THE ROLE OF TRADITIONAL BIRTH ATTENDANTS IN THE PROVISION OF MATERNAL HEALTH IN LESOTHO

By

LUCIA NTHABISENG MAKOAE

Submitted in accordance with the requirements of the degree

DOCTOR OF LITERATURE AND PHILOSOPHY

In the Department of Advanced Nursing Sciences

At the UNIVERSITY OF SOUTH AFRICA

PROMOTER: PROFESSOR R. TROSKIE

CO- PROMOTER: PROFESSOR M V L H LOCK

JUNE 2000
I declare that **THE ROLE OF TRADITIONAL BIRTH ATTENDANTS IN THE PROVISION OF MATERNAL HEALTH IN LESOTHO** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

**SIGNATURE**
(MS L.N. MAKOA)
THE ROLE OF TRADITIONAL BIRTH ATTENDANTS IN THE PROVISION OF MATERNAL HEALTH IN LESOTHO

STUDENT : L N Makoae
DEGREE : Doctor of literature and philosophy
DEPARTMENT: Advanced Nursing Science, University of South Africa
PROMOTER: Professor R. Troskie
CO-PROMOTER: Professor MVLH Lock

Summary

A descriptive quantitative study was undertaken in the Leribe and Butha-buthe northern districts of Lesotho. Thirty-six trained, twenty-four untrained TBAs and nine nurses involved in training TBAs were recruited.

In line with research by Clarke and Lephoto (1989:3) the TBAs were elderly females who had children of their own. In contrast with the MOH (1993: 10) where TBAs were found to be illiterate, most (93%) of the TBAs in this study had at least a primary education.

The art of primary midwifery was learned through assisting with a delivery and being taught by mothers or mothers-in-law. The public health nurses conduct formal training of TBAs in Lesotho over a period of two weeks, where subjects like ante-natal care, delivery of the baby and post-natal care are addressed.
The majority (78.8%) provide antenatal care at their homes or the home of the mother. This includes palpation, history taking, and abdominal massage and health education. An important role is identifying women at risk. During labour the progress of labour is monitored and care is given to the mother and baby post-natally. Trained TBAs could identify women at risk more readily than untrained TBAs. Cases referred most frequently were prolonged labour and retained placenta. Trained TBAs practiced hygiene more often and gave less herbs than untrained TBAs.

The health care system is providing support to the TBAs through training and supervision, but was found to be inadequate. Community leaders are involved in the selection of TBAs for training. Regular meetings are held with the TBAs to discuss problems. Communication is one of the problems the TBAs have to face, because of the long distances from health care centres. A lack of infrastructure and supplies is also of concern.

It can be concluded that TBAs play an important role in maternal health care in Lesotho and are supported to a lesser degree by the health care system, which causes problems for the TBAs in their practices.

It is recommended that the ministry of health becomes more aware of the need for training TBAs and that a programme for training should be more appropriate, taking cultural practices into account.
Key concepts:

Professional midwife, traditional birth attendant, cultural care, cultural care repatterning, cultural care preservation, cultural care accommodation, traditional care practices, antenatal care practices,
ACKNOWLEDGEMENTS

I wish to thank Professor R Troskie, my promoter, for her guidance and support throughout the research study.

I would also like to thank Professor M.V.L.H Lock my co-promoter for her contribution in the study.

My sincere thanks go to the following people who contributed to the undertaking and completion of the study.

The late Mr. D. Thakhisi for sample determination
Mrs. Mamabela Molapo for assisting with data collection
N.U.L – Consuls for typing the document
Dr. Motlomelo for Editing
Mr J. Nthoba and Ms S. Mthombeni for final editing

I would like to thank my family and friends for moral support and encouragement they gave me. Special thanks go to my husband Dr.C Nyambuyi who tirelessly supported me.
# List of Acronyms and Abbreviation

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquire immunity deficiency syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>GOL</td>
<td>Government of Lesotho</td>
</tr>
<tr>
<td>HSAs</td>
<td>Health service area</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NUL</td>
<td>National University of Lesotho</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PHAL</td>
<td>Private Health association of Lesotho</td>
</tr>
<tr>
<td>PNC</td>
<td>Post Natal Care</td>
</tr>
<tr>
<td>RSA</td>
<td>Republic of South Africa</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children Education Fund</td>
</tr>
<tr>
<td>UNISA</td>
<td>University of South Africa</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION AND GENERAL BACKGROUND

1.1 INTRODUCTION

1.1.1 Geography

1.1.2 Population in Lesotho

1.1.3 Economy

1.1.4 Education

1.2 HEALTH CARE SYSTEM IN LESOTHO

1.2.1 Referral system in Lesotho

1.2.2 Maternal health problems in Lesotho

1.2.3 Involvement of community health workers

1.3 BACKGROUND TO THE PROBLEM

1.4 RESEARCH PROBLEM

1.5 GENERAL OBJECTIVE

1.5.1 Specific objectives

1.6 RESEARCH QUESTIONS

1.7 SIGNIFICANCE OF THE STUDY

1.8 CONCEPTUAL FRAMEWORK

1.8.1 The use of the model in the study

1.9 LIMITATIONS OF THE STUDY

1.10 DEFINITIONS AND CONCEPTS

CLARIFICATION

1.10.1 A dependent variable

1.10.2 Independent variables

1.10.3 Definition of terms

1.11 SUMMARY

1.12 ORGANIZATION OF THE STUDY
CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION 27

2.2 A CONCEPTUAL FRAMEWORK 29

2.3 THE ROLE AND PRACTICES OF TBAs IN THE PROVISION OF MATERNAL HEALTH

2.3.1 Antenatal care practices 34

2.3.2 Use of herbal medicines during pregnancy 36

2.3.3 Promoting adherence to taboos 37

2.3.4 Abdominal massage during pregnancy 38

2.3.5 Antenatal care practices in Lesotho 39

2.3.6 Delivery practices 42

2.3.7 Practices during third stage of labour 46

2.3.8 Delivery practices in Lesotho 46

2.3.9 Postnatal care 50

2.4 PROBLEMS TBAs EXPERIENCE IN THEIR PRACTICE 54

2.5 THE ROLE PLAYED BY THE HEALTH CARE SYSTEM IN SUPPORT OF TBAs' PRACTICE 57

2.5.1 Training of TBAs 57

2.5.2 Curriculum for TBAs in Lesotho 59

2.5.3 Length of training of TBAs in Lesotho 60

2.5.4 Supervision of trained TBAs 61

2.5.5 Supervision of TBAs in Lesotho 63

2.6 HISTORICAL BACKGROUND TO TRADITIONAL BIRTH ATTENDANTS IN LESOTHO ATTENDANTS IN LESOTHO 65
<table>
<thead>
<tr>
<th>2.7</th>
<th>RESEARCH ON PRACTICES OF TBAs IN LESOTHO</th>
<th>66</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.8</td>
<td>RECRUITMENT OF TRADITIONAL BIRTH ATTENDANTS</td>
<td>67</td>
</tr>
<tr>
<td>2.8.1</td>
<td>Becoming a TBA in Lesotho</td>
<td>67</td>
</tr>
<tr>
<td>2.8.2</td>
<td>Recruitment for training as a TBA in Lesotho</td>
<td>68</td>
</tr>
<tr>
<td>2.8.3</td>
<td>Characteristics of TBAs</td>
<td>69</td>
</tr>
<tr>
<td>2.8.4</td>
<td>Characteristics of TBAs in Lesotho</td>
<td>70</td>
</tr>
<tr>
<td>2.9</td>
<td>RELATIONSHIP WITH THE HEALTH STAFF AND CLINTELE</td>
<td>70</td>
</tr>
<tr>
<td>2.9.1</td>
<td>RELATIONSHIP WITH THE HEALTH STAFF AND CLINTELE IN LESOTHO</td>
<td>72</td>
</tr>
<tr>
<td>2.10</td>
<td>SUMMARY</td>
<td>74</td>
</tr>
</tbody>
</table>
### CHAPTER 3

**RESEARCH METHODOLOGY**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 INTRODUCTION</td>
<td>75</td>
</tr>
<tr>
<td>3.2 A HYPOTHESIS</td>
<td>75</td>
</tr>
<tr>
<td>3.3 STUDY TYPE</td>
<td>76</td>
</tr>
<tr>
<td>3.4 TARGET POPULATION</td>
<td>76</td>
</tr>
<tr>
<td>3.5 STUDY AREA</td>
<td>77</td>
</tr>
<tr>
<td>3.6 SAMPLING</td>
<td>77</td>
</tr>
<tr>
<td>3.6.1 Sample size for TBAs</td>
<td>77</td>
</tr>
<tr>
<td>3.6.2 Sampling procedure for selection of TBAs (both trained and untrained)</td>
<td>77</td>
</tr>
<tr>
<td>3.6.3 Sampling for nurses</td>
<td>79</td>
</tr>
<tr>
<td>3.6.4 Limitation in sampling</td>
<td>79</td>
</tr>
<tr>
<td>3.7 DEVELOPMENT OF QUESTIONNAIRES FOR TBAs NURSES</td>
<td>80</td>
</tr>
<tr>
<td>3.8 PERMISSION TO CONDUCT THE STUDY</td>
<td>82</td>
</tr>
<tr>
<td>3.9 PROCEDURES</td>
<td>82</td>
</tr>
<tr>
<td>3.10 PRE-TESTING OF THE QUESTIONNAIRE</td>
<td>83</td>
</tr>
<tr>
<td>3.10.1 Results of the pretest</td>
<td>84</td>
</tr>
<tr>
<td>3.11 DATA COLLECTION</td>
<td>86</td>
</tr>
<tr>
<td>3.12 VALIDITY AND RELIABILITY OF TOOLS</td>
<td>87</td>
</tr>
<tr>
<td>3.12.1 Validity</td>
<td>87</td>
</tr>
<tr>
<td>3.12.2 Reliability</td>
<td>88</td>
</tr>
<tr>
<td>3.12.3 Factors observed to ensure quality of data</td>
<td>90</td>
</tr>
<tr>
<td>3.13 DATA HANDLING AND QUALITY CONTROL</td>
<td>90</td>
</tr>
<tr>
<td>3.14 PLAN FOR DATA ANALYSIS</td>
<td>91</td>
</tr>
<tr>
<td>3.15 ETHICAL CONSIDERATION</td>
<td>91</td>
</tr>
<tr>
<td>3.16 SUMMARY</td>
<td>92</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

CHAPTER 4

ANALYSIS OF DATA OBTAINED FROM TBAs QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>INTRODUCTION</td>
<td>93</td>
</tr>
<tr>
<td>4.2</td>
<td>FINDINGS FROM DATA OBTAINED FROM TBAs</td>
<td>94</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Personal profile of TBAs</td>
<td>94</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Practice of TBAs</td>
<td>98</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Training of TBAs</td>
<td>102</td>
</tr>
<tr>
<td>4.2.4</td>
<td>Antenatal care provided by TBAs</td>
<td>109</td>
</tr>
<tr>
<td>4.2.5</td>
<td>Treatment of illness during the antenatal period</td>
<td>118</td>
</tr>
<tr>
<td>4.2.6</td>
<td>Labour</td>
<td>122</td>
</tr>
<tr>
<td>4.2.6.1</td>
<td>First stage of labour</td>
<td>122</td>
</tr>
<tr>
<td>4.2.6.2</td>
<td>Second stage of labour</td>
<td>131</td>
</tr>
<tr>
<td>4.2.6.3</td>
<td>Third stage of labour</td>
<td>135</td>
</tr>
<tr>
<td>4.2.7</td>
<td>Post partum care carried out by TBAs</td>
<td>143</td>
</tr>
<tr>
<td>4.2.8</td>
<td>Support and supervision of Traditional birth attendants</td>
<td>148</td>
</tr>
<tr>
<td>4.2.9</td>
<td>Informal discussions with TBAs</td>
<td>152</td>
</tr>
<tr>
<td>4.2.10</td>
<td>SUMMARY</td>
<td>155</td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>FINDINGS FROM THE NURSE QUESTIONNAIRE</td>
</tr>
<tr>
<td>5.1 INTRODUCTION</td>
</tr>
<tr>
<td>5.2 ANALYSIS OF DATA OBTAINED FROM NURSES</td>
</tr>
<tr>
<td>5.2.1 Involvement of community leaders in the selection of TBAs</td>
</tr>
<tr>
<td>Training of TBAs by nurses</td>
</tr>
<tr>
<td>Number of trained TBA in a year for initial training</td>
</tr>
<tr>
<td>Number of trained TBAs attending refreshers course in a year</td>
</tr>
<tr>
<td>Course content of the initial training programme for TBAs</td>
</tr>
<tr>
<td>Methods of teaching used for TBAs</td>
</tr>
<tr>
<td>5.2.3 Management of TBA programme</td>
</tr>
<tr>
<td>5.2.4 Support from health service area</td>
</tr>
<tr>
<td>5.3 SUMMARY</td>
</tr>
<tr>
<td>156</td>
</tr>
<tr>
<td>156</td>
</tr>
<tr>
<td>157</td>
</tr>
<tr>
<td>157</td>
</tr>
<tr>
<td>161</td>
</tr>
<tr>
<td>161</td>
</tr>
<tr>
<td>161</td>
</tr>
<tr>
<td>162</td>
</tr>
<tr>
<td>163</td>
</tr>
<tr>
<td>164</td>
</tr>
<tr>
<td>169</td>
</tr>
<tr>
<td>170</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER 6</th>
<th>FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>6.2</td>
<td>WHAT IS THE ROLE AND PRACTICES OF TBAs IN THE PROVISION OF MATERNAL HEALTH AT COMMUNITY LEVEL</td>
</tr>
<tr>
<td>6.2.1</td>
<td>Characteristics of TBAs</td>
</tr>
<tr>
<td>6.2.2</td>
<td>Practice of TBAs</td>
</tr>
<tr>
<td>6.2.3</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>6.2.4</td>
<td>Labour</td>
</tr>
<tr>
<td>6.2.5</td>
<td>Post partum care</td>
</tr>
<tr>
<td>6.2</td>
<td>WHAT ARE THE PROBLEMS TBAs EXPERIENCE IN THEIR PRACTICE</td>
</tr>
<tr>
<td>6.3</td>
<td>WHAT ROLE DOES THE HEALTH CARE SYSTEM PLAY IN SUPPORTING TBAs</td>
</tr>
<tr>
<td>6.4.1</td>
<td>Training of TBAs</td>
</tr>
<tr>
<td>6.4.2</td>
<td>Content of training course for TBAs</td>
</tr>
<tr>
<td>6.4.3</td>
<td>Refresher courses</td>
</tr>
<tr>
<td>6.4.4</td>
<td>Number of TBAs trained</td>
</tr>
<tr>
<td>6.4.5</td>
<td>Methods of Training TBAs</td>
</tr>
<tr>
<td>6.4.6</td>
<td>Selection of TBAs for training</td>
</tr>
<tr>
<td>6.4.7</td>
<td>Supervision of trained TBAs</td>
</tr>
<tr>
<td>6.4.8</td>
<td>Availability of delivery kits</td>
</tr>
<tr>
<td>6.4</td>
<td>CONCLUSIONS ON THE ROLE AND PRACTICES OF TBAs IN THE PROVISION ON MATERNAL HEALTH</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>PAGE</td>
</tr>
<tr>
<td>------------------</td>
<td>------</td>
</tr>
<tr>
<td>6.6  CONCLUSIONS ON PROBLEMS TBAs EXPERIENCE IN THEIR PRACTICE</td>
<td>197</td>
</tr>
<tr>
<td>6.7  CONCLUSIONS ON THE ROLE OF THE HEALTH CARE SYSTEM IN THE SUPPORT OF TBAs' PRACTICE</td>
<td>197</td>
</tr>
<tr>
<td>6.8  RECOMMENDATIONS ON THE ROLE OF TBAs IN THE PROVISION OF MATERNAL HEALTH</td>
<td>198</td>
</tr>
<tr>
<td>6.9  RECOMMENDATIONS ON SOME PROBLEMS TBAs EXPERIENCE IN THEIR PRACTICE</td>
<td>199</td>
</tr>
<tr>
<td>6.10 RECOMMENDATION ON THE ROLE OF THE HEALTH CARE SYSTEM IN SUPPORT OF TBAs' PRACTICE</td>
<td>199</td>
</tr>
<tr>
<td>6.11 LIMITATIONS OF THE STUDY</td>
<td>200</td>
</tr>
<tr>
<td>6.12 APPLICATION OF LEININGER'S SUNRISE MODEL</td>
<td>201</td>
</tr>
<tr>
<td>6.12.1 Cultural care preservation</td>
<td>204</td>
</tr>
<tr>
<td>6.12.2 Cultural care accommodation</td>
<td>205</td>
</tr>
<tr>
<td>6.12.3 Cultural care repatterning or restructuring</td>
<td>206</td>
</tr>
<tr>
<td>6.12.4 Assumptions linked to Leininger's theory</td>
<td>207</td>
</tr>
<tr>
<td>6.13 CONTRIBUTION OF THE STUDY TO NURSING</td>
<td>209</td>
</tr>
<tr>
<td>6.14 RECOMMENDATIONS FOR FURTHER RESEARCH</td>
<td>209</td>
</tr>
<tr>
<td>6.15 FINAL CONCLUSION</td>
<td>210</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>211</td>
</tr>
</tbody>
</table>

