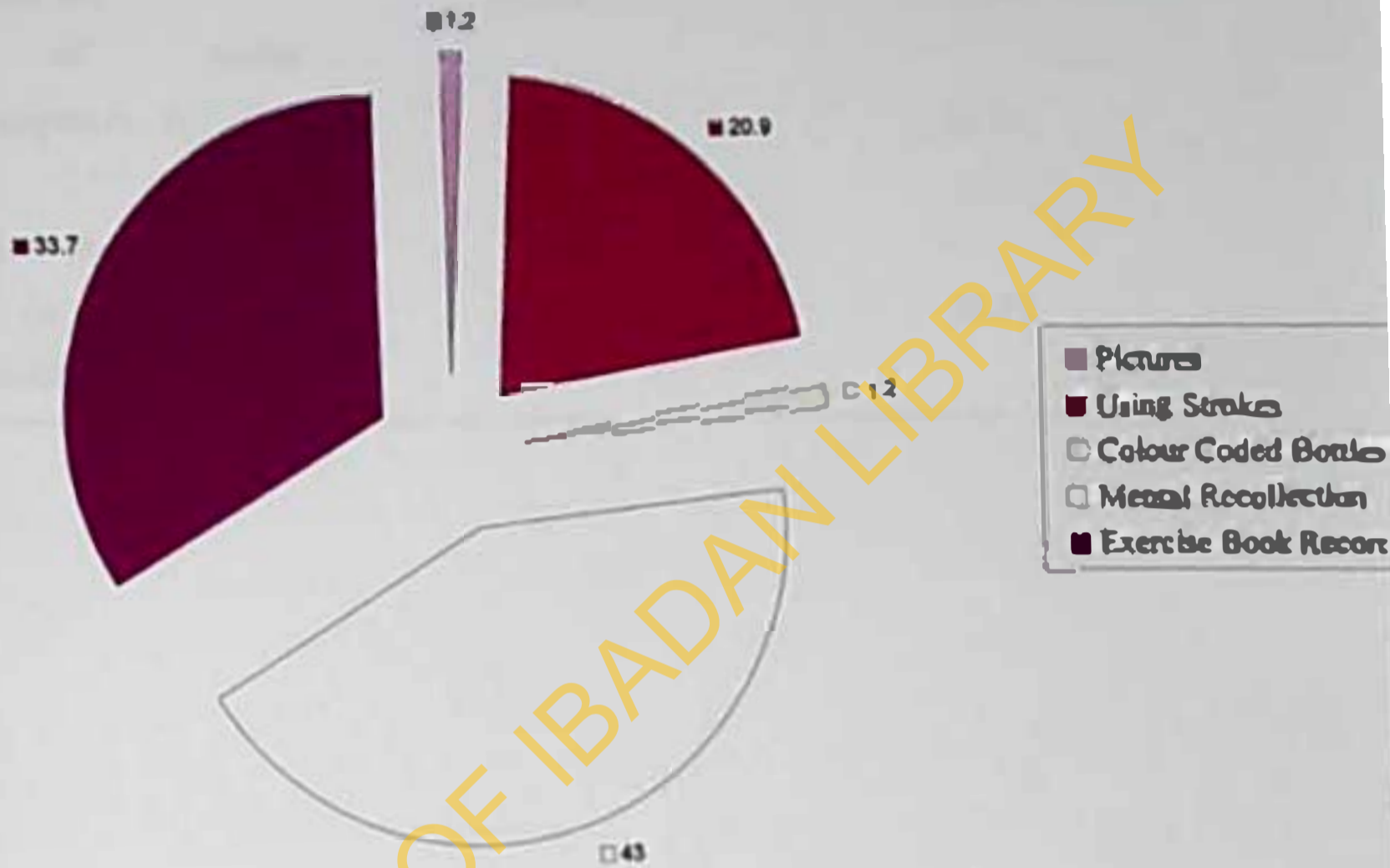
Figure 4.3 illustrates the percentage distribution of the number of live births delivered by the TBAs monthly. The highest number (76.2%) was those that delivered 1 to 5 live births monthly and the least number (5.2%) belonged to those that delivered 16 or more live births monthly. During the FGDs participants revealed that they were trained not to attend to cases like short pregnant women, women at first pregnancy, women with multiple births, women with pale eyes and those with complications.

### 4.3.3 Challenges faced by TBAs in Their Practices

In a multiple response on the major problems faced by the TBAs, the respondents gave the following: inadequate funds (86.6%), inadequate training (63.4%) and insufficient material (61%). Suggestions to improving TBA activities included regular stipends (89%), constant supply of TBA kits (72.7%) and networking between TBAs and CHEWs (45.3%). Challenges encountered by TBAs in carrying out their activities as enumerated by the FGD discussants, included police officers' arrest and extortion of money; lack of funds as they sometimes lived on the mercy of people; lack of delivery kits and materials; lack of government incentives and inadequate training. IDI respondents suggested that government should intensify her effort in providing qualitative education and training, drugs and materials for TBAs, and encouraging the CHEWs to improve their supervisory duties. Although, monitoring of the TBAs by the CHEWs was supposed to be on routine basis, this could not be achieved due to the shortage of manpower and other logistic problems that included inadequate transportation and communication facilities.

### 4.3.4 Government Policy on TBA Job

Majority of the respondents (87.8%) reported that government had not put anything in place to help them in their practices. Kits were provided for 4.7% of respondents, funds for the kits provided in 2.3% of the cases and 5.2% received drugs. The perceived relationship between orthodox medical practice and the TBA association was described as conflict by 69.2%, strained in 3.5%; 20.3% claimed there was no relationship at all and 7.0% gave no response because of the reasons best known to them.