APPENDIXES

Appendix 1  TBA questionnaire
Appendix 2  Nurses questionnaire
Appendix 3  Request to the Ministry of Health to conduct a study
Appendix 4  Request to CHAL to conduct a study
Appendix 5  Request to HSAs to conduct a study
Appendix 6  Permission to conduct a study
**LIST OF FIGURES**

<p>| Figure 1.1 | Population distribution by geographical zones | 3 |
| Figure 1.2 | Health service areas in Lesotho | 8 |
| Figure 2.1 | Leininger's sunrise model depicting theory of cultural care diversity and universality | 28 |
| Figure 2.2 | Model of assessing the role of TBAs | 30 |
| Figure 4.1 | Age distribution of TBAs | 94 |
| Figure 4.2 | Occupation of TBAs by training | 96 |
| Figure 4.3 | Attendance of school by TBAs | 97 |
| Figure 4.4 | Travelling distance by TBAs | 99 |
| Figure 4.5 | First antenatal attendance by TBAs | 112 |
| Figure 4.6 | Delivery positions recommended by TBAs | 133 |
| Figure 4.7 | Examination of the placenta by TBA | 139 |
| Figure 6.1 | Application of the sunrise model to the role of TBAs | 203 |</p>
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Taboos in Lesotho</td>
<td>41</td>
</tr>
<tr>
<td>4.1</td>
<td>Place of practice of TBAs</td>
<td>100</td>
</tr>
<tr>
<td>4.2</td>
<td>The content of initial training course for TBAs</td>
<td>104</td>
</tr>
<tr>
<td>4.3</td>
<td>Content of refresher training courses for TBAs</td>
<td>107</td>
</tr>
<tr>
<td>4.4</td>
<td>Diagnosis of pregnancy by TBAs</td>
<td>109</td>
</tr>
<tr>
<td>4.5</td>
<td>A place where antenatal care is provided by TBAs</td>
<td>111</td>
</tr>
<tr>
<td>4.6</td>
<td>Antenatal care procedures done by TBAs</td>
<td>113</td>
</tr>
<tr>
<td>4.7</td>
<td>Health education given during pregnancy by TBAs</td>
<td>114</td>
</tr>
<tr>
<td>4.8</td>
<td>Frequency of visits done by TBAs</td>
<td>115</td>
</tr>
<tr>
<td>4.9</td>
<td>Conditions referred during antenatal care by TBAs</td>
<td>116</td>
</tr>
<tr>
<td>4.10</td>
<td>Use of herbs by TBAs for illness during pregnancy</td>
<td>118</td>
</tr>
<tr>
<td>4.11</td>
<td>Duration of labour considered acceptable by TBAs</td>
<td>124</td>
</tr>
<tr>
<td>4.12</td>
<td>Fluids given by TBAs during labour</td>
<td>125</td>
</tr>
<tr>
<td>4.13</td>
<td>Cleaning the vulva of the women in labour by TBAs</td>
<td>127</td>
</tr>
<tr>
<td>4.14</td>
<td>Washing hands by TBAs during labour</td>
<td>128</td>
</tr>
<tr>
<td>4.15</td>
<td>The stage at which TBAs encourage women to bear down in labour</td>
<td>131</td>
</tr>
<tr>
<td>4.16</td>
<td>Maternal signs indicating that birth is eminent</td>
<td>132</td>
</tr>
<tr>
<td>4.17</td>
<td>Procedures done by TBAs after delivery</td>
<td>136</td>
</tr>
<tr>
<td>4.18</td>
<td>Management of a retained placenta by TBAs</td>
<td>140</td>
</tr>
<tr>
<td>4.19</td>
<td>Methods used by TBAs to resuscitate the baby</td>
<td>142</td>
</tr>
<tr>
<td>4.20</td>
<td>Time at which first home visits are done by TBAs after delivery</td>
<td>143</td>
</tr>
<tr>
<td>4.21</td>
<td>Duration of postpartum care given by TBAs</td>
<td>144</td>
</tr>
<tr>
<td>4.22</td>
<td>Postnatal care activities performed by TBAs</td>
<td>145</td>
</tr>
<tr>
<td>4.23</td>
<td>Initiation of breast feeding by TBAs</td>
<td>146</td>
</tr>
<tr>
<td>4.24</td>
<td>Contents of a delivery kit used by TBAs</td>
<td>148</td>
</tr>
<tr>
<td>4.25</td>
<td>Herbal medicines used during pregnancy and labour</td>
<td>154</td>
</tr>
<tr>
<td>5.1</td>
<td>Means of contact with the clinic nurse if a TBA has a problem</td>
<td>160</td>
</tr>
<tr>
<td>5.2</td>
<td>Course content of the initial training programme for TBAs</td>
<td>162</td>
</tr>
<tr>
<td>5.3</td>
<td>Types of cases referred to nurses by TBAs</td>
<td>167</td>
</tr>
<tr>
<td>5.4</td>
<td>Supervisors of nurses</td>
<td>169</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION AND GENERAL BACKGROUND

1.1 INTRODUCTION

Traditional Birth Attendants (TBAs) have been providing health care in child birth for many decades in Lesotho and continue to do so to date. It is widely held that two-thirds of all live births in Lesotho are delivered by TBAs. These midwives are not trained in western midwifery but rather in a traditional system of birth (Clarke & Lephotse 1989:1). The women's health survey reported a gradual increase of facility based deliveries from 40 percent to 51 percent (MOH 1995:52).

A study by the United Nations Children’s Fund (UNICEF) (1998:44) found that trained TBAs supervised 50.3 percent of deliveries in Lesotho while 84 percent of home deliveries were supervised by untrained TBAs. A further analysis of who supervised the deliveries of 235 children born after 1995 showed that untrained TBAs supervised 30.2 percent of them.
The rapid evaluation method on maternal and child health care (REM) conducted by the Ministry of Health (MOH) in Lesotho found that TBAs in Lesotho gave advice on complications that arose from pregnancy, delivered women at home and referred them to health facilities when complications occurred (MOH 1993:92). Clarke and Lepoto (1989:1) report that TBAs in Lesotho do not only assist in childbirth. Many TBAs are healers and care for and advise women right through their reproductive years. They also give advice on child-care, infertility and traditional forms of child spacing.

TBAs represents an important resource for primary health care in many developing countries. Training programs to upgrade TBAs’ skills are common and are encouraged by the World Health Organisation (WHO). This training varies with the resources of individual countries and the health beliefs and practices of local people (Sparks 1990:156).

It was the realisation of the importance of the role TBAs played in their communities, that the Government of Lesotho (GOL) embarked on the training of TBAs. The purpose of the training was to upgrade TBAs’ skills, enable them to assess high risk pregnant mothers and refer them to appropriate health facilities, conduct clean safe deliveries, with an ultimate goal of reducing maternal morbidity and mortality in Lesotho (UNICEF & PHAL 1988:4).
Map 2.1 1996 population by geographical zones

LESOTHO

BOUNDARIES
International
District

Topographic Regions of Lesotho

Lowlands
Foothills
Mountains
Senqu River Valley

Kingdom of Lesotho census 1996 : 25
1.1.1 Geography

Lesotho is a mountainous country, wholly surrounded by the Republic of South Africa (RSA). The geographical area is approximately 30,350 square kilometres, the topography ranges from 1,500 and 2,000 metres above sea level in the western lowlands and the foothills and rises to 3,500 metres above sea level in the eastern mountains. The mountainous area occupies 75 percent of the entire land area with the most difficult terrain as can be seen in figure 1.1. The climate is temperate characterised by very cold winters, rainfall occurs mainly between the months of October and April (MOH, WHO & UNICEF 1993:3).

The Lesotho’s difficult terrain poses a problem of access to health care services particularly for pregnant women. They find it difficult to attend maternal services due to long distances they have to travel to reach available health care facilities, for this reason utilisation of TBAs is very significant in the underserved and remote areas of Lesotho.

MacCarthy and Maine (1992) in (Kinoti & Mpanju 1993:49) describe the importance of access to essential maternity services. They indicate that in developing countries 60 to 90 percent of the population live in rural areas, whilst most of the adequately and well staffed medical institutions are located in the urban areas. Most of the maternal deaths seen in the rural areas can be attributed to long distances which women have to travel to reach health services. Access to health services is much broader than physical distances. Access includes poor roads, climatic condition that permit seasonal travel only and poor or non-existent public transport.
1.1.2 Population in Lesotho

Lesotho has a population of 1.9 million people, 23.5 percent of whom are women of reproductive age (15-49 years) this group forms 45 percent of the total female population. Total fertility is currently at 4.1 births per woman, which indicate a decline from 5.3 from the 1986 census (Kingdom of Lesotho census 1996:51).

The Basotho are still largely rural people, with 83 percent of them living in the rural villages as can be seen from figure 1.1. The current annual growth is estimated at 2.45 percent. The infant mortality is estimated at 74 per 1,000 live birth (Kingdom of Lesotho census 1996:33), and maternal mortality was estimated to be 280 per 100,000 live births by the REM (1993) in (MOH,WHO & UNICEF 1993: 2).

1.1.3 Economy

Lesotho has a limited economical resource base. Lesotho's greatest natural asset is its water resources now being developed through the Lesotho Highlands Water Project (LHWP) which entails transference of water to the Republic of South Africa (RSA) and generation of electricity for Lesotho. Agriculture is the main economical activity that, includes farming and husbandry (MOH & WHO 1997:9).
The population depends on low productivity subsistence farming that accounts for a declining 20 percent of the gross domestic product (GDP), unemployment is estimated at 30 to 40 percent. Increasing numbers of mine workers are being retrenched annually from the South African mines. The largest item of revenue accruing to the government of Lesotho is derived from the Southern African Custom Union, a customs protocol negotiated among RSA, Botswana, Lesotho and Swaziland (MOH & WHO 1997:9).

Due to pressure from the world bank and International Monetary Fund (IMF) Lesotho adopted a three-year program of structural adjustment (1989 to 1991) this included policies to improve collection of revenues and productivity. As a result of increased fees for health services, a temporary drop in the utilisation of health services particularly in the mountain health services was experienced (MOH,WHO & UNICEF 1993:2).

The ministry of health in Lesotho is allocated 8 to 9.9 percent of the total national budget. The ministry of defence and education get much larger shares in comparison to other ministries (Kingdom of Lesotho 1996: 43). With the fall of Lesotho's economy, health services have become unaffordable to those in need, women deliver and manage pregnancy ailments at home sometimes with drastic consequences.
1.1.4 **Education.**

The primary health care review in Lesotho found that education policies favoured the provision of basic education to all, such that the country has a high adult literacy rate of 72 percent. This is particularly significant for community based health development. The same review revealed that almost all community health workers interviewed could communicate in English (*if they wanted to*) (MOH & WHO 1997:10).
A MAP OF HEALTH SERVICE AREAS IN LESOTHO

Figure 1.2: Health service areas in Lesotho

1.2 HEALTH CARE SYSTEM IN LESOTHO

The Ministry of Health (MOH) in Lesotho is the national body responsible for all health activities in Lesotho. The Minister assisted by the Principal Secretary for Health heads the ministry. The ministry has direct responsibility over public institutions hospitals and clinics. In addition to these curative institutions the ministry of health runs preventive programmes such as the maternal and child health programme which provides family planning, antenatal care (ANC) post natal care (PNC) and under five services (GOL & UNICEF 1994:6).