**Figure 4.2: Percentage distribution of methods of recording births**

**Table 4.5: Practice of universal precaution by the TBAs**

<i>Universal Precautions</i>	<i>Yes</i>	<i>No</i>
Use of glove during delivery	48.5%	51.5%
Soaking of instruments in bleach after use	46.3%	53.7%
Use of sterile needle/equipment for each client	40.2%	59.8%
Education of community members on family planning and immunizations	23.8%	76.2%

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#### 4.4 Test of Hypotheses

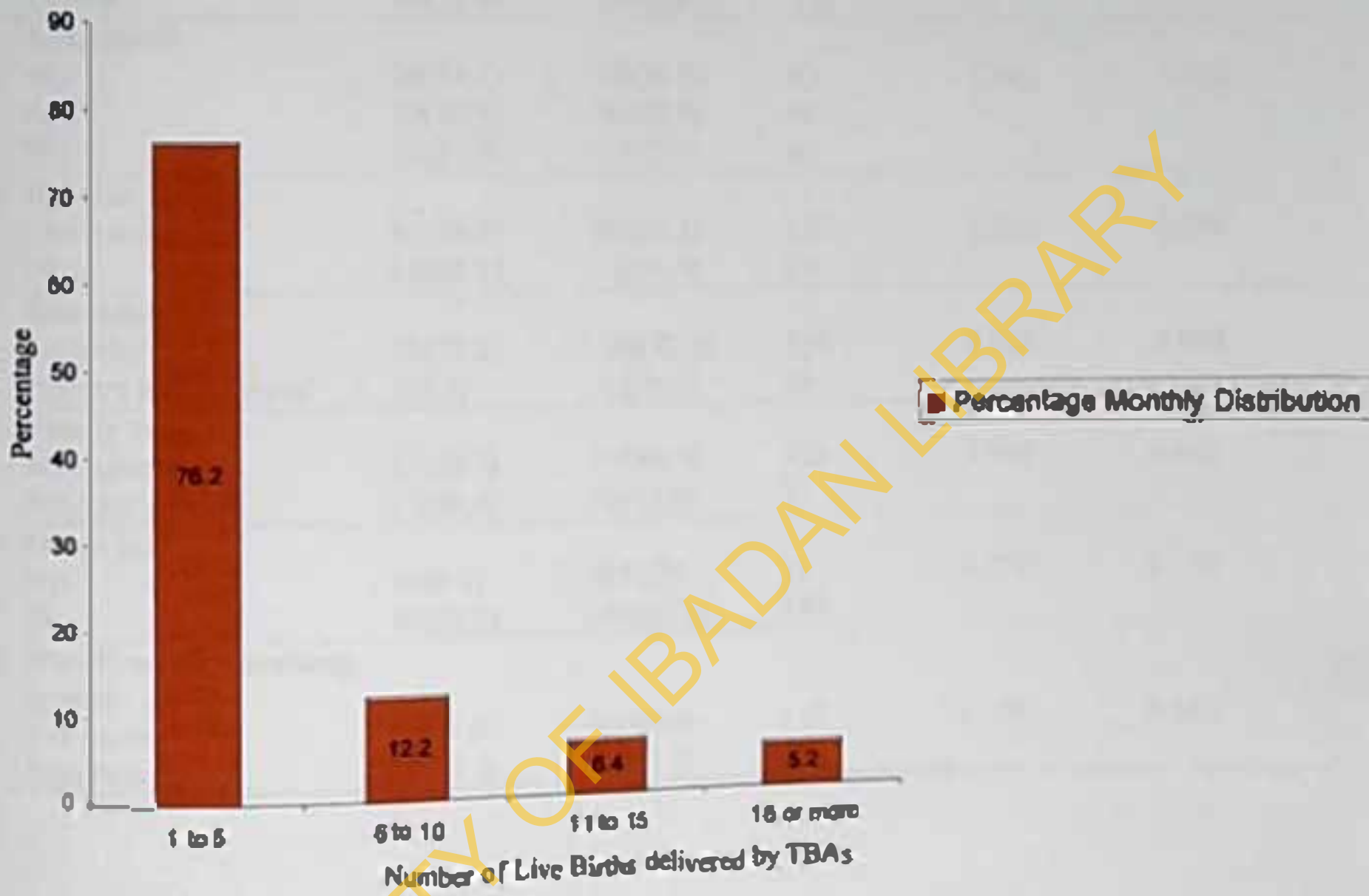
The following hypotheses were tested by the study: Demographic variables of the respondents and good record keeping practices

**Hypothesis 1:** There are no association between good record keeping practices and demographic variables of the respondents.

**Hypothesis 2:** There are no association between kits use and demographic variables of the respondents.

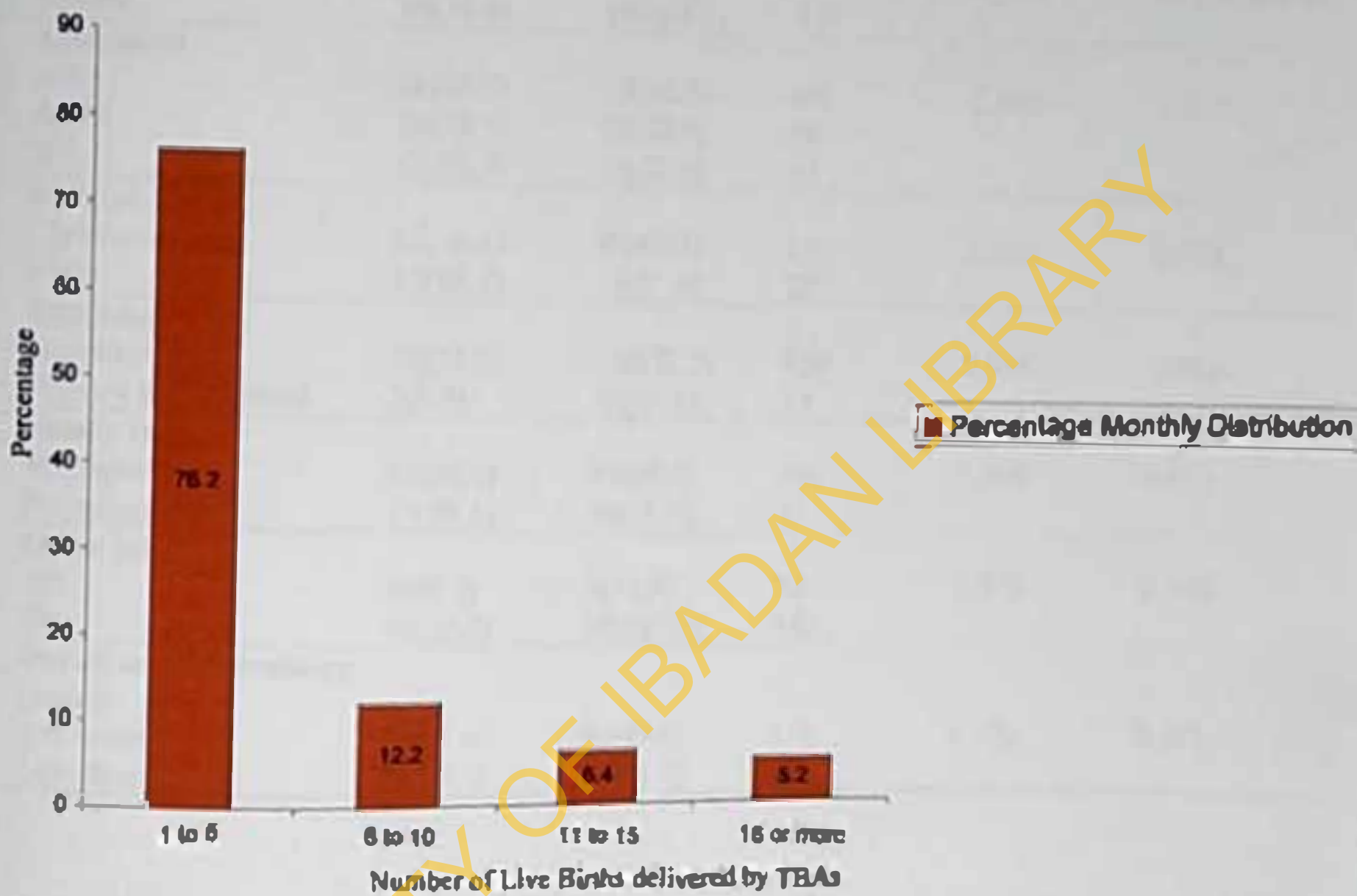
##### 4.4.1 Association between Good Record Keeping and Demographic Variables of the Respondents