Access to health services particularly to the rural population, remains a big challenge to the Government of Lesotho due to the difficult terrain. After the Alma Ata declaration of "Health For All by the year 2000" the Government through the ministry of health, in March 1979 established nineteen Health Service Areas (HSAs) as a framework for decentralised provision of health services, in an effort to ensure accessibility of health services in Lesotho (see figure 1.2 a map depicting the health service areas).

Each HSA consists of:

- an HSA hospital which may be government or non-governmental.
- health centres around the particular hospital irrespective of the ownership.
- health centres are supported by village health workers (VHW) and TBAs at the community level.
- village health posts are run by VHW visited by the health centre nurse monthly.
The nineteenth HSA is the Lesotho Flying Doctors Service (LFDS) based in Maseru and responsible for the supervision of 12 health centres in the inaccessible mountain areas, using light aircraft under mission aviation (GOL & UNICEF 1990: 7). The Government of Lesotho and the Private Health Association of Lesotho (PHAL) run the health care provision in Lesotho in partnership, about 60 percent of health centres are owned by this organisation. (GOL & UNICEF 1994: 86).

Lesotho has 169 health centres 50 percent of which belong to non-governmental organisations and the rest belong to government. The Government of Lesotho’s target is to ensure access to a clinic within two hour’s walk, but this is not always the case particularly in the mountain areas. Every health centre or clinic should be professionally staffed by a nurse clinician, a nursing sister and a nursing assistant, but frequent shortage of nursing personnel means that this is not possible (GOL & UNICEF 1994: 87). The health centre system is run by nurse clinicians and supervised by public health nurses and doctors on a monthly basis.

1.2.1 Referral system in Lesotho

The referral system is clearly defined through the HSA concept, which is based on a pyramid. At the bottom of the pyramid are community health workers who were intended to refer patients to health centres but this almost never happens. Instead patients present themselves to health centres. Health centre nurses refer patients to HSA hospitals. For serious cases HSA hospitals refer patients to Queen Elisabeth II hospital (QEII) a national referral hospital in Maseru.
If Queen Elizabeth II hospital cannot deal with a case, then the patient is referred to Pelonomi hospital in Bloemfontein South Africa. In the year 1991-92 there were 514 referrals to Pelonomi the majority of which were cancer, cardiac problems, renal failure, and neurological disorders (GOL & UNICEF 1994:88).

1.2.2 Maternal health problems in Lesotho

The most common health conditions affecting women, are pregnancy related conditions and sexually transmitted diseases including HIV/AIDS which is growing at an alarming rate, hypertension and other infectious diseases such as tuberculosis (GOL & UNICEF 1994:88). The HIV/AIDS epidemic is taking its toll on young people particularly young women. The incidence of AIDS among the 20 to 39 years age group contributes to 57 percent of reported cases. Female AIDS cases are higher than male cases. It should be noted that the progression from HIV infection to a full-blown status of AIDS is higher among women than men because women by their make are vulnerable to sexually transmitted diseases and HIV infection, for example:

- women are receptive partners during sex. Infected semen is deposited in the vagina and remains there for some time, which gives the virus the opportunity to gain entrance into the body

- sexually transmitted diseases in women often go unnoticed or hidden and therefore they may not seek treatment
menstruation results in a large, raw exposed area of the inner uterine lining which makes the transmission of HIV easier before, during and immediately after menstruation (Ministry of Health 1998 (a):13)

The evaluation of maternal health services by the MOH, WHO & UNICEF (1993:26) found that the most frequent causes of morbidity during pregnancy among 86 women interviewed were:

- vaginal discharges 24 percent
- pregnancy induced hypertension 18.76 percent
- other conditions not described in the study accounted for 22 percent
- pain in general was 24 percent

The inpatient data gathered centrally by the ministry of health statistics unit sometimes may not be reliable due to irregular reporting from hospitals. GOL & UNICEF (1994:196) reported ante partum haemorrhage, post partum haemorrhage, hypertension and uterine rupture as the common causes of admission among women.
The ministry of health's out patient morbidity report (1998(b): 2) showed that the maternal conditions often reported were:

- normal pregnancy 3.75 percent that is 35,771 women presenting in the out patient department
- hypertension in pregnancy was 0.12 percent 1,117 pregnant women
- other complications of pregnancy were 0.47 percent 4,459 pregnant women
- complications of delivery accounted for 0.14 percent 1369 deliveries

The data indicate that pregnancy induced hypertension is still a major problem among women during pregnancy.

1.2.3 Involvement of community health workers

The Community Health Worker (CHW) program was adopted as a national strategy for Primary Health Care (PHC) in 1979 after the Alma Ata declaration of “Health For All by the year 2000”. It was felt then that the program if properly implemented would be crucial to Lesotho in attaining its PHC goals.
It was after the Alma-Ata declaration and adoption of CHW program, that the program was jointly supported by the Government of Lesotho (GOL), Private Health Association of Lesotho (PHAL) and UNICEF (GOL & UNICEF 1994: 9).

Each village has at least one community health worker. These workers are unpaid individuals nominated by their communities and have been given basic training in health care. The community health workers' Census showed that there were 2041 Traditional Birth Attendants (TBAs) 1522 (74.57%) of the TBAs were active, while 519 (25.43 %) were inactive according to the census (MOH 1992:15).

To ensure access to health services and an understanding of good health practice, there was a need for a strong cadre of community health workers who could be in closer and more frequent contact with the community and seen as point of contact with the health care system. In order to deliver health services to all, the government of Lesotho embarked on the training of health professionals that is the nurses, doctors, dentists, pharmacists and others. However, most of these professionals, left in search for better working conditions in South Africa (GOL & UNICEF 1994:90).

To reach the rural population Lesotho like many other governments has utilised community health workers to provide health care services to these people.
The community health workers were originally intended to be the first source of medical help and to play an important role in their communities in sanitation, nutrition, antenatal care (ANC), immunization and family planning. Community health workers in Lesotho have been issued village registers to record and standardize data collection at the community level. These registers record births, deaths and children's nutritional status (GOL & UNICEF 1994: 89)

1.3 BACKGROUND TO THE PROBLEM

Existing facilities in Lesotho like in other developing countries lack a full complement of personnel and equipment. With the lack of adequate facilities and the inadequate access to health services, there is little question that improved maternal and child health care, can be most realistically achieved by utilisation of locally trained community health workers (GOL & UNICEF 1994:85).

The evaluation of maternal and child health care (MOH 1993:24) showed that 90 percent of pregnant mothers in Lesotho attend antenatal care (ANC) in health facilities but only 50 percent of women choose to deliver their babies in these health facilities. The remaining 50 percent deliver at home, of which 26 percent is delivered by trained TBAs, 20 percent by untrained TBAs and 54 percent is delivered by relatives.

It is very clear from the available data that many women are exposed to unsafe deliveries by untrained personnel and this has adverse consequences on both the health of the mother and her child when complications arise.
Because of many deliveries that are supervised by untrained TBAs at home, the ministry of health in the implementation of PHC embarked on the training of TBAs as a necessary strategy to reduce maternal morbidity and mortality (MOH, WHO & UNICEF 1993:26).

In Mokhotlong one of the rural district in Lesotho, Kamphost (1993:25) found that only 25 percent of women delivered in health facilities, many women lived too far to reach a facility in time for obstetric assistance if complications developed during labour. TBAs conducted most of the deliveries in the area. In the same study Kamphost (1993:25) reported that Mokhotlong HSA had no reliable information on maternal mortality, but referrals of ruptured uterus, obstructed labour and haemorrhage in late stages could not give an optimistic estimate. He reported on the worst experience where the neighbours and TBAs struggled for three days to remove a retained placenta.

The ministry of health’s study on factors influencing poor referral of obstetric emergencies in Lesotho, found that the performance of TBAs was the same regardless of whether they were trained or not. But trained TBAs referred more cases than the untrained. The untrained managed even the most complicated emergencies such as antepartum haemorrhage, obstructed labour, malpresentation (by external and internal version) and retained placenta.

The study concluded that this indicated lack of knowledge in recognition of risk or complications and the use of harmful practices in management of complications (MOH 1994:20).
A multi centre study on risk factors associated with maternal mortality in Lesotho, Malawi, Uganda and Zambia showed that women who died had more difficulties of access to services in terms of distance, transport and cost. Further more of these women tended to use TBAs in the event of illness during pregnancy (Kinoti & Mpanju 1994:71).

Kinoti and Mpanju (1994:71) showed a 3.6 risk (odds ratio) of maternal death if a woman had been initially attended to by a TBA as the first contact prior to admission and the risk of maternal death was 4.3 greater, if a woman was delivered by a TBA compared to delivery by a nurse midwife. The study concluded that maternal mortality and morbidity were higher among women cared for and delivered by TBAs.

This suggested inadequate or lower care provided by the TBAs. However, the study did not differentiate performance of trained TBAs from the untrained, and did not collect enough data to demonstrate the causes of death and morbidity attributable to TBAs.

The knowledge and skills of TBAs in the provision of antenatal care and performance of a delivery are essential, because it is only on the basis of a sound obstetric knowledge and the ability to recognise risk factors or complications that a TBA can make a decision to refer cases to a health centre in time.

However, referral for risk pregnancies and obstetric emergencies can only be effective if there is a well-established functioning referral system. An inadequate referral system and delays in providing prompt care at the hospitals can negate the possible benefits of pre-natal care at the hospitals (Royston & Armstrong1989: 160).
Nurses can maintain the new skills and knowledge that TBAs receive from training through supervision, although it has been shown that there is inadequate supervision of TBAs by health centre nurses. In some cases supervision is absent. In the absence of support and supervision, TBAs cannot maintain safety standards and skills in their practice (MOH & WHO 1997:3).

TBAs will always exist in Lesotho and will continue to serve pregnant mothers within their communities. They are seen as authorities in their communities and have great influence on the health care seeking behaviour of pregnant mothers (UNICEF & PHAL 1988:4).

It is on the basis of these issues that an assessment of the role and practices of TBAs was undertaken, for the purpose of generating the necessary information that can assist in designing appropriate TBA programs and improve their performance.

1.4 RESEARCH PROBLEM

Some women in Lesotho deliver at home and the majority of these home deliveries are supervised by untrained personnel, in spite of the availability of trained TBAs. It is among home deliveries that complications are often mismanaged and referrals delayed when an emergency arises. The health professionals attribute these to ignorance and traditional practices of TBAs, which they themselves may be unfamiliar with hence there is a need to understand the practices and the role TBAs play in the provision of maternal health care.
1.5 GENERAL OBJECTIVE

The general objective of this study was to assess the role of TBAs and the problems related to their performance and practice in maternal health care at the community level, for the purpose of strengthening TBA training programs.

1.5.1 Specific objectives.

The specific objectives of the study were to:

1. assess the role and practice of TBAs in the provision of maternal health in the two northern districts of Lesotho namely Leribe and Butha-butha

2. identify problems related to the role and practices of TBAs

3. determine the role of the health care system in the support of TBAs' practices.

1.6 RESEARCH QUESTIONS

On the basis of the objectives of the study the research questions were as follows:

■ What is the role and practices of TBAs in the provision of maternal health at community level?

■ What are the problems TBAs experience in their practice?

■ What role does the health care system play in supporting the practice of the Traditional Birth Attendants?
1.7 SIGNIFICANCE OF THE STUDY

Given the present status of home deliveries in Lesotho which are supervised by untrained TBAs and characterised by mismanagement of complications, it is important to understand the present TBA practice, reinforce beneficial practices and gradually eliminate harmful ones through relevant and appropriate training programmes.

1.8 CONCEPTUAL FRAMEWORK

The study utilises the sunrise model by Leininger (theory of cultural care diversity and universality) to assess the role of the traditional birth attendants in maternal health care, which is based on the premise that people of each culture defines the ways in which they experience and perceive their health care world and can relate these experiences and perceptions to their general health beliefs and practices. Based upon this premise, health care is derived and developed from the cultural context in which it is provided (George 1995: 379). "Emphasis is given to historical, social and cultural context of human beings in order to explain and predict the broad dimensions of human care behaviour" (Fitzpatrick & Whall 1996:184).
1.8.1 The use of the model in the study

The role of the traditional birth attendant was assessed based upon some assumptions described by Leininger in her theory of cultural care diversity and universality.

Assumptions

- TBAs can be viewed as a social cultural institution, which has survived within a culture through time.

- TBAs represent a generic system or indigenous, traditional system, based on"" the values, beliefs and life-style of people from diverse cultures’’ (Fitzpatrick & Whall 1996:184)

- From understanding the cultural beliefs, practices and values (*cultural and social structure dimensions embedded in their worldview*) of the TBAs in maternal health provision, nursing can ensure that TBAs provide cultural congruent care. Cultural congruent care can be provided through the three modes of nursing care decisions and activities namely *cultural care repatternig, cultural care accommodation and cultural care preservation*. This is the central goal of Leininger’s theory of culture care diversity and universality as depicted in the sunrise model (George 1995:376-7).

- The role of a nurse as link between the two health care systems namely the traditional midwifery and professional midwifery.
1.9 LIMITATIONS OF THE STUDY

The results of the study cannot be generalised to the whole country since the study focused mainly on the two districts in the northern region of Lesotho.

1.10 DEFINITIONS AND CONCEPTS CLARIFICATION.

1.10.1 A dependent variable

A dependent variable in the study is the role of TBAs and the indicators are performance of activities such as safe deliveries, provision of antenatal care, assessment of risk, timely interventions during obstetric emergencies and postpartum care.

1.10.2 Independent variables

Factors, assumed to influence the role of traditional birth attendants are:

- Cultural beliefs and values associated with care during pregnancy and childbirth, within communities served by TBAs. These were measured by questions that addressed rituals, taboos, perceptions, and norms pertaining to childbirth.

- A number of supervisory visits, venue, and types of activities undertaken during the visit by the health centre nurse measured supervision of trained TBAs.

- Assessment of risk was measured by asking questions that elicited knowledge of risks during pregnancy and during labour and delivery.
Availability of supplies and equipment (delivery kit and contents) was measured using a checklist and observation to validate the availability and also the functioning of the delivery kit. Questions were asked to ascertain frequency of replenishment of supplies, and replacement of non-functioning equipment.

Community involvement was assessed by finding out what the community and their leaders do to support TBAs as well as determining their role in the selection of TBAs for training.

1.10.3 Definition of terms

**Antenatal care:** Antenatal care refers to the care given to a pregnant mother, to ensure that a woman reaches the end of her pregnancy physically and emotionally prepared for her delivery.

**First of stage of Labour:** First stage of labour begins with regular rhythmic contractions and is complete when the cervix is fully dilated.

**Labour:** Labour is described as the process by which the foetus, placenta and membranes are expelled through the birth canal.

**Maternal health care:** Maternal health care refers to health care provided to women during pregnancy, delivery and after delivery.
**Normal labour:** Normal labour occurs at term, is spontaneous in onset with the foetus presenting by the vertex. The process is completed within 18 hrs and no complication arise.

**Nurse clinician:** A registered nurse is someone who in addition to basic nursing training has undergone training in diagnostic skills and is registered with the Lesotho Nursing Council.

**Nurse midwife:** A nurse midwife is someone who has undergone specific training in general nursing and midwifery and is registered with the Lesotho Nursing Council and functions in a health centre.

**Post partum period or puerperium:** Is a period of 6 weeks, which begins as soon as the placenta is expelled. During this time physiological and psychological changes take place.

**Public health nurse:** A public health nurse is a registered nurse who in addition to basic nursing training has undergone training in public health and is registered with the Lesotho Nursing Council.

**Role:** In the context of this study a role is defined as the functions and responsibilities a TBA carries out and is expected to undertake in her practice.

**Second stage of labour:** Second stage begins when the cervix is fully dilated and is completed when the baby is completely born.
Third stage of labour: Third stage is that of separation and expulsion of the placenta and membranes and also involves the control of bleeding. It lasts from the birth of the baby until the placenta and membranes have been expelled.

Traditional Birth Attendant: A "TBA" is defined as a mature woman who is a well known village resident and well accepted by the community for her able skill in performing home deliveries, some TBAs are trained some are not.

1.11 SUMMARY

This chapter is an overview of the study. The overview includes an introduction to the involvement of TBAs in the provision of maternal health within the environmental and socio-cultural context of Lesotho. It also includes problems facing women, and the interventions undertaken by TBAs during an obstetric emergency are discussed. The overview further outlines the research problem, research questions, the purpose and objectives of the study. The concept clarification and definitions for the study are stated.
1.12 ORGANISATION OF THE STUDY

Chapter one: Overview of the study, gives an overview and motivation for the study

Chapter two: Literature review is an in depth study on the literature related to the topic, to give the researcher information on previous research conducted.

Chapter three: Research methods indicate the planning phase of the research to ensure that valid and reliable data is collected.

Chapter four: Presentation of findings from TBAs questionnaire are discussed and contrasted with the literature studied, using tables and figures to present the analysis.

Chapter five: Presentation of findings from nurses questionnaire, gives an overview of the role played by nurses to support TBAs using training program.

Chapter six: Discussions, summary, conclusions and recommendations, based on the data collected and analysed are given. The application of the theoretical framework to the findings were given.

The next chapter will provide a comprehensive review of related literature.
CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of the literature review was to obtain information from other research findings on the subject of TBAs and to use this information to identify commonalties and diversities.

The University of South Africa (UNISA) provided assistance in the literature search. Some literature was obtained from other Universities through, popline and medline data bases. The ministry of health in Lesotho and WHO provided information that was useful in providing an overview of a TBA programme in Lesotho.

The research questions were used as the basis for the literature review.
LEININGER'S SUNRISE MODEL TO DEPICT THEORY OF CULTURAL CARE DIVERSITY AND UNIVERSALITY

Figure 2.1 Leininger's sunrise model depicting theory of cultural care diversity and universality

Source: GEORGE 1995: 378
2.2 CONCEPTUAL FRAMEWORK

The study utilises as a basis Leininger sunrise model that depicts her theory of culture care diversity and universality. The theory will assist the researcher to understand better the role played by TBAs in maternal health care and their relationship with the health care system from the TBAs' worldview, social structure and their environmental context.

The major component of Leininger's theory as depicted in the model shows the interrelated components of the worldview, culture and social structure dimensions within the context of language and environment as they influence care patterns and expressions.

Leininger (1978) in George (1995:381) discusses with concern culture shock or culture imposition, which she refers to as "efforts of an outsider, both subtle and not subtle to impose his or her own cultural values, beliefs and behaviours upon an individual, family, or group from another culture". This can be overcome through development of knowledge about cultures, people and care systems. The main focus of the sunrise model is the client, families and communities. Hence there is a need to know the culture of TBAs before embarking on their training.

The major goal of the model is provision of culturally congruent care, which is achieved through three nursing modes of decision and actions which are: cultural care preservation, cultural care accommodation and cultural care repatterning (Spangler1992:29). The nursing modes to guide actions and decisions in providing cultural congruent care are displayed in figure 2.2 and they comprise the following:
APPLICATION OF LEININGER’S SUNRISE MODEL

Culture care preservation
Untrained TBAs

Retain and Protect care
Values to Maintain Health and Recover illness

Assistive Supporting Facilitative Enabling Actions And decisions

Adapt and Negotiate For beneficial Or satisfying Health outcomes

Help client to reorder, change, modify lifeways to new, different beneficial care patterns, respecting clients values and beliefs: Providing more beneficial lifeways

Culture care repatterning
Trained TBAs

Figure 1.3 model of assessing the role of TBAs
Figure 2.2 depicts how the assessment of the role of TBAs in the provision of maternal health was done based on Leininger’s assumptions of the theory of cultural care diversity and universality described in chapter 1. The model shows how the major components of Leininger’s theory are applied in the study.

**Cultural care preservation or maintenance:** in the context of this study refers to the maintenance, through supervision, refresher courses for trained TBAs, while on the other hand it refers to preservation of TBAs’ tradition of childbirth, through passing over the skill to younger generations in apprenticeship.

**Cultural care accommodation:** in this phase TBAs are assisted by the professional actions and decisions of the nurse to adapt or to negotiate the acceptance for a more beneficial way of performing deliveries. Nurses should therefore, ensure that the environment in which they train TBAs are conducive to accommodation and negotiation and that the scientific concepts of professional midwifery are adapted to concepts that can be understandable to TBAs. Nurses can also assist the untrained TBAs to retain and preserve care values to maintain health and recovery from illness (Fitzpatrick & Whall 1996:185).

**Cultural care repatterning:** this action refers to training of TBAs. From understanding TBAs’ cultural values, and practices their training could be adapted to their needs, without imposition of a foreign western training of midwifery so that they can provide culturally congruent care (George 1995:382).
Another dimension of Leiningers' theory is to discover knowledge derived from *folk* (generic) and *professional health systems*. Leininger (1991) in George (1995:376) describes folk or generic health system, which refers to the indigenous care, and cure practices provided by local or folk healers, known and protected within their communities.

In contrast, the professional health care system refers to care or cure services provided by persons who have been formally educated and prepared, usually according to prescribed professional curricula which usually include academic and hospital clinical experience. These systems were predicted by Leininger (1991) in Spangler (1992:29) to be different and a source of conflict.

In the context of this study, the relationship between the traditional birth attendants and the health care system was examined against the assumption that all cultures have generic or folk health practices, and that professional practices usually vary across cultures and that in any culture there will be cultural similarities and differences between the care receivers and the care givers.

The nurse who trains these TBAs serves as a link between the two health care systems namely traditional midwifery and professional midwifery. The nurse can help TBAs to understand the modern medical system and assist them to retain their care values to maintain health and recover from illness. TBAs in turn assist the nurses to understand the needs of the community. TBAs should be seen as providing care that is an expression of, or influenced by the cultural care worldview and social structure dimensions.
2.3 THE ROLE AND PRACTICES OF TBAs IN THE PROVISION OF MATERNAL HEALTH

The World Health Organisation (WHO) believes that the health of mothers and babies can be improved by giving TBAs special training and support to enable them to carry out their activities with greater safety. This is seen as one of the most cost-effective approaches to reducing maternal and infant mortality and morbidity (Safe motherhood newsletter 1990: 192).

In the developing world or countries it is estimated that 60 to 70 percent of deliveries are assisted by TBAs and it will be some time before there are enough trained personnel to provide maternal health services. Given this situation and the scarcity of health services, integration and recognition of TBAs into primary health care has received increasing attention as a necessary strategy (Safe motherhood newsletter 1990: 192).

Almost all countries have embarked on training of TBAs. Some TBA evaluations suggest that the training has been effective but the impact on maternal and infant mortality is unknown (Safe motherhood newsletter 1990: 192).
2.3.1 Antenatal care practices

Antenatal care is one of the most effective interventions for the prevention of maternal mortality and morbidity, particularly in places where the general health status of women is very poor. Antenatal care has several functions, for example, promotion of health during pregnancy through advice and health education as well as the screening and identification of women with risks and referral if the need arise.

The main purpose of screening for risk factors is to detect those women who are more likely than others to have an adverse outcome of pregnancy and to refer them to a more skilled and better equipped level of care during the antenatal period. It also ensures safer management of potentially difficult labour, and aims to provide regular screening because women may develop risk factors late in pregnancy.

Cephalo-pelvic disproportion and inefficient uterine action are two of the biggest obstetric problems in African primigravidae and primiparas. The high incidence of vesico-vaginal fistulae, ruptured uteri and maternal mortality bear testimony to this. TBAs can help reduce tetanus and other infections by adopting hygienic measures. They cannot do anything about obstructed labour and malpresentations, but they can be trained to recognise complications early and refer promptly (Williams, Baumslag & Jellife 1994:222).
The role of a TBA in the provision of antenatal care differs from community to community but some similarities can be identified. In Ghana an evaluation on the potentials of a trained traditional birth attendant to reduce maternal mortality found that TBAs during pregnancy visited the pregnant mother, the visits ranged from daily to monthly from the third to the eighth month of pregnancy. A simple obstetrical history was taken, woman were examined and nutritional advice given (Eades, Brace, Osei & Languardia 1993:1503-7).

In Guatemala a study on the beliefs and birthing practices of TBAs showed that TBAs visited their clients during the prenatal period. However, the visits began late and were not regularly scheduled. The midwives purpose of the visit was to perform an abdominal examination and massage. She would attempt to turn the baby if in a breech or transverse position. Massage was performed repeatedly in the weeks and months before delivery, with daily massage there was a high rate of successful versions reported (Lang & Elkin 1997:27).

In a pregnancy monitoring study conducted on 8034 hospitals and TBAs’ deliveries in the Kawara Health Zone, Zaire from 1984 to 1986 an assessment of trained TBAs was done with emphasis on hospital referral and interventions they made. It was found that TBAs are often confused about assessment of risk during pregnancy and about indication of referral for acute delivery complications. They often lack authority and plans for referral in the event of an emergency (Hermann & Duale 1990:66).
A TBA has very limited training and therefore she has limited skills to identify risk factors and make judgement on how serious an indication may be for future problems. Therefore, will need a different referral protocol from someone with deeper knowledge and better judgement).

2.3.2 Use of herbal medicines during pregnancy.

The use of herbal medicines forms an important part of the TBAs prenatal care. These medicines are usually made from the roots, bark or leaves of locally available plants this practice has been reported from Kenya, Malawi Zimbabwe and in South Africa among the Sothos, Zulus and Xhosas (Lefeber 1994:15).

Herbal medicines serve different purposes such as treating abdominal pain, preventing abortions, ensuring safe pregnancy, keeping the foetus slim, making the pregnant woman strong, enlarging the birth canal and enhancing stronger contractions during labour. A large number of herbal medicines serve the purpose of correcting either constipation or diarrhoea conditions. People are usually concerned with a dirty stomach, which is described as a condition of having no bowel movement. This is of particular concern to a pregnant mother, as the gastro-intestinal tract and the uterus are believed to be connected organs according to Bullough & Leary (1982) in Lefeber (1994:16).

Sparks (1990: 154) reports that in Zimbabwe a woman is given a special drink believed to open and widen the pelvis for birth. The TBA also stretches the vagina manually. The TBA lubricates her hand with a soapy leaf called sepo. She introduces several fingers into the vagina and gently stretches the vagina.
The process is repeated many times on subsequent days until the TBA can insert the entire hand to make a fist and gently withdraw it.

2.3.3 Promoting adherence to taboos

People believe in witches and bad influences from a supernatural world and precautions must be taken in order to protect the mother and the foetus against these forces. Chalmers (1991:226) reports on some taboos imposed on pregnant mothers in South Africa, for example:

- A woman should not move on certain pathways that harbour the evil spirits of wizards or witches that may harm the baby.
- Plaiting of hair may form knots in the umbilical cord.
- If a woman sleeps during the day, the baby may sleep on its delivery day.
- Peeping through windows or doors may make the foetus’s head protrudes and recedes but not proceed through the vaginal canal at delivery.

In Kenya mothers are advised to avoid intercourse during pregnancy as it may cause either neonatal vomiting or a lot of semen covering the baby’s skin at birth according to Solomon & Rogo (1989) in Lefeber (1994:18). This has also been reported by Chalmers (1990:226) in South Africa.
In Zimbabwe there is a delay in the announcement of pregnancy, it is believed this helps to avoid jealous or malevolent witches who could jinx the pregnant woman. As a further effort to avoid danger during pregnancy, only primigravida have formalised prenatal care from TBAs. This begins at about seven months of gestation, when a woman leaves the husband's village and returns to her parent's home (Sparks 1990: 154). Also the Venda people in South Africa have the same belief. The range of customs and rituals observed during childbirth are amazing. Many women in some cultures fear the evil eye of witchcraft. Pregnancy is kept secret until the seventh month. Such customs may mean a delay in attendance at the antenatal clinic (Williams et al 1994:33).

2.3.4 Abdominal massage during pregnancy

Abdominal massage during pregnancy has been recorded in Ghana among the Ga people and the Akamba people in Kenya. The TBA puts her arm around the woman's abdomen from the back and jerk the uterus from side to side. This is supposed to alter the position of the foetus, which it is believed will otherwise lie in one place causing pressure symptoms in the mother according to Solomon & Rogo (1989) in Lefeber (1994:26).