In testing the first hypothesis, of whether there is an association between good record keeping and demographic variables as shown in Table 4.6, there was a significant association between gender and proper record keeping ( $p=0.030$ ). A higher proportion of males (61.5%) compared with females (31.8%) kept proper records. A higher proportion of Muslims (48.1%) kept proper records compared with Christians (30.7%) but this wasn't significant ( $p=0.078$ ). The proportion with proper record keeping reduced with increasing age but this was also not significant ( $p=0.272$ ). Education was found to be significantly associated with proper record keeping as higher proportion of proper record keeping was found among those with secondary education ( $p=0.003$ ). Though higher figure was found for those in polygamous unions, it was not significant ( $p=0.052$ ). Having other jobs or duration of training was not significantly related to record keeping method ( $p=0.258$  and  $p=0.283$  respectively). Thus the hypothesis was rejected meaning there was association between good record keeping and respondents' demographic variables.



**Figure 43: The percentage distribution of number of live births delivered by TBAs monthly**





**Figure 4.3: The percentage distribution of number of live births delivered by TBAs monthly**

**Table 4.6: Relationship between good record keeping and demographic variables**

<i>Variable</i>	<i>Proper record keeping (%)</i>	<i>Improper record keeping (%)</i>	<i>Total</i>	<i>Chi square</i>	<i>P value</i>
<b>Gender</b>					
Male	8(61.5)	5(38.5)	13	1.709	0.030 (FET)
Female	50(31.8)	107(68.2)	157		
<b>Age(years)</b>					
<10	26(11.3)	37(58.7)	63	2.602	0.272
40-49	20(30.3)	46(69.7)	66		
50+	12(27.9)	31(72.1)	43		
<b>Religion</b>					
Christianity	42(30.7)	95(69.3)	137	3.096	0.078
Islam	13(48.1)	14(51.9)	27		
<b>Education</b>					
Secondary	38(27.5)	100(72.5)	138	8.966	0.003
Primary and informal	2(5.9)	32(94.1)	34		
<b>Family type</b>					
Monogamy	41(30.1)	95(69.9)	136	3.768	0.052
Polygamy	15(48.4)	16(51.6)	31		
<b>Other job</b>					
Yes	7(46.7)	8(53.3)	15	1.271	0.258
No	48(32.2)	101(67.8)	149		
<b>Duration of training (years)</b>					
5 or more	36(31.0)	80(69.0)	116	1.150	0.283
Less than 5	22(39.3)	34(60.7)	56		

#### 4.4.2 Association between Kit Use and Demographic Variables of the Respondents

In testing the second hypothesis, the cross tabulation between ever using kits and demographic variables is shown in Table 4.7. There was no significant association between all socio demographic variables and kit use. Though males had higher proportions with kit use, this was not significant ( $p=0.069$ ). Also there were no significant relationships between age ( $p=0.492$ ), religion ( $p=0.529$ ), education ( $p=0.166$ ), family type ( $p=0.111$ ) and involvement in other jobs ( $p=0.168$ ). Therefore the null was accepted.

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Table 4.7: Relationship between kit use and demographic variables

Variable	Ever used kits		Total	Chi square	P value
	Yes (%)	No (%)			
<b>Gender</b>					
Male	10(83.3)	2(16.7)	12	3.299	0.069
Female	83(56.5)	16(43.5)	117		
<b>Age(years)</b>					
<40	29(51.8)	27(48.2)	56	1.419	0.492
40-49	40(62.5)	24(37.5)	64		
50+	24(58.5)	17(41.5)	41		
<b>Religion</b>					
Christianity	72(56.7)	55(43.3)	127	0.359	0.529
Islam	17(63.0)	10(37.0)	27		
<b>Education</b>					
Secondary	69(55.2)	56(44.8)	125	1.920	0.166
Lower than secondary	22(68.8)	10(31.3)	32		
<b>Family type</b>					
Monogamy	71(55.0)	58(45.0)	129	2.536	0.111
Polygamy	20(71.4)	8(28.6)	28		
<b>Other job</b>					
Yes	6(40.0)	9(60.6)	15	1.904	0.168
No	82(58.6)	58(41.4)	140		

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## CHAPTER FIVE

### DISCUSSION

#### 5.0

#### 5.1 Discussion

This chapter is organized into sub-sections as follows: socio-demographic characteristics; participants' place of training as traditional birth attendants and the contents of their training; TBAs' practices, competences and challenges including charges for TBA services; participants' kit use and methods of replenishing consumable kits; record keeping and relationship between record keeping and variables; supervision of TBAs; and distribution of the number of live births delivered by the TBAs monthly; government input; and implication of the findings for health education. The chapter ends with the conclusion and recommendations.