TBAs attribute lower abdominal pain to the wrong position of either the foetus or the placenta and this is treated by massaging the abdomen with butter and soap and the TBAs believe and claim that this does turn the baby and, the placenta as well, into the upright position. During the last few months of pregnancy a special method is applied in order to prepare the birth canal (Lefeber 1994:17).
2.3.5 Antenatal care practices in Lesotho

In Lesotho health facility based antenatal care attendance is relatively good at 90 percent national coverage. However, this high attendance does not occur during deliveries. It is assumed that women tend to deliver at home because of the long distance between where the women live and where health facilities are located. The reasons for non-use of health facilities for delivery are not clear (MOH & WHO 1995: 39).

The evaluation of maternal and child health care health programs showed that 90.6 percent of women in Lesotho attend antenatal care clinics. However only 37 percent attended before the fifth month of gestation with the rest attending for the first time in their last trimester. The study recommended promotion of early attendance of antenatal care clinics (GOL & UNICEF 1994:195).

The data from several studies indicates that women in Lesotho do not consider the traditional health care and the modern health care systems as mutually exclusive. If encouraged they will attend ANC in health centres but once back in the village they seek advice and care from the TBAs. This is largely due to the cultural and bio-social context of the birth process (Clarke & Lephotso 1989: 23).
2.3.5.1 Examination of a pregnant mother in Lesotho

Among the Basotho people, TBAs examine the mother’s abdomen during antenatal care, to ascertain the height of the fundus, the position of the foetus and foetal movements. Obstetrical history is determined by inquiring if the previous pregnancies were normal, or if the delivery was difficult and if the woman was referred to a clinic/health centre/hospital before or after delivery (Clarke & Lephoto 1989:56).

2.3.5.2 Abdominal Massage during antenatal care.

Massage is commonly performed during pregnancy to correct malpresentation of the foetus and to relieve low back pain, believed to be caused by the foetus lying in the wrong position. The massage is performed also to prepare the womb and the placenta for delivery. This is done as early as the third to fifth month of pregnancy. The mother is palpated approximately every two to three weeks. The main lubricants used during palpation are vaseline and a traditional oil called *letsoku* (Clarke & Lephoto 1989: 56).

2.3.5.3 Promoting taboos in Lesotho

Clarke and Lephoto (1989:24,60) describe some traditional beliefs they obtained through extended and informal interviews with TBAs, mothers and health personnel. The data showed the beliefs and the supposed consequences if the taboo is transgressed as shown in the table 2.1.
Table 2.1 Taboos in Lesotho

<table>
<thead>
<tr>
<th>Taboo</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>A pregnant mother must not eat eggs.</td>
<td>She will experience difficult labour, that is, the membranes will delay rupturing and an egg will protrude through the vagina.</td>
</tr>
<tr>
<td>A woman is not supposed to stand on the doorway, or peep through windows</td>
<td>She will have prolonged labour and the head or the presenting part will recede.</td>
</tr>
<tr>
<td>If someone has travelled a long distance to visit the nursing mother, she must sit outside the hut for a while to cool off the feet before entering.</td>
<td>Travelling exposes one to evil spirits particularly very early in the morning.</td>
</tr>
<tr>
<td>Babies should be carried on the back and not in her arms,</td>
<td>The baby will encounter evil or harm.</td>
</tr>
<tr>
<td>Most of the traditional birth attendants do not advise the pregnant mother to rest or sleep during the day</td>
<td>It is believed that if a woman sleeps or rests during the day the baby will become lazy and the delivery would be difficult</td>
</tr>
</tbody>
</table>

These taboos are quite similar to taboos described by Chalmers (1991:226) among the Pedi women of South Africa, probably because Basotho and Pedis belong to the same ethnic group of Sothos in Southern Africa.

The role of TBAs in the provision of antenatal care differs from country to country, as are their characteristics. However, the literature shows more similarities than differences. For instance, research findings indicate that the majority of TBAs examine the woman during the antenatal period, they do abdominal palpation and abdominal massage. TBAs provide health information, administer herbs and adhere to traditional beliefs and taboos.
Zimbabwe so far is the country where there are reports of performing a vaginal examination and the stretching of the vagina during pregnancy.

2.3.6 Delivery practices

A basic essential of maternal health care is that every woman should have the assistance of a trained person during labour, whether birth takes place at home or in a health facility. However, this is very far from being realised. There is a long way to go in the training and deployment of more midwives, before the modest objective of giving every woman in labour a chance of skilled attendance can be achieved. In such circumstances the upgrading of existing TBAs and their incorporation into the national health systems has been considered by many as the most practical response to the problem. In the developing world more deliveries are conducted at home than at health facilities. Trained health workers or TBAs, who may or may not have received additional training; or relatives of a woman, who are rarely trained may attend to deliveries outside health facilities.

2.3.6.1 First stage of labour practices

There are not many descriptions of the immediate preparation for delivery recorded. From several studies one gets the impression that very little immediate preparation is done only some equipment such as pots for water, razors, knives and rugs are kept ready.
Mapondera (1989) in Lefeber (1994:24), reports that in Zimbabwe the floors of the hut in which the delivery takes place are swept clean and that the fire is made to keep the house warm and to ensure that the baby arrives into a warm environment as the dangers of hypothermia are recognised.

In South Africa TBAs may advise the woman in labour to push as soon as the first labour pain is felt or when the contractions become stronger. But they may wait until a woman is perspiring heavily. Contractions are examined for strength and frequency. The TBAs appear able to assess whether the contractions are increasing or decreasing in strength and frequency by abdominal palpation (Jepson & MacDonald 1988: 177).

2.3.6.2 Vaginal examination during labour

Among the Zulus vaginal examination is done by inserting two to three fingers into the vagina. The TBA's hands may or may not always be washed with water and soap before performing a vaginal examination. This is not done to monitor the degree of cervical dilatation but to feel for the head of the baby. A woman may be encouraged to walk around during early labour. Different arguments given for this practice are either to stimulate the contractions or relax the woman in order to stimulate the descent of the foetus into the birth canal (Jepson & MacDonald 1988:177). Hygienic practices are desirable outcomes of training. This study will assess the problem of hygienic practices among both trained and untrained TBAs to determine the effects of training and to identify hygienic practices that exist among untrained TBAs.
2.3.6.3 Second stage of labour

In India the untrained traditional birth attendant commonly known as Dai has had a significant role in the provision of maternal services. The TBA is generally called to conduct the delivery or when a woman is in pain or has some associated complaint. TBAs do not have a delivery kit. They perform a vaginal examination on a pregnant mother without washing hands. They know that enema facilitates labour but are not familiar with this technique. Most of them have no understanding of asepsis and are often blamed for high maternal mortality, perinatal and early neonatal mortality rates (Mathur, Sharma & Tain 1983: 473-81).

Sparks (1990: 156) reports that in Zimbabwe TBAs are very often called to the pregnant woman’s hut during advanced labour when it is too late to arrange transport to the clinic. Women are given a special muti sunungure to enhance labour contractions. The mother or mother in-law gives the muti before a TBA is called, the muti has been described in the formal health care system to be a powerful oxytocin.

The mother or the mother in-law attends the birth as a witness so that if a problem occurred testimony could be provided that jinxing had not been done. Husbands, children and nulliparous women are not allowed to witness birth.

Vaginal examinations during this period were commonly done by untrained TBAs using the soap or sepo and were less aware of principles of hygiene. Trained TBAs performed few vaginal examinations mainly when they suspected malpresentations like breech presentation. Washing of hands was seldom reported (Sparks 1990: 156).
2.3.6.4 Positions during delivery

Sparks (1990:158) in her study mentions that untrained TBAs encourage the sitting position. Untrained TBAs also stated that flexibility was important, whatever position the woman preferred was acceptable. However, the trained TBAs asked their patients to lie flat.

Kneeling, sitting squatting or standing are common positions reported in many countries. Many mothers in Kenya among the Digo people may deliver seated on the TBA’s lap with legs partly abducted to allow the passage of the baby. TBAs find no discomfort in this arrangement so long as the mother is of moderate weight and second stage is not prolonged. Many women prefer the position. A semi recumbent position has been reported in Tanzania among the Waheehe and Wagogo people. In South Africa TBAs encourage the lithotomy position (Lefeber 1994:26).

A review by WHO of trained TBAs noted that a large number of technologies which are widely practised correspond to our understanding of the physiology of normal labour and delivery. Common in most traditional cultures is, for example, the squatting, kneeling and standing positions for delivery which is associated with a greater size of the pelvic outlet, improved effectiveness of the contractions and better uterine flow during labour (UNICEF 1986: 27).
2.3.6.5 Care of the perineum during second stage of labour

TBAs in Sierra Leone may lubricate the rim of the birth canal with palm oil in an attempt to minimise lacerations of the anterior vagina. In Southern Africa women support the perineum by spreading knees apart and bringing the heels together supporting the perineum this is also common among the Basotho. Brink in Lefeber (1994:25) reports that in Nigeria TBAs place a woman in a supported squatting position, which stretches the perineum and reduces tears. Mapondera in Lefeber (1994:25) also reports from Zimbabwe that the perineum is prevented from tearing during the second stage by massaging with herbs from time to time throughout the first stage.

2.3.7 Practices during third stage of labour

In Sierra Leone TBAs wait up till one hour before taking action. TBAs in Benin do not wait as long as TBAs in Zambia or Sierra Leone, they believe that the placenta is part of the baby, and for that reason they consider it necessary that the two must be delivered together. If the placenta does not follow within five or ten minutes, the woman is ordered to push. Massages, pressing or rubbing on the mother’s abdomen have been reported in Kenya and Egypt (Lefeber 1994:270).

2.3.8 Delivery practices in Lesotho

In Lesotho consumers are dissatisfied with current locations of maternity care as they find them inconvenient. In some instances few women go to these facilities because midwives do not treat them kindly and therefore, prefer to deliver at home with the assistance of a TBA (GOL & UNICEF 1994:196).
2.3.8.1  *First stage of labour practices in Lesotho*

In Lesotho the TBA is called at the onset of labour or when the membranes rupture, and the TBA stays with the woman until the birth event is completed. The TBA knows that labour has started when the mother becomes restless and complains of backache and abdominal contractions. Once labour begins the anxiety for timely delivery increases.

TBAs usually encourage the woman to bear down with every contraction even if the cervix is not fully dilated (Clarke & Lephoto 1989:11 -12). Encouraging a woman to bear down when the cervix is not fully dilated is an indication of lack of understanding of the physiology of labour. The practice is common and it has been reported among Zulus by Lefeber (1994: 23). It was important therefore, in this study to assess if the practice continued to exist.

The literature shows that practices during first stage of labour in Lesotho do not differ from other countries as have been reported in Zimbabwe and South Africa (Lefeber 1994:16).

2.3.8.2  *Vaginal examination during labour in Lesotho*

TBAs perform a vaginal examination to determine the level of the head. If the head is not felt, an examination is done by inserting a finger into the birth canal. If the finger goes in completely, she knows that the head has not descended. If the membranes are not ruptured, she ruptures them with a piece of grass and encourages the woman to push. Some TBAs are aware of signs which indicate that labour does not progress well and herbal medicines, holy water and an ostrich egg are used (Clarke & Lephoto 1989: 12).
Heavy bleeding before delivery in Lesotho is of major concern to TBAs and herbal medicines are administered. In contrast, post partum bleeding is generally accepted as purifying and women are encouraged to bleed by taking herbal medicines. If the bleeding is heavy and persistent the woman is given *pitsa* or referred to the nearest health facility. Some of the traditional herbs given to arrest bleeding are; red ochre or *letsoku*, *qobo*, *mohlana pere*, *khomo ea balisa*, *soap and water*, *ash and holy water*, *tlokofiloane*, *koena* and *burnt dog's hair* (Ministry of Health 1994: 20) and (Clarke & Lephoto 1989: 40).

2.3.8.3 Management of second stage of labour in Lesotho

Clarke and Lephoto (1989:29) report that once a TBA is called to assist the mother, she stays with the woman until the whole process of delivery is complete. The woman is given a variety of traditional Sesotho medicinal herbs *lipitsa* to stimulate contractions, these include *khomo ea balisa*, *phakisane* and *mosistli*. TBAs do not regard pain as a danger sign therefore, management of pain in labour is of less concern. However, some TBAs use warm water or vaseline to massage the back and abdomen to relief pain.

2.3.8.4 Vaginal examination during delivery

Vaginal examination is done at this stage to feel for the head and to find out if the ischial spines (*litaloane*) are wide apart, generally TBAs look for danger signs such as prolonged labour and vaginal bleeding (Clarke & Lephoto 1989:30).
2.3.8.4  Position during delivery

Squatting is the position commonly used for delivery by the untrained TBAs while the trained TBAs use the lithotomy position as in health facilities. This has been reported in the previous discussion of delivery positions recommended by TBAs.

To prevent tearing of the perineum, 45 percent of TBAs place a khare that is a cloth pad under the mother for support. Other practices include using pillows or heels to support the perineum. Some TBAs do not use support (Clarke & Lephoto 1989:30).

2.3.8.5  Practices of third stage of labour in Lesotho

During the delivery of the placenta, to ensure that the placenta is not further withdrawn inside the woman, a piece of cloth is tied around, under the breast. After delivery, TBAs massage the mother’s abdomen with hot fomentation in order to allow the womb to return to its normal position and to expel blood clots. If the placenta is retained the TBA resort to a variety of procedures to speed up the delivery, for example:

- the woman blows into a bottle to exert pressure on the uterus
- a soot mixture is drunk to increase the rate of contractions and to expel the placenta
- the mother is turned upside down and attempts are made to pull the placenta, out
- the woman is made to vomit, the woman is given herbal infusion e.g. sehlapitsa and mothimolo
the traditional healer and the spiritual healer are called to assist in divination. If all
the procedures fail, the mother is referred to a clinic or hospital and (Clarke &
Lephoto 1989:44)

Research findings on delivery practices from other countries show that squatting
standing and kneeling are common delivery positions used among untrained while
lithotomy position is common among trained TBAs.

2.3.9 Postnatal care practices

The puerperium is an important period and recognised as such by many cultures. A wide
variety of practices and customs exist throughout the world. Many are beneficial such as a
period of seclusion, and a generous special high calorie diet.