##### 5.1.1 Socio Demographic Characteristics of the Participants

A majority of the TBAs were adults above 30 years of age. This is in accordance with the Federal Ministry of Health criteria for recruitment and training of persons to be providing TBA services (FMOH, 1992). This criterion is based on the idea that a woman who is aged 30 years and above would be a mother with years of experience. It is also believed that they would be more stable (i.e. less likely to migrate to other communities after training). This was in line with the study carried out in Atakumosa in Osun state of Nigeria by Abioye-Kuleyi et al (2001) where they reported that most TBAs were older women.

The study shows that an overwhelming majority of the respondents were females. This agrees with what has been documented by Abioye-Kuleyi et al. (2001). This is to be expected because TBA services involve dealing with women and children. Moreover, in most Yoruba communities, especially in the study areas, it is culturally acceptable for women to provide services relating to pregnancy, labour and childcare.

Another observation was that an overwhelming majority (96.0%) of respondents had formal education with secondary school education topping the list. This was contrary to a previous study by Itina (1997) in South-Eastern Nigeria which reported that majority of the TBAs had no formal education. The presence of a high proportion of literate TBAs in the study areas may probably be due to the fact that education is one of the criteria used in selecting TBAs for training and to the numerous educational opportunities in Ibadan land. It is desirable to have

literate TBAs because ability to read and write has great potential in enhancing their performances. In Oyo state, TBAs are expected not only to provide maternal and child health services but, also to keep record and render health education services to community members. Without some degree of literacy, it will be difficult for them to do this.

There were more Christian respondents than Muslim in the study areas which was at variance with the findings of Inogic et al. (2002). Furthermore, Christian organizations do encourage Christian women to be involved in volunteer primary health care services and there are churches or missions that have maternities or delivery homes.

### 5.1.2 Participants' Place of Training as Traditional Birth Attendants and the Contents of their Training

Results have shown that TBAs were trained by different organizations. More than half (58.8%) were trained by older TBA colleagues, especially those that were family members. Training and capacity development is of high importance for quality service delivery of any sector of the economy. This is also in line with the requirements of primary health care services where formal training is recommended by the Alma Ata declaration as part of the strategy for the attainment of health for all (NPHCDA, 1997; Delano et al. 1999). Moreover, it has also been advocated that for the TBAs to be properly integrated into PHC, they should focus on safer modern techniques for the provision of PHC services (Umar et al. 2003). These services include care during pregnancy and labour as well as on ways of identifying and referring 'at risk' cases to higher levels of care for adequate management (Umar et al. 2003).

Key elements common to the TBA training programmes include principles of hygienic practices in delivery, and identification of high-risk cases and appropriate referrals. Although a training curriculum and manual exists nationally, there have been considerable differences in the TBA training programme of various states and organizations (Akpan, 1999). Also, various organisations are also known to have designed or adopted curriculum deemed appropriate for their own situation, for example St. Mary's Hospital, Uva Akpan and the CAC Church Training Centre, Ede (WIIARC, 1998).

To ensure uniformity in standards of practice however, it will be desirable to produce a common curriculum for their training exercise. As a result of the prevailing economic depression in the country, many LGAs find it difficult to train and supervise the TBAs. This may also account for the reason why they resort to training from older members of their families.

Various studies conducted in Nigeria have shown that TBA practices improved after training, and trained TBAs performed better than untrained ones (Akpala, 1991; Matthews, Walley, Ward, Akpaldem, Williams, and Umoh, 1995; Zoskoff and Ikoku, 1997). On the basis of historical and observational evidence on the association between having a skilled health worker at delivery and reduced maternal mortality, it is recognized that a key strategy to reduce maternal deaths is that all births should be attended by skilled health workers (Etuk et al, 1999). However, in a work carried out in Ibadan by Taiwo et al (2007), they blamed maternal deaths were blamed on healthcare workers not being skilled enough. Most of those who have received initial training have not been given refresher training, some after more than 5 years of the initial training (Oyeyipo, 1997).

### 5.1.3 TBAs' Practices and Challenges

#### Charges for TBA Services

Majority of the respondents did not charge money for their services. According to Lawoyin (1998), the TBAs are usually recruited, trained and encouraged to be providing community-based maternal and child health services in medically underserved communities. Most of the time these communities comprise low socio-economic group of people that have little financial power to patronize formal health sectors (Carvalho et al, 1998; Ahioye-Kuteyi et al, 2001). In addition to this, some of the respondents were involved in supportive jobs like petty trading, clergy, auxiliary nurse and tailoring that served as source of their income.

Though TBAs are non-salaried health workers who are expected to be motivated by incentives from LGA and Community Development Committee, some of them reportedly received monetary incentives from their clients and relations. This is probably so because many communities in the study areas hardly contributed towards the welfare of volunteer health workers including TBAs (Odebiyi, 1990)

To ensure uniformity in standards of practice however, it will be desirable to produce a common curriculum for their training exercise. As a result of the prevailing economic depression in the country, many LGAs find it difficult to train and supervise the TBAs. This may also account for the reason why they resort to training from older members of their families.

Various studies conducted in Nigeria have shown that TBA practices improved after training, and trained TBAs performed better than untrained ones (Akpala, 1991; Matthews, Walley, Ward, Akpoidem, Williams, and Umoh, 1995; Zoakah and Iloko, 1997). On the basis of historical and observational evidence on the association between having a skilled health worker at delivery and reduced maternal mortality, it is recognized that a key strategy to reduce maternal deaths is that all births should be attended by skilled health workers (Etuk et al. 1999). However, in a work carried out in Ibadan by Taiwo et al (2007), they blamed maternal deaths were blamed on healthcare workers not being skilled enough. Most of those who have received initial training have not been given refresher training, some after more than 5 years of the initial training (Oyejipo, 1997).