However, some can be harmful for example, not giving the baby colostrum or dietary
restrictions of the mother. TBAs provide a variety of services, they perform household
chores, prepare meals for the nursing mother as well as advise the mother on breast feeding.
In some cases they stay with the mother during the post partum period (Williams et al

Lang & Elkin (1997:28) in Guatemala report that TBAs visit the mother every day for up
to two weeks after birth. An important part of their role was to wash the family’s clothes
and linen so that the mother could rest. A third of TBAs interviewed mentioned that they
massaged the mother’s uterus and half said that they checked the babies cord.
Steel (1990: 54) in Kenya found that even before training TBAs stimulated the uterus to expel clots after delivery and relieved the engorged breasts through creating warm steam suction with a narrow lipped container.

In Yemen TBAs apply antimony and turmeric to the perineum to hasten healing. They insert alum and sweet smelling herbs into the vagina to improve the tone of the vaginal walls and narrow the orifice. Women sit in a squatting position over smoking herbs. This is believed to heal the perineum. In some cultures sexual intercourse is taboo for 40 days after birth (Williams et al 1994: 227).

2.3.9.1 Breastfeeding

TBAs in Guatemala voiced different opinions regarding the initiation of breast-feeding. Twenty nine percent felt that colostrum was dirty or bad for the baby and that only sugar water should be given for the first 2-3 days. Some believed that colostrum caused diarrhoea, vomiting and infection. Fifty-nine percent believed that colostrum was not harmful and that breast-feeding could begin immediately after birth (Lang & Elkin 1997:28). Steel (1990:54) in Kenya also reported that TBAs delayed breast-feeding for three days because colostrum was believed to be thin and non-nourishing.

Lang and Elkin (1997:28) report that in Guatemala women were generally encouraged to wait one to three days after birth before bathing. TBAs instructed women to use warm water to preserve their warmth. Bathing with cold water was believed to cause fever, infection, oedema and decreased milk production. Bathing too soon was believed to cause a stomach pain or prolapsed uterus.
2.3.9.2 Postnatal care in Lesotho

The Women's Health Survey found that the level of postnatal care attendance was low (40%) especially when compared to the level of antenatal attendance. The study further showed that the urban women attended PNC services better than rural women (UNICEF 1998:43).

During the postnatal period a woman was kept indoors after delivery, she could go outside the hut but not beyond the reed enclosure, until after the remains of the umbilical cord had separated. The baby was not taken out of the hut until three months old. Anecdotes show that some of these practices are gradually fading away particularly in the urban areas where most women are working (UNICEF 1998:19).

Clarke and Lephoto (1989:42) reports that in their study on TBAs in Lesotho 90 percent of TBAs interviewed reported that they stayed with the mother after childbirth for a varying length of time, approximately 10 days after delivery or until the umbilical cord separates. The study also indicated that the amount of time spent with the mother depended on several factors such as whether the mother was a primigravida or multipara, whether it was a difficult delivery with complications and many other factors. During the postnatal period TBAs assist with fetching water, cooking, washing clothes and looking after the baby. The mother does no strenuous activity. She is waited on and fed the best food available.
2.3.9.3  Care of the newborn

Trained TBAs use a blade to cut the cord. Otherwise, the cord is cut with a river reed. The majority of TBAs do not use any hygienic practices like washing hands before attending to mothers (Clarke & Lephotol 1989: 42). The TBA usually cleans the face and the mouth of the baby by using her index finger or a piece of cloth. Later the baby is given a bath and wrapped in a blanket or a special cloth used by the mother during pregnancy, which remains attached to the mother until the placenta is delivered. The baby is inspected for physical abnormalities.

2.3.9.4  Breast feeding

Breast feeding is crucial to the nutrition of the baby. The majority of TBAs in Lesotho recommended breast-feeding immediately after delivery, while other TBAs believe that breast-feeding should begin much later. Some TBAs give the newborn *pitsa* to take out *tsilana*, which is to make the baby active and clean inside (Clarke & Lephotol989:44-47). In Lesotho sexual intercourse is taboo while a woman is breast-feeding, so migrant workers bring home formula artificial milk substitutes, to bottle feed babies and to enable them to have sex with their wives (Williams et al 1994:29).
2.4 PROBLEMS TBAs EXPERIENCE IN THEIR PRACTICE

TBAs have problems regarding the relationship between themselves and health care staff. Clarke & Lephoto (1989:50) indicate that staff assigns low status to TBAs, which leads to obstacles to effective co-operation. This is supported by Nompondana (1999:29), who experienced a negative attitude of health care personnel regarding the manner in which TBAs managed labour. Ntoane (1988:21) confirms this negative attitude which leads to TBAs not referring patients to the health care services. Also patients do not inform the health care staff that they have been to a TBA before coming to the clinic.

Sparks (1990:154) highlights the following problems that TBAs experience:

- poor technical support and administration
- isolation and poor infrastructure
- a lack of rapport between health care centres and TBAs

Shortage of water supply, difficulty in heating and lack of facilities and equipment are other aspects that cause problems for TBAs. This is also combined with low standards of living of most women that consult TBAs (Chalmers 1991: 220). A similar situation exists in Lesotho where the lack of infrastructure adds to these problems.
Sparks (1990:154) mentions that nurses are often the people designated to provide TBAs with delivery kits. If the nurses themselves are in short supply, they may not be able to provide the TBAs with delivery kits.

Clients visit the TBA at a very late stage of pregnancy. This is partly due to the fact that according to the culture of the people, pregnancy should be secret (Chalmers 1991:220). The long distances people have to travel and lack of transport also contribute towards late consultations.

TBAs find it difficult to attend training sessions at the health care facilities. They cannot leave their homes for long periods of time and there is no transport available to them. It has been found that often the health care staff makes appointments with TBAs, but does not keep them. All of this contributes towards a lack in confidence and poor co-operation (Clarke & Lephoto 1989:14). If these problems are not addressed co-operation will not be effective. A lack of supervision of trained TBAs is noted by the WHO (1984:14) and verified by Makhetha (1988:31) as well as (Clarke & Lephoto 1989:14) who reported that only 18 percent of eighty trained TBAs in their study was supervised.

Limited training and skills result in incompetence in identifying risk factors and judging when to refer clients (Hermann & Duale 1990:60). Nompandana (1999:53) adds to this by mentioning that the problems most frequently experienced by TBAs, during pregnancy, were swelling of the face, hands and feet, nausea and vomiting as well as vaginal sores. Only 40 percent of TBAs in Nompandana’s study could sometimes manage these problems and did not know that they should be referred.
Ante partum haemorrhage is of major concern to TBAs in Lesotho and a variety of herbs are given, only if bleeding persists are women referred to a health facility (MOH 1994: 20).

Hermann & Duale (1990:66) mention that TBAs often lack the authority and plans for referral of an obstetric emergency. This is made even more difficult where there is no official recognition of TBAs.

When looking at the problems most frequently experienced by TBAs it becomes clear that a change in the relationship between TBAs and the health staff is necessary. Cultural care preservation is of importance here, at the same time adapting to new ways should be the aim.
2.5 THE ROLE PLAYED BY THE HEALTH CARE SYSTEM IN SUPPORT OF TBAs' PRACTICE.

2.5.1 Training of TBAs.

Training TBAs is not easy because they have never been exposed to basic education and the majority of TBAs are illiterate since they have learned their art by observation and practice (apprenticeship) they may have difficulties in understanding things which they cannot see or touch. Therefore, abstract concepts, complex language and flat pictures may be beyond their comprehension. The responsibility of trainers is to translate abstract concepts into concrete realities (Williams 1986: 7). The curriculum of TBAs therefore, should be made simple with the intention to improve their practice, not to make them professional midwives.

It is vital that the midwife has some idea of how deliveries are normally conducted by TBAs and the problems that they experience during delivery for instance shortage of water and difficulties in heating. It is important to the midwife to be aware of the normal standard of living, the local customs and obstetric problems prevalent in the community she is working with. A midwife who is unaware of these factors may teach the TBAs issues, which are impossible for them to practice (Cabral, Kamal & Mehra 1992 (a): 9).

In Zimbabwe a study on training of TBAs (Conway-Turner 1997:569) showed that the ministry of health sponsored the training and the district nursing staff was conducting training.
The training focused on ten critical elements, among them were:

- health education, nutrition, hygiene and sanitation
- risk factors and diagnosis of pregnancy
- management of first, second and third stage of labour
- cord care
- family planning
- sexual transmitted diseases
- immunisation

(Conway-Turner 1997:570).

The length and content of training, needs careful consideration. Most TBAs have limited time to spend on this activity. It is important that trainers discover from the TBAs the knowledge and beliefs that have been the basis of their traditional practice, and adapt the training accordingly (Royston & Armstrong 1989:169).

A study in Malawi (Smit 1994: 26) showed that training of TBAs was the responsibility of the ministry of health. TBAs were selected from among those who carried out deliveries in their own maternity units and those who performed five or more deliveries per month. The training took two weeks and the TBAs were exposed to training in groups of three or four.
Training was followed by three visits by the trainer. The syllabus included instruction in hygiene, the normal events of pregnancy, labour and the recognition of women at risk of obstetric anomalies, and management of labour, puerperium and the newborn child. Great emphasis was placed on the fact that normal labour is short and that referral was essential when delays occurred. Lectures, observation, discussion, role-play, demonstration and practice were the commonly used methods of training.

2.5.2 Curriculum for TBAs in Lesotho.

In Lesotho the curriculum for TBAs was envisaged to enable the TBAs to:

- provide antenatal care to mothers with emphasis on screening high risk clients and referring them
- assist mothers to have safe clean deliveries when the need arises, and above all be able to recognise early obstetric complications and ensure timely referral
- provide care to the baby, immediately after birth up to the age when a village health worker takes over, this includes initiation of lactation and motivation of the mother to attend immunisation services as scheduled.

The curriculum comprises a wide number of topics on midwifery, such as

Antenatal care: Anatomy and physiology of the reproductive system, physiological changes during pregnancy, and nutrition during pregnancy.
Intra natal care: First stage of labour, second stage of labour and the third stage of labour.

Care of the newborn: Birth asphyxia, weighing the baby, examination of the newborn, baby bath and initiation of breast-feeding.


2.5.3 Length of training of TBAs in Lesotho

For the majority the training period is two weeks or less. The Lesotho’s report on village health worker evaluation, Makhetha (1988:56-57) showed that to adhere to the training manual and the number of topics covered, time allocated seemed short.

The frequency of in-service training was inadequate since this occurred once a year and therefore, not much of the curriculum could be adequately covered. Consequently a wide gap existed between what the TBA knew and could do according to the prescribed curriculum. Many TBAs are illiterate so their training should be as practical as possible. The criteria for selecting topics for in-service training also depended on the health centre nurse, and in some cases this did not cater for the needs or situational problems of the trainees.
Training of TBAs in Lesotho is a responsibility of the Family Health Division of the Ministry of Health, and UNICEF funds the training. The nurse in charge of the health centre in collaboration with the district public health nurse usually does the training. Methods of teaching are lecturing, discussions, group work and case studies (UNICEF & PHAL 1988:27).

2.5.4 Supervision of trained TBAs

In a tandem with the TBA programme training and supervision are equally important for the functioning of the TBAs and the programme. The most cited reason for unsatisfactory results from TBA training is lack of supervision after training. This is so because provision for supervision is not built into the training program.

Inadequate resources are allocated for the activity and the nurse who is expected to supervise TBAs is already committed to health centre activities. Without supervision TBAs easily become disillusioned with their new roles and may revert to their old ways or practices. Follow up after training is very crucial in motivating them to put into practice what they have learned. (Royston & Armstrong 1989:167-168).

Among the Pedi speaking women of South Africa a study was carried out to assess how TBAs' birth practices had been modified in the process of moving towards the western medical system. It was found that detection of pregnancy was at 4-5 months when compared to one or two months in the western medicine (Chalmers 1991:220).
Cultural beliefs resulted in this information being kept secret. Signs of determining conception were similar to western diagnosis although the majority of women relied on dreams to indicate conception, such as dreams about snakes and water. Forty-three percent of the women were unaware of the functions of the placenta (Chalmers 1991:220).

The study implies that health workers should make a cross cultural assessment of the TBA's practices and knowledge in child birth, in order to understand what is common in all cultures as it pertains to physical safety, emotional, social and spiritual needs before embarking on training of TBAs.

For trained TBAs to function effectively they require constant supervision, support and effective supervision to maintain safe standards of care (Sparks 1990:154).

In Manicaland, in Zimbabwe a study that looked at supervision of TBAs revealed the following constraints:

- poor technical support and administration
- infrastructure isolation
- poor rapport between TBA and health care system
- lack of community involvement

It was also observed that supervision is rarely incorporated into plans for TBA training and what is claimed as supervision was only a check of equipment for delivery (WHO 1984:29).
2.5.5 Supervision of TBAs in Lesotho

Makhetha (1988:31) in a study on evaluation of village health workers showed that there were cases where supervision was not done, and many parties performed the supervision. For example, the clinic nurses the public health nurse and the primary health co-ordinator. Clarke and Lephoto’s (1989:14) study showed that only 18 percent of the eighty-trained TBAs reported being supervised. Visits from the health centre nurse were irregular. Most TBAs reported receiving a visit once or twice a year and the clinic nurse often did not keep appointments. One TBA, who expressed her frustration and annoyance, noted that she had changed her plans “to go to the fields” in order to meet the clinic nurse who never arrived. no apology was made.

Some TBAs admitted to not being visited for over a year. Those who received regular visits from the health centre nurse reported that they were being assisted in examining and delivering the mothers. They also mentioned that the nurse on her visits presented medicines and held pitso( meeting). This breakdown in supervision affected the morale of TBAs and the standard of maternal care provided. In some instances TBAs admitted having reverted to some traditional practices, because they had forgotten the new techniques taught briefly during a one or two weeks training in the health centre (Clarke & Lephoto 1989:15).
The first primary health care evaluation in Lesotho since its inception, showed that supervision at clinic and community level was inadequate. Doctors, nurses and other health officers interviewed at the health service area (HSA) level and health centre staff revealed that due to shortage of staff and logistic constraints, supervision visits were not as frequent as expected from the HSA hospital to health centres and from health centres to communities (MOH & WHO 1997:3). It can be concluded that the findings do not show any improvement in supervision since 1988 when the last evaluation of village health workers was done.
2.6 HISTORICAL BACKGROUND TO TRADITIONAL BIRTH ATTENDANTS IN LESOTHO

Voluntary community health workers have been used in Lesotho since the sixties. This cadre was later trained as Village Health workers in 1975 by Scott Tebellong and Quthing hospitals. TBAs are an older cadre than village health workers and are by far more recognised and respected by the communities they serve. TBA training in Lesotho was started in 1985 and was formally integrated into the health care system. Some health service areas had already started training and utilising TBAs as early as 1979 for example Roma, Scott and Mafeteng hospitals (Lephoto 1988: 3). In 1986 an agreement for cooperation in the training and support of community health workers including TBAs, was signed between the Government of Lesotho and UNICEF. The project was entitled “Support for the integrated community health worker”. Thus combining village health worker and traditional birth attendants.

At the inception of the community health worker project there was no organised national program, no standard curriculum and the number of trained TBAs was not known due to lack of follow up and supervision (Lephoto 1988: 4).

The community health workers' project facilitated the development of a standardised TBA curriculum, which was piloted in 1987 at Roma, Scott and Mafeteng health service areas. The curriculum was finalised in 1988.
The major objectives of the project were to:

- reduce infant mortality through the increase in utilisation of maternal and child health services
- reduce maternal mortality through safer deliveries

Village health committees and health centre committees were established during the primary health care inception as a framework, to facilitate the functioning of the TBAs and village health workers, and to ensure participation of communities in their health care provision. Presently these structures exist in few villages, even where they exist the involvement of TBAs and VHW is minimal (MOH & WHO 1997:5).

The nurse clinician co-ordinate PHC activities at Health Centre level. They train and supervise village health workers including TBAs and they are a link between the traditional birth attendants and the health care system while the TBA is the key link between the health care system and villages or communities.

2.7 RESEARCH ON PRACTICES OF TBAs IN LESOTHO.

There has been one study, which provided baseline information on the practices of TBAs in childbirth in Lesotho in 1989. Since then not many studies conducted have elicited TBA practices. Therefore, the study conducted by Clarke and Lephotso in 1989 has been used more often than other studies as the major source of information on TBA practices in Lesotho in this document.
2.8 RECRUITMENT OF TRADITIONAL BIRTH ATTENDANTS.

In Zimbabwe TBAs who are selected for formal government training, are chosen by their village communities, and the basis for selection is experience and a reputation as a successful birth attendant (Sparks 1990: 157). In contrast in Lesotho the selection is based on the ability to read and write Sesotho and experience as a birth attendant.

Most authors report that female TBAs acquire their skills from learning by doing usually when they are young. They join their grand mothers, mothers or aunts and watch and listen while they are conducting the labour. They continue to do so until the elder TBA indicates she is no longer able to do the work, then they take over and become TBAs. TBAs may tell that they have acquired their skills from God or spirits or by some supernatural experience such as dreams or a vision (Lefeber 1994: 10).

Hermann and Duale (1990: 66) in Zaire also noted that TBAs’ selection was based on respect rather than interpersonal skills and that TBAs were not paid or considered professionals.

2.8.1 Becoming a TBA in Lesotho

Clarke and Lephoto (1988: 12) describe two categories of selection of TBAs in Lesotho. Firstly self-selection to become a TBA and secondly recruitment to become a trained TBA.

In the first category all women (mainly married) who have had one or more children are regarded as TBAs. Here the initiation to maternity care is acquired through ones first and subsequent birthing experience.
The woman is encouraged by the TBA to take an active role in her delivery: for example the mother is encouraged to cut the baby’s umbilical cord. As a result of this initiation most TBAs are self selected and learn their skills mainly from their mother or mother-in-law.

2.8.2 Recruitment for training as a TBA in Lesotho

Training is usually done at community or village level. The chief or the chieftainess calls a pitso (a meeting) where elders of the village are present. Individuals usually women are then chosen to be formally trained as TBAs. Some women have reported that they find it difficult to decline the selection because of fear and community pressure (Clarke & Lephoto 1989: 13). The clinic nurse and her staff are excluded at the meeting to ensure that they do not influence the selection. The nurse in charge of the clinic organises a meeting with selected individuals, to discuss their willingness and acceptance to serve their community. The nurse clinician and the district public health nurse decide upon a date and the venue for training if funds are immediately available.

What is common in the selection of TBAs is the fact that communities and their leaders are responsible for the selection of TBAs. Various studies indicate that TBAs acquire their skills by observation and practice (apprenticeship). This study will assess the role selection plays in the practice of TBAs in Lesotho because GOL & UNICEF (1994: 188) suggested that the methods of selecting might be responsible for lesser use of trained TBAs.
2.8.3 Characteristics of Traditional Birth Attendants

Long before the qualified midwife arrived on the scene, the local midwife/TBA helped fellow women during labour and still continue to do so. TBAs learned their trade from a relative or a friend.

Most studies describe a TBA as post-menopausal illiterate and one who has mothered children. She might be an accomplished herbalist or a spiritual healer. Women would have chosen her because of her kindness, calmness, reassuring attitude, being respected and a loved member of the community (Williams 1986: 7).

The majority of TBAs are women, a male TBA is usually a herbalist providing antenatal care and treating complications of pregnancy and delivery and have been reported in Ghana, Nigeria, Bolivia and Mexico (Lefeber 1994: 10). In Lesotho they are relatively unknown, but where available his role is that of performing curative rituals and prescribing medicinal herbs (Clarke & Lephotl989: 3).

Sparks (1990:156) in a study of changing roles and the practice of TBAs in Zimbabwe found that the majority of the TBAs were elderly women who were unsure of their age, who did not have accurate documentation of specific dates and who estimated dates by major events in life. The majority of TBAs was illiterate and had their husbands working in the urban areas, and these midwives had total responsibility for childcare.
2.8.4 Characteristics of TBAs in Lesotho

A study done by Clarke and Lephotlo (1989: 3) in Lesotho among 237 TBAs, described similar characteristics where most of the TBAs were middle-aged to elderly women, lacked formal education and practised midwifery as part-time occupation. In Lesotho a TBA is usually a member of the community in which she practices and restricts her practice to the local area (village). She is familiar with her clients and family, speaks their language and shares the local system of health beliefs and behaviour. She is more accessible and readily available than the professional trained midwife (Clarke & Lephotlo 1988:4).

The literature shows that TBAs are not a homogenous group therefore, it is important to know their characteristics since their characteristics differ from country to country sometimes from ethnicity context.

2.9 RELATIONSHIP WITH THE HEALTH STAFF AND CLIENTELE.

In most societies cultural and spiritual aspects of pregnancy and child birth have a strong influence on the health seeking and health caring behaviour of the traditional birth attendants and mothers who give birth. It is important that the health providers are aware of these aspects so that they can plan or organise services that are appropriate and acceptable to the people. Unfortunately there are limited opportunities for health providers to explore the socio-cultural context of childbirth (Royston & Armstrong 1989: 168).

The relationship between TBAs and nurse midwives vary widely. Sparks (1990:158) has shown that where TBA training exists, the nurse midwife is often the person designated to teach, supervise and provide delivery kits to the TBA.
Problems sometimes arise where the midwife herself may be under supplied, overworked and less supported by the health care system.

Problems may also arise if the TBA is older, more experienced and better accepted in the community than the midwife, she reports to. One of the most important arguments in favour of collaboration between the TBA and the health services is that it is a way of bridging the gap between two very different cultures (Royston & Armstrong 1989: 68 -169).

Steel (1990:54) in building trust with the TBAs began by meeting TBAs before training. The meetings used to be held in the home of the head TBA of the area. She there by respected the hierarchical system among TBAs.

There was a natural bonding between her and the TBAs because they were all midwives and discussed common problems within their work such as antenatal problems, prolonged labour, breech delivery, post partum care haemorrhage and still births. It was only after she had established a good trusting relationship that she began planning a basic midwifery course for TBAs. The relationship between the traditional midwife and her client is usually personal, informal, supportive and holistic and based on confidence and trust, in contrast with the depersonalised, formal, authoritarian and segmented characteristics of the western mode of child birth. Whether this is really so, it is not clear but some studies have shown that sometimes relationship between nurses and TBAs is not always friendly.
2.9.1 Relationship of TBAs with the health staff and clientele in Lesotho

Despite the respect the TBAs may command within their community, the TBAs tend to be assigned a low status by the hospital personnel and medical practitioners and the educated class who regard them as superstitious, ignorant and dangerous. These attitudes have constituted obstacles to effective co-operation (Clarke & Lephoto 1989:50). Clarke & Lephoto (1989: 50) further noted that the TBA is not only concerned with biological aspects of the child birth process but also with the woman's emotional and spiritual aspect of life and does not hesitate to invoke traditional rituals if the birth is impeded. The two health systems provide different care catering for different needs, one with an emphasis on the socio-cultural aspects, and the other stressing the physiological aspects of birth.

This is confirmed by Leininger's theory of trans-cultural nursing which suggest two systems of health care, the traditional and the western systems of health care each of these system focus on different aspects of health care but similarities exist (George 1995:385).

The focus group discussions on the relationship of TBAs and the community from the rapid assessment of maternal and child health study in Lesotho showed that, on being asked to comment on the services that trained TBAs provided, the community was aware of the availability of trained TBAs (MOH 1993:90)
Four groups out of nine mentioned that TBAs were not being fully utilised because:

- TBAs bewitch the mothers with the placenta and the umbilical cord
- they are illiterate as a result of which they misdiagnose and end up with wrong intervention
- they failed to keep patients’ problems in confidence as a result everyone in the village ends up knowing the clients’ problems
2.10 SUMMARY

The purpose of a literature review is to gain insight and understanding of findings of other researchers on the subject of interest to the researcher. The literature showed that the role of TBAs in the provision of maternal health differ form community to community. Trained TBAs have an expanded role apart from attending to deliveries. In some countries they provide, immunisation and family planning. The literature also shows that many countries in Africa, Asia and Latin America have embarked on the Training of TBAs.

Various studies have been undertaken in these regions on the practice, training and supervision of TBAs. The findings show that, TBA practices differ but similarities can be identified. Training programmes differ from country to country in terms of content, length of training and the methods of training used.

The relationship of TBAs and the health professional also differ. Where consultation and involvement of communities was done prior to training TBAs and nurses have developed mutual respect and trust.

Many researchers recommend further investigation into TBA practices, training and supervision.

The next chapter presents the research methods used.
CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methodology, population, research instruments and the strategy that was used to collect and analyse the data to answer the research questions. The objectives of the study were to:

- assess the role and practice of TBAs in the provision of maternal health in the two northern districts of Lesotho namely Leribe and Butha-bute.
- assess problems related to the role and practices of TBAs
- determine the role of the health care system in the support of TBAs’ practices.

3.2 A HYPOTHESIS

The study was descriptive in nature. Therefore, no hypothesis was formulated. The study did not seek to establish any explanation or cause and effect relationship. Polit and Hungler (1993:142) describe the appropriateness of descriptive studies in a situation where there is a need to observe, describe and explore.
3.3 STUDY TYPE

This study was explorative and descriptive and used a quantitative approach. A descriptive design was used to describe the role and functions of a TBA, the role of a nurse, who is the TBA trainer and to determine the support that the health care system provides to TBAs.

The main advantage of this type of study is that it is practical feasible and relatively economical and easy to manage. There are however, problems with using a descriptive type of design such as problems in inferring changes and trends over time. Given all changes that take place in a society it is questionable to assume in many situations, that differences in behaviour and attitudes observed with TBAs and nurses, are the results of passage through time rather than the cohort or generation difference (Polit & Hungler 1993: 146). The purpose of descriptive studies is to observe, describe and explore the situation and does not explain or understand the underlying causes of variables of interest.

3.4 TARGET POPULATION

The target population in the study was TBAs trained under the community health program of the ministry of health as well as those untrained. Health centre nurses formed a very important subgroup because they train and also supervise TBAs in their practice.
3.5 STUDY AREA

The study was carried out in two districts namely Leribe and Butha-bute. These districts have both urban and rural features and the practices of TBAs could be demonstrated in both areas.

3.6 SAMPLING

3.6.1 Sample size for TBAs

The sample size for TBAs was determined by the number of trained TBAs in the three health service areas namely Leribe, which had (126) trained TBAs Seboche and Butha-bute health service areas with (245) trained TBAs. The researcher and the statistician felt that a sample size of 16% of trained TBAs would be large enough to study research variables given the available funding, time and the feasibility to conduct the study.

3.6.2 Sampling procedure for selection of TBAs (both trained and untrained)

A combination of a purposive and proportional sampling was employed. Polit and Hungler (1993:177) indicate that purposive sampling can be used where a researcher is studying or seeking people, or an area with certain characteristics of interest to him or her. Purposive sampling method is based on the judgement of the researcher regarding subjects, who are knowledgeable about the research or the question at issue, as it was the case in the selection of untrained TBAs.
The purposive sampling can be used in small in-depth studies where selection of subjects is based on known characteristic. However, generalising the findings from purposive sampling may be risky (Brink 1996:141) & (Polit & Hungler 1993:179). Two districts were selected conveniently. A list of health centres that train TBAs in each of the selected health service area was obtained from the public health nurse. Health centres within the two districts were selected randomly based on whether they are urban or rural.

Trained TBAs were selected randomly from the registers available in each health centre. Selection of five trained TBAs from each clinic register was done by listing only TBAs who could be accessible by road, a systematic random sampling was used. Names with odd numbers counted from the top of the list were selected.

For every five-trained TBAs selected, two untrained TBAs were recruited, with the assistance of the village health worker and the chief in each village, visited. This was to ensure that trained TBAs are not over represented because it was much easier to find trained than untrained TBAs. Untrained TBAs were selected on the basis of the number of deliveries they performed, which were at least two to three deliveries in a year and who are respected and recognised by the community.

A total number of 60 TBAs were recruited for the study, 36 of whom were trained and 24 were untrained, which means untrained TBAs formed 40 percent of the total sample.
3.6.3 Sampling for nurses

The nurse in charge of training TBAs in each health centre was selected but in three of the health centres there were no registered nurse midwives involved in training. The number of nurses recruited was less than the twelve (12) facilities visited. A total number of 9 nurses were recruited.