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## Participants' Kit Use and Methods of Replenishing Consumables in Kits

Overwhelming majority of TBAs did not use delivery kits. The delivery kit is a small box which contains the essential materials for the provision of maternal and child care services by TBAs. They are pre-requisites for effective and efficient functioning of TBAs. Most of the contents of kits such as razor blades, soap, gloves, mackintosh and nientholated spirit are expected to facilitate the practice of universal precaution against blood-borne pathogens. The box is also expected to contain a number of essential drugs. The reason for non-use could be that some of the contents are not culturally acceptable (Menendez et al., 1991) to this set of people or that the skills required, if any, are not there. There are innovations which some people find difficult to adopt; it will only take a lot of persuasion and advocacy for such innovation to be adopted. The ministry of health and the health department of local government have a lot of roles to play in ensuring that this important set of health care providers are helped for quality health care delivery and for infection control (Hukumawan et al., 1994).

The fact that the kits are not used by TBAs is a clear indication of service that creates potential opportunity for the transmission of communicable diseases such as HIV/AIDS from the TBAs to their patients and from their patients to the TBAs. Forgetfulness might account for the reason why the respondents did not use gloves and other materials in their kits while carrying out some invasive procedures like cutting of umbilical cord, circumcision etc. This calls for urgent need for educating the TBAs on the importance of using their kits and practising the universal precautions (Akpala, 1991). In addition, consumables in kits are mostly replenished by purchasing them from local market, a clear indication that services of the TBAs were not well supervised.

## Record Keeping

The factors associated with record keeping included duration as a VHW/TBA, previous training on record keeping and receiving feedback (Umar et al., 2003). The data this category of workers generates about their communities will strengthen primary health care management information system in Nigeria. Most of the TBAs did not have the VHW/TBA record of work or the community profiles (wall charts) developed and recommended by the Federal Ministry of Health (FMOH) because they were not supplied. Also, more of the respondents used mental recollection (13.0%), as a means of keeping record. This might be probably due to the lack of

knowledge on the value of record keeping. Hence the need to emphasize the need for good record keeping by all and sundry and not only the TBAs alone.

The cross tabulation between method of record keeping and demographic variables showed that there were significant relationships between gender and education, and good record keeping. A higher proportion of males (61.5%) compared with females (31.8%) kept proper records. This finding could be due to lower number of males TBAs in the study area which accounted for the higher proportion; this does not suggest that males keep records more than females as subsequent research can throw more light on this. Education was found to be significantly related to proper record keeping as higher proportion of proper record keeping was found among those with secondary education ( $p=0.003$ ). Respondents with secondary school education are more favourably disposed to the proper record keeping than those with lower and informal education. It could be deduced that the reason for this is because there were more educated respondents. This may likely be due to their exposure to continuing educational programmes, which emphasize the need for all health workers to keep records.

#### **Practice of Universal Precaution**

Although, the relationship between the various practices of universal precautions and the respondents' socio-demographic variables such as level of education and gender was not statistically significant, their practices of universal precaution including soaking away of instrument in bleach after use, using sterile needle/ equipment for each client and wearing of glove during delivery were very poor. The reasons for this could be poor monitoring and supervision of the TBAs by CHW. Some of the respondents reportedly soaked their instruments in bleach solution so as to sterilize them. This knowledge was acquired during refresher training on blood-borne pathogen control. Bleach solution is an acceptable solution for inactivating such pathogen like that of HIV (UNAIDS, 2000; Shokunbi, 2001).

#### **Others Services Rendered**

Majority of TBAs encourage pregnant women to attend antenatal clinic and recommended early referral of people with complications in addition to circumcision, family planning and care of umbilical cord among others. This may likely be due to cordial relationship between them and formal health sector. Not only this, TBAs are important informal primary health care providers who seek the welfare of the masses and this is reflected in the service they provide.

## Supervision

Supportive supervision is an efficient way of promoting good quality services. However, the findings of this study revealed that the supervision of TBAs was inadequate as only a few of them were being supervised. This finding corroborates an earlier study (Odebiyi, 1990) that one of the weaknesses of PHC services in part of the study areas was poor or inadequate supervision of PHC workers including TBAs. However, this could not be achieved due to the shortage of manpower and other logistic problems that included inadequate transportation and communication facilities. It could also be due to lack of government input in TBA practices.

## Recorded Birth Distribution

It was also observed that an appreciable proportion (80%) of TBAs delivered a range of 1-5 babies per month while less than 10% delivered up to 16 or more babies monthly. This is an indicative of social acceptability of TBAs in terms of effective promotion of safe motherhood in Nigerian communities (Odebiyi, 1990 and Isenalumbe, 1990).

### 5.1.4 Implications of the Findings for Health Education

The findings of this study revealed the health education training needs of TBAs with special reference to the practice of universal precautions against blood borne infections and proper record keeping practices. Apart from this, there is need for supervision of the volunteer health workers including the TBAs whereby the use of kit will be encouraged.

Also, pregnant women should be encouraged to purchase the essential materials necessary for delivery such as gloves, new razor blade and soap for their individual use in case the TBAs supplies are inadequate. All these have implications for the health of people at the community level; if the health of the people is properly managed by care givers at this level, their health will be improved and there will be less disease burden.

## 5.2 CONCLUSION

The study showed that the traditional birth attendants are not sufficiently motivated and provided with supportive supervision. Despite training received, there was poor record keeping and adherence to universal precautions against blood-borne infections that should be adopted by health workers. Hence, several opportunities for the transmission of communicable diseases like HIV/AIDS from HIV positive TBAs to their clients or from HIV positive clients

to the TBAs exist. Therefore, strategies such as advocacy, regular supervision and continuous education opportunities are needed to improve the practice of TBAs.

### 5.3 RECOMMENDATIONS

The recommendations based on the findings of this study are as follows.

- I. TBAs with no formal education should be exposed to adult literacy opportunities to facilitate increase in their knowledge on how to keep record properly and on contemporary issues such as HIV/AIDS in the communities. Also health education programmes such as training and workshop for TBAs are urgently required.
- II. Health care workers (CHEWs) in the LGAs should be motivated to provide adequate and regular supervision to the TBAs. This could serve as golden opportunity to enforce the use of kit by the TBAs.
- III. To ensure availability of materials for enhancing the practice of universal precautions, the revolving system should be established and sustained by the LGAs and community Development Committee. This will help to replenish the supplies of needed materials.
- IV. Government should support registered TBAs with incentives and practising kits and should also prevent police from harassing the TBAs. Government should also provide drugs especially malaria drugs as it is a serious health problem in the society.
- V. In order to control TBA practices there should be penalties for the TBAs that commit offence or violate the set standard rules.

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## APPENDIX A

# PATTERN OF PRACTICE AND CHALLENGES EXPERIENCED BY TRADITIONAL BIRTH ATTENDANTS IN IBADAN SOUTH EAST AND OLUYOLE LOCAL GOVERNMENT AREAS OF OYO STATE.

### Consent form for Survey Respondents

Name of Investigator: Jimoh, S. Olugbenga

Name of Organization: University of Ibadan

Greetings. My name is Jimoh, S. Olugbenga and I am a graduate student of the Department of Health Promotion & Education, College of Medicine, University of Ibadan. I am part of a team doing a research study on pattern of practice and challenges experienced by traditional birth attendants in Ibadan South East and Oluyole Local Government Areas of Oyo State.

The findings from this study will help in suggesting programmes aimed at combating problems that will be highlighted.

1. Purpose of the research:

I am planning to conduct a study on the pattern of practice and challenges experienced by traditional birth attendants in Ibadan South East and Oluyole Local Government Areas of Oyo State.

2. Duration of the research:

The duration of this research, which you are being requested to participate in, is 1 month.

3. Procedures:

I invite you to take part in this research project and participate in the questionnaire. If you accept, you will be asked to participate in the filling of the questionnaire which will be given to you. If you do not wish to answer any of the questions posed in the questionnaire, you may say so and can move on to the next question. No one else but the researcher alone will be present. The information recorded is considered confidential, and no one else except Mr. Jimoh Olugbenga and his colleagues will have access to the information documented during the research.

We will record your answers to these questions on this questionnaire. This is done so that we can remember everything that you have told us. Although it is important for the research that you answer all questions, if you do not wish to answer any of the questions included in the survey, you may ask to move on to the next question. Filling the questionnaire will last for approximately 25 minutes.

4. Risks and Discomforts:

There is a slight risk that you may feel uncomfortable talking about some of the topics. However, we do not wish this to happen, and you may refuse to answer any question or not take part in a portion of the interview if you feel the question(s) makes you uncomfortable.

## 5. Benefits:

There will be no direct benefit to you but the information obtained from this study will help to provide suggestions that will enable the researcher make suggestions for improvement in the services delivered by TBAs based on the findings which will ultimately influence the competence of traditional birth attendants and prevent TBAs attrition in Oyo State.

## 6. Confidentiality:

We have taken the following steps to ensure that you are safe and that the information you provide is confidential.

1. Filling of questionnaire will take place in a private place
2. The information that we collect from this research project will be kept confidential.
3. Information collected from you will be stored in a file that will not have your name on it, but a number assigned to it instead.
4. The questionnaire containing the interview will be stored for the duration of 2 years after which it would be destroyed.
5. The name associated with the number assigned to each file will be kept under lock and key and will not be disclosed to any one except colleagues working on this study.
6. You may talk to the leader of the research team in case you have any concern or question.

## 7. Alternative to participation:

You do not have to take part in this research if you do not wish to do so. Even if you do not wish to answer these questions you may still benefit from the study. You may stop participating in the interview at any time that you wish and there will be no negative consequences for you in any way.

## 8. Who to contact:

If you have any question you may ask those now or later. If you wish to ask questions later, you may contact any of the following:

Mr. Junch S. Olugbenga,

Address: Department of Health Promotion & Education, College of Medicine, University of Ibadan, Ibadan.

• 0805 225 9571

or

Dr. O. S. Arulogun

Address: Department of Health Promotion & Education, College of Medicine, University of Ibadan, Ibadan.

• 0803 579 4630

9. Certificate of Consent for Qualitative Study.

I have been invited to take part in the research on the Assessment of Factors Influencing Competence & Attrition of Traditional Birth Attendants in Oluoyole Local Government Area, Oyo State. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions I asked had been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without in any way affecting my medical care.

Print name of Participant

Date and Signature of Participant

.....

.....

\_\_\_\_\_ (dd/mm/yy)

Print Name of Researcher/Moderator

Date & Signature of  
researcher/moderator

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(dd/mm/yy)

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**APPENDIX B**  
**FOCUS GROUP DISCUSSION (FGD) GUIDE**

**TOPIC: PATTERN OF PRACTICE AND CHALLENGES EXPERIENCED BY TRADITIONAL BIRTH ATTENDANTS IN IBADAN SOUTH EAST AND OLUYOLE LOCAL GOVERNMENT AREAS OF OYO STATE.**

**Focus Groups**

1. Traditional Birth Attendants (8 – 10)

**Site**

1. Ibi Ayunre  
2. Manu

**Moderator  
Rapporteur**

The researcher  
Yoniba speaker (One research assistant)

**Guidelines (G)**

1. General introduction
2. Services offered
3. Clients (Demographics, frequency)
4. Accessibility (Distance, working hours)
5. Requirements
6. Government contributions (Training, provision of kits)
7. Effects of trainings
8. Referral services (Pregnant women, complications)
9. Problem encountered
10. Suggestions

**Questions**

- G2.** 2.1 What types of services do you offer?
- G3.** 3.1 Who comes to you for services?  
3.2 What kinds of health problems do people bring to you?  
3.3 At what point in their condition do they come to you?  
3.4 What do you do with them?
- G4.** 4.1 How long do people travel to come to your services?  
How long do they wait till they get the services?  
How much do people pay for the services you provide?
- G5.** 5.1 What are the necessary requirements for a person to be a TBA?
- G6.** 6.1 In what ways does government contribute to your profession?  
6.2 What are the kits that you expect to be provided?
- G7.** 7.1 In what ways does the training you received contribute to your performance?

- G8. 8.1 In your own opinion, on what basis do you refer pregnant women to a more competent TBA or hospital?
- G9. 9.1 What problems do you encounter in service delivery and utilisation?  
9.2 What do you think about the conditions in which you have to work?  
9.3 What do you think about other TBAs who are not interested in this work again?
- G10. 10.1 What suggestions do you make for your self improvement and improvement of health services?  
10.2 What suggestions do you make for others who are not interested in this job again?  
10.3 What suggestions can you make to bring back those who have left the profession?

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APPENDIX C  
INDEPTH INTERVIEW (IDI)

TOPIC: PATTERN OF PRACTICE AND CHALLENGES EXPERIENCED BY  
TRADITIONAL BIRTH ATTENDANTS IN IBADAN SOUTHEAST AND OLUFEMI  
LOCAL GOVERNMENT AREAS OF OYO STATE

Interviewees

1. Health workers (2 female, 2 male)

Site

1. Idi Ayunre  
2. Mamu

**INTERVIEW**

- 10
1. Sex
  2. Age
  3. Religion
  4. Ethnic group
  5. Marital status
  6. Profession/occupation
  7. What types of services do TBAs offer?
  8. Who are those who go for these services?
  9. What kinds of health problems do people bring to TBAs?
  10. At what point in their condition do they come to TBAs?
  11. What do you do with them?
  12. How long do people travel to come to these services?
  13. How long do they wait till they get the services?
  14. How much do people pay for the services provided by TBAs?
  15. How do you see the quality of services offered to the people by TBAs?
  16. In what ways does government contribute to the profession of TBAs?
  17. What do you think the government should do about the services provided by TBAs?
  18. What do you think about the training TBAs received?
  19. In what ways does the training received by TBAs contribute to their performance?
  20. What problems do TBAs encounter in their service delivery and utilisation?
  21. Where else do people go for these services?
  22. What suggestions do you make for TBAs self improvement and improvement of health services?

APPENDIX C  
INDEPTH INTERVIEW (IDI)

TOPIC: PATTERN OF PRACTICE AND CHALLENGES EXPERIENCED BY  
TRADITIONAL BIRTH ATTENDANTS IN IBADAN SOUTH EAST AND OI/OI/E  
LOCAL GOVERNMENT AREAS OF OYO STATE

Interviewees

1. Health workers (2 female, 2 male)

Site

1. Idi Ayunre  
2. Alamu

**INTERVIEW**

- II
1. Sex
  2. Age
  3. Religion
  4. Ethnic group
  5. Marital status
  6. Profession/occupation
  7. What types of services do TBAs offer?
  8. Who are those who go for these services?
  9. What kinds of health problems do people bring to TBAs?
  10. At what point in their condition do they come to TBAs?
  11. What do you do with them?
  12. How long do people travel to come to these services?
  13. How long do they wait till they get the services?
  14. How much do people pay for the services provided by TBAs?
  15. How do you see the quality of services offered to the people by TBAs?
  16. In what ways does government contribute to the profession of TBAs?
  17. What do you think the government should do about the services provided by TBAs?
  18. What do you think about the training TBAs receive?
  19. In what ways does the training received by TBAs contribute to their performance?
  20. What problems do TBAs encounter in their service delivery and utilisation?
  21. Where else do people go for these services?
  22. What suggestions do you make for TBAs self improvement and improvement of health services?

## APPENDIX D

### SAMPLE OF QUESTIONNAIRE

#### PATTERN OF PRACTICE AND CHALLENGES EXPERIENCED BY 172 TRAINED TRADITIONAL BIRTH ATTENDANTS IN IBADAN SOUTH EAST AND OLUYOLE LOCAL GOVERNMENT AREAS OF OYO STATE

Dear respondent,

I am Jimub Olugbenga, a student of the department of Health Promotion & Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan. The purpose of this study is to assess pattern of practice and challenges experienced by traditional birth attendants in Ibadan South East and Oluyole Local Government Areas of Oyo State.

The findings from this study will help in making suggestions to the appropriate bodies in order to improve the quality of work by TIAs.

I wish to inform you that there are no right or wrong answers to the questions I will ask you. Please be informed also that participation is voluntary. Your identity, responses and opinions will be kept confidential and no name is required in filling the questionnaire. Please try and give honest responses to the questions I will ask you as much as possible. You are free to ask questions as the interview progresses.

Thank you for cooperation.

#### Section A - Demographic information

Instruction: I would like to ask you some questions that are a bit personal, please do not be offended. Your answers to the questions will enable me to learn from you and better understand and appreciate the issue being investigated. Kindly respond correctly to the questions below without holding back any piece of information. Please tick (✓) the box in front of the correct answer.

1. Age: 1. 30 - 35 years  2. 36 - 40 years  3. 41 - 45 years   
4. 46 - 50 years  5. 51 - 55 years  6. 56 - 60 years   
7. Above 61 years

2. Sex: 1. Male  2. Female

3. Ethnic Group: 1. Yoruba  2. Igbo  3. Hausa  4. Others (specify) .....

4. Marital status: 1. Never married  2. Married  3. Separated  4. Divorced   
5. Widowed

5. Level of Education: 1. No formal education  2. Primary school   
3. Secondary school  4. ~~Other~~ school .....

6. Religion: 1. Christianity  2. Islam  3. Traditional  4. Others (specify) .....

APPENDIX D

SAMPLE OF QUESTIONNAIRE

PATTERN OF PRACTICE AND CHALLENGES EXPERIENCED BY 172 TRAINED TRADITIONAL BIRTH ATTENDANTS IN IBADAN SOUTH EAST AND OLUYOLE LOCAL GOVERNMENT AREAS OF OYO STATE.

Dear respondent,

I am Jimoh Olugbenga, a student of the department of Health Promotion & Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan. The purpose of this study is to assess pattern of practice and challenges experienced by traditional birth attendants in Ibadan South East and Oluyole Local Government Areas of Oyo State.

The findings from this study will help in making suggestions to the appropriate bodies in order to improve the quality of work by TLAs.

I wish to inform you that there are no right or wrong answers to the questions I will ask you. Please, be informed also that participation is voluntary. Your identity, responses and opinions will be kept confidential and no name is required in filling the questionnaire. Please try and give honest responses to the questions I will ask you as much as possible. You are free to ask questions as the interview progresses.

Thank you for cooperation.

Section A – Demographic information

**Instruction:** I would like to ask you some questions that are a bit personal, please do not be offended. Your answers to the questions will enable me to learn from you and better understand and appreciate the issue being investigated. Kindly respond correctly to the questions below without holding back any piece of information. Please tick (☑) the box in front of the correct answer.

- 1. Age: 1. 30 – 35 years  2. 36 – 40 years  3. 41 – 45 years   
 4. 46 – 50 years  5. 51 – 55 years  6. 56 – 60 years   
 7. Above 61 years

- 2. Sex: 1. Male  2. Female

- 3. Ethnic group: 1. Yoruba  2. Igbo  3. Hausa  4. Others (specify).....

- 4. Marital status: 1. Never married  2. Married  3. Separated  4. Divorced   
 5. Widowed

- 5. Level of education 1. No formal education  2. Primary school   
 3. Secondary school  4. Quranic school.....

- 6. Religion: 1. Christianity  2. Islam  3. Traditional  4. Others (specify).....

7. Family type: 1. Monogamy  2. Polygamy

8. Other job(s) engaged in, in addition to present jobs.....

**Section B: Knowledge and Type of Training Received**

9. Where did you receive training to become a TBA?  
1. Training from older family member in order to succeed them   
2. No training, started practising in response to emergency situations   
3. No training, but was invited to start practising because they display unusual bravery   
4. No training, but started taking deliveries because I was adept at taking deliveries of animals such as goats, sheep etc.

10. Have you ever received any training from or through government in the last 10 years?  
1. Yes  2. No

11 (a) If yes, when did you receive the training? (Date).....

(b) Did the training add to your knowledge?  
1. Yes  2. No

12. Did you find the training useful in your job?  
1. Yes  2. No

13. Which of the following were taught during the training? (Tick  as many as applied to you)

- 1. To encourage pregnant women to attend antenatal clinics
- 2. To identify high risk pregnancies and refer
- 3. Identify and refer pregnancy related complications early
- 4. Take deliveries aseptically
- 5. Promote acceptable modern family planning
- 6. Discourage traditional practices harmful to new borns, girls and pregnant women
- 7. Promote early initiation of breast feeding
- 8. Manage umbilical stump properly
- 9. Encourage mothers to take children to clinic for immunisations
- 10. Promote proper nutrition and use of Oral Rehydration Therapy

14 (a) Are there issues or topic you did not understand when you had the training?  
1. Yes  2. No

(b) If yes list them .....

15. Are there things taught during the training that is not in agreement with your culture or beliefs? 1. Yes  2. No

16. Are the skills or knowledge acquired through the training relevant to your practice?  
1. Yes  2. No

17. Were you selected for the training as a result of your involvement in politics in your community?  
 1. Yes  2. No
18. After the training, are you or your activities as TBA being monitored or controlled by the government? 1. Yes  2. No

**Section C: Practice of TBAs and their Competence**

19. Are you still practicing the job of a traditional birth attendant?  
 1. Yes  2. No
20. If No to question 20 why did you leave it .....
21. If Yes to question 20, are you willing to leave it anytime from now?  
 1. Yes  2. No
22. If Yes to question 23, why do you wish to leave? .....
23. Do you still have the kits given to you after the training?  
 1. Yes  2. No
24. Have you ever use the kits given to you after the training?  
 1. Yes  2. No
25. If yes to question 25, are you still using the kits?  
 1. Yes  2. No
26. If No to question 26, why is it so? .....
27. What do you think is the major problem affecting you in your job? .....
1. Inadequate fund  2. Inadequate training  3. Insufficient materials   
 4. Others (specify) .....
28. What are your suggestions in improving the job of traditional birth attendants? .....
1. Give stipend to recognised trained certificated TBAs by local government   
 2. Constant supply of TBAs kits   
 3. Networking between TBAs and CHEWs   
 4. Others (specify) .....
29. What do you think are your responsibilities in making improve health care services to community members? .....

30. What role do you play during pregnancy period of your clients? 1. Administration of herbal concoctions to ease labour  2. Provision of ante-natal care  3. Health education  4. No action taken during this period until time of delivery
31. On average, how many live births do you deliver in a month?  
1. 1-5  2. 6-10  3. 11-15  4. Above 16
32. How many still birth do you record in a month?  
1. 1-3  2. 4-6  3. Above 7
33. Do you refer pregnant women to any government hospital within your area?  
1. Yes  2. No  (If No, go to 35)
34. What condition makes you refer pregnant women to hospitals?  
1. When they cannot pay the bill  2. When there are danger signs   
3. When pregnant women do not visit regularly
35. What other services do you render? 1. Family planning  2. Treatment of wounds  3. Cord ligation  4. Circumcision of babies  5. Promotion of vaccination  6. Community adviser on reproductive health issue  7. Reproductive health education to clients and their families  8. Identification and referral of complications  (Tick (☑) as many as possible)
36. How engaged are you with the job?  
1. Fully engaged  2. Partially engaged  3. Occasionally engaged   
4. Not engaged at all
37. How do you keep records of birth? 1. Use of picture  2. Entering either vertical or horizontal stroke in an exercise book for live or still birth respectively  3. Using colour-coded bottles to signify either live or still birth  4. Mental recollection  5. Proper recording in exercise books  (Tick (☑) as many as applied to you)
38. Is there any link between you and formal health sector? 1. Yes  2. No
39. How do replenish consumables in the kits? 1. Make purchase from local market  2. Depend on donor agencies  3. Through local government  4. Through TBAs association  5. Don't know
40. Do you need regular supervision by orthodox practitioners?  
1. Yes  2. No

Section D: Government policy on TBAs

41. Since the last time you were trained, what has government put in place to help you function as TBAs?
1. Provision of TBA kits  2. Provision of fund to purchase kits   
3. Provision of drugs  4. No provision at all
42. What is the relationship between orthodox medical workers and your association members?
1. Cordial relationship  2. Strained relationship  3. No relationship
43. Do you think you need further training on the job? 1. Yes  2. No
44. If yes, what type of training do you need?.....  
.....

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