3.6.4 Limitations in sampling

TBAs who were resident in areas accessible by road were more likely to be selected in the study than those who lived in inaccessible, remote villages, because of limited resources in terms of transport, drivers and time. Another factor is that Lesotho has a very difficult terrain. Roads are bad and it takes hours to reach health centres and villages.

A sample frame for untrained TBAs did not exist. Therefore, their selection was based upon being known by the chief or the village health worker. Registers for trained TBAs within the clinics were out dated, some of the trained TBAs could not be traced after selection from the registers. Where TBAs could not be traced replacement was done by recruiting TBAs from other health centres.

The numbers of nurses were very few (9 nurses) therefore, the information cannot be generalised to all nurse midwives who train TBAs in the two districts studied.
3.7 DEVELOPMENT OF QUESTIONNAIRES FOR TBAs AND NURSES

Questionnaires were developed through several stages. First by reading previous and recent studies on TBA training and practices and identifying how these were measured. The questionnaires were discussed with the promoter, the co-promoter, and officers responsible for community health programs in the ministry of health. A local statistician was consulted to assist in determining the sample size, while the statisticians at UNISA were consulted to ascertain the structure and layout of the questionnaires.

Lastly the department of research support at UNISA was consulted to ensure that precoding and scales used for responses were appropriate for data capturing and analysis. When questionnaires were acceptable to all, those mentioned above, the study tools were translated into Sesotho and back to English to ensure that the meaning was not lost. Two questionnaires were used to collect data, one for the nurses and the other for TBAs. TBAs’ questionnaires comprised of structured and unstructured questions.

The TBA questionnaire was divided into sections relating to the profile of TBAs, training, supervision, antenatal care, delivery, and postnatal care (see appendix 1).

The nurses’ questionnaire also comprised of training, selection of TBAs, involvement of the community and their leaders, support, supervision and evaluation (See appendix 2).
An assistant was recruited for data collection. The research assistant was a retired public health nurse who had wide experience of working with various communities in the country. She was also familiar with the location of all health centres, including the health care system in the country.

The researcher and the assistant discussed extensively the content of English and the Sesotho versions of the questionnaires and made modifications accordingly.

**Questionnaires were administered to TBAs** through face to face interview, which allowed to develop rapport. Polit and Hungler (1993:200) argue that sometimes it may be appropriate to impose minimum structure and provide the subjects with the opportunity to reveal relevant information in a naturalistic way, hence open-ended questions were included.

**For the health centre nurses**, structured questionnaires were delivered by hand to be completed and collected there after. The advantage of self-delivery of a questionnaire is that the questionnaire can be collected after completion, where self-administering is used. It is also cost effective since there is no posting of questionnaires. The disadvantages are that subjects may be reluctant to complete the form, and there is no opportunity to clarify questions that are not clear.
3.8 PERMISSION TO CONDUCT THE STUDY

Permission to conduct the study was sought from the following authorities.

- Director general for health services in the ministry of health (see appendix 3)
- The executive secretary of Private Health Association of Lesotho who is responsible for all church health facilities in Lesotho. The Private Health Association of Lesotho owns 50 percent of health care facilities in the country (see appendix 4)
- District medical officers of Leribe, Butha-buthe and Seboche HSAs (see appendix 5).

3.9 PROCEDURES

Communication with the authorities mentioned under 3.8 was made through letters and meetings as deemed appropriate. The researcher had to wait for the response from the ministry of health before she could commence on data collection. After permission was granted by the ministry of health in Lesotho, letters of permission were attached to letters of request to conduct the study and sent to all concerned health facilities one month prior to the date of data collection see appendix 5. The concerned HSAs responded by telephone hence there are no letters of response to the request made to them in appendix 6. The researcher carried a copy of the letter of permission to carry out the study, with her when she presented herself to the chiefs in the villages and authorities of the health facilities concerned see appendix 6.
Permission to interview individual TBA was sought by explaining the purpose of the study, and the intended use of information that the study would yield. If the TBA agreed then an interview was undertaken. TBAs could choose not to participate or to withdraw from the study if they felt uncomfortable. This is also described under 3.15 ethical considerations.

3.10 PRETESTING OF QUESTIONNAIRES

Pretesting of the questionnaires was carried out in Maseru and Berea health service areas, these areas and villages where nurses and TBAs were interviewed, were outside the study area therefore, the possibility of contamination of data was highly unlikely. The purpose of the pretest was to:

- ascertain feasibility of the study
- ensure that the questionnaires were clear,
- prevent ambiguity of questions
- determine the length of the interviews.

Brink (1996:60) views this as part of the planning phase.
3.10.1 Results of the pretest

Two trained and one untrained TBA including two nurses were interviewed. The pretest was accomplished within a period of three days, with the help of the ministry of health who provided transport and a driver for the activity.

3.10.1.1 Responses of TBAs

Responses from TBAs showed that questions were clear, understandable and relevant to the subject of the study. A few questions to TBAs required rewording particularly in Sesotho, because although Basotho are a homogenous group there are geographical differences in the use of Sesotho words.

Response differences were observed between the two trained and the untrained TBAs. Trained TBAs provided antenatal care, and referred cases more often than the untrained. The untrained TBAs adhered more to cultural beliefs, traditional medicine and traditional taboos as part of their care for a pregnant woman than the trained TBAs.

Both groups had confidence in their practice and experienced similar problems, for instance they both mentioned the problem of not being paid for the work they did.
The trained TBAs were not permitted by the ministry of health to charge for the service while the untrained said that as custom a TBA was paid in kind, by being given gifts and invited to ceremonies. The untrained TBA showed that all these gestures were dying slowly because people can no longer afford it.

It became very clear that TBAs recented the structured interviews, in preference to discussions. Therefore, what the TBAs preferred was adopted in order to create a conducive environment. Once that was achieved interviews went on smoothly. Initially the interviews with TBAs took a period of 45 minutes to an hour. With subsequent interviews time was reduced to 30 minutes.

3.10.1.2 Nurses’ responses

The nurses’ responses did not show any differences, except that one nurse had recently been posted to the clinic and was in the process of familiarising herself with the community and therefore, had not done any training for TBAs in that area.
3.11 DATA COLLECTION

Data collection was done over a period of two months. The researcher and the assistant first visited the health service areas (HSAs) concerned that is Butha-bute, Seboche and Leribe. Seboche is a health service area within Butha-bute district (see figure 1.2 P: )

After discussions with the authorities of these HSAs, health centres were visited. The assistant interviewed older TBAs because they were very reluctant to discuss birth issues with the researcher. Reasons were not explicit but its assumed they felt uncomfortable with the researcher because she was younger when compared to the assistant.

To develop rapport with TBAs the researcher and the assistant introduced themselves by name, the clan they belonged to seboko, where they came from and explained the purpose of the interview.

The TBA’s questionnaire was administered with great care, there were more discussions, and this gave the TBAs more opportunity to explain and elaborate on issues arising from the interview. After completion of the interview informal discussions between the interviewer and TBAs arising out of mutual interest were conducted. These discussions were useful in complementing the data collected through a questionnaire and provided information on the names of herbal medicine taboos and traditional practices related to pregnancy and child birth.
3.12 VALIDITY AND RELIABILITY OF TOOLS

3.12.1 Validity

Validity refers to the ability of a tool to accurately measure what it is supposed to measure given the context within which it has to be applied (Brink 1996: 167). Brink (1996:168) describes four types of validity of the instrument namely, content, face, criterion and construct validity.

**Face validity** means that the instrument appears to measure what it is supposed to measure. Face validity is the weakest kind of them all. Comparing the instrument with literature on the practices of TBAs, the problems they experience and support given by health services, it appeared to measure what it was supposed to measure.

**Criterion validity** refers to comparing a newly developed tool to another tool known to be valid. If the data collected closely matches the data collected, using the valid instrument, then it can be concluded that the new instrument is also valid. Previous research conducted on the role of TBAs were studied and revealed similar finding
**Construct validity** is the most important and often used. Construct validity refers to the construct the instrument is measuring. It is used to explore the relationship of the instrument's results to measures of the underlying theoretical concepts of the instrument. Literature on the role of TBAs as discussed in the literature reviewed was used to explore the relationship of the findings to measure theoretical concepts.

**Content validity** was ensured before the development of the tools. First by reviewing literature on TBA practices and their training by the health professional. The review revealed the essential aspects of the study that had to be included to ascertain that the questionnaire represented all questions possible on the subject of TBAs and their training. Factor analysis, a statistical measure of validity could not be calculated because the data were not continuous but categorical.

3.12.2 Reliability

Reliability refers to the degree to which an instrument can be depended upon to yield consistent results if used repeatedly over time on the same person if used by two investigators (Brink 1996:171). Three types of reliability are often evaluated, stability, internal consistency and equivalence reliability (Brink 1996:170).
Stability refers to administering of an instrument to the individual on two occasions within a short period of time and examining the responses for similarities. This is done in test-retest. Test-retest could not be done due to inadequate, funding and time. The results of the pre-test were however, similar to those of the main study.

Internal consistency addresses the extend to which all items of the instrument measure the same variable and split half method can be used. The literature served as a measure. The most frequently used measure of internal consistency is the Crohnbach’s alpha method, which is used, in a highly structured questionnaire. The questionnaire for TBAs and nurses combined both structured and unstructured questions. The Crohnbach’s alpha was not used to measure consistency on the structured questions because the data was categorical and not continuous.

Equivalence determine whether similar instruments if given at the same time would yield the same results or whether the same findings can be obtained by using different observers at the same time. Consistency was ensured through the pretesting of the questions, and checking of responses during fieldwork. A research assistant was used who was reliable and trained to administer the instrument.
3.12.3 Factors observed to ensure quality of data

These factors were:

- reducing of recall bias by recruiting only those TBAs who were active in their work
- the researcher and the assistant dressed in a simple manner nurse’s uniform was not used. This was to ensure that no party felt threatened because of different background of the health care systems each group represented

3.13 DATA HANDLING AND QUALITY CONTROL

Questionnaires were given numeric identification numbers to reflect whether a questionnaire belongs to a TBA or health centre midwife and were sorted according to the different study populations.

Quality checks for consistency and completeness of responses were done at the field level by the principal researcher and the assistant researcher. Where necessary interviews were repeated, the questionnaires were once more checked at the office level and registered to ensure that none were missed, or lost by the principal investigator.
3.14 PLAN FOR DATA ANALYSIS

The data was entered into a computer at UNISA using the statistical package for the social sciences computer program (SPSS). Open-ended questions were categorised and coded. A descriptive analysis was employed where frequency distributions were run, and cross tabulations were computed to determine relationships between variables, interpretations and conclusions were made.

3.15 ETHICAL CONSIDERATIONS

Because the subjects of inquiry in interviewing are human beings, extreme care must be taken to avoid any harm to them. Traditional ethical concerns have evolved around the topic of informed consent. That is a consent received from the subject after he or she has been carefully and truthfully informed about the research, the right to privacy, that is protecting of the identity of the subject and protection from harm be it physical or emotional or any kind (Fontana & Frey 1994: 372).

To ensure observation of ethical considerations in this study, informed consent was obtained by requesting a TBA or a nurse to participate in the study, informing them of the purpose of the study, its importance and how the study would benefit them. Where individuals refused or felt uncomfortable to participate they were excluded from the study without demeaning. Names of TBAs, nurses, clinics or villages were not recorded in the questionnaires. Codes were used for identification to ensure protection of identity.
2.16 SUMMARY

A descriptive quantitative research on the role of TBAs in the provision of maternal health was undertaken in Leribe and Butha-Buthe districts of Lesotho.

The target population was TBAs and nurses formed a sub-group, which was included in the study for the purpose of determining the role-played by the health care system in supporting the practice of TBAs.

A combination of a purposive and probability sampling were employed to recruit TBAs. Sixty TBAs formed the sample size, out of which 36(60%) were trained while 24(40%) were untrained. Nine nurses were recruited from health centres, where trained TBAs were selected. Questionnaires for TBAs and nurses were pretested for validity and reliability and modified where necessary. The questionnaire for TBAs was administered through face to face interview while nurse questionnaire was handed to them to be completed and collected thereafter.

Data was analysed using an SPPS computer program at UNISA.

The findings of the data analysis are presented in the next two chapters.
CHAPTER FOUR

ANALYSIS OF DATA OBTAINED FROM TBAs’ QUESTIONNAIRE

4.1 INTRODUCTION

This chapter presents findings from data obtained from TBAs’. The objective of the analysis was to describe

- the role and practices of TBAs, with regard to their personal profile, provision of antenatal care, delivery, post natal care, including the supervision and support given to them by the health care system
- the problems TBAs experience in their practice
- the role played by the health cares system in support of TBAs’ practice

A total of 60 TBAs were interviewed this included 36 trained and 24 untrained TBAs recruited from Leribe and Butha-butha districts within the northern region of Lesotho.

To answer the research questions a descriptive analysis was employed. Frequencies were run to describe the role TBAs played in the provision of maternal health. To compare the role and practices of trained and untrained TBAs, a chi-square was computed. A significant level of (p value) less than 0.05 was considered to show a statistical difference between trained and untrained TBAs while a p value of more than .05 showed no statistical difference between the two groups.
4.2 FINDINGS FROM DATA OBTAINED FROM TBAs

4.2.1 Personal profile of TBAs

Traditionally in many African societies the personal profile of an individual determines the role one plays in a community. Leininger in George (1995:378) in her sunrise model predicts that cultural and social structure dimensions have a great influence on care patterns and expressions of individuals. Therefore, it is important to know the demographic profile of TBAs in order to understand how it influences their role and practice.

**Item I: Age distribution of TBAs**

![Age distribution of TBAs](image)

*Figure 4.1 Age distribution of TBAs (Trained) N=36
(Untrained) N=24*
Figure 4.1 shows that the majority of TBAs are of middle to elderly age. However, there are more untrained TBAs within the age group of 61 and above. This confirms findings by Singh (1994:120), Conway-Turner (1997:567) and Troskie (1997:17) where they described a TBA as an elderly woman above the age of 50.

Because of their age TBAs are respected in their communities, as they play an important role of being educators and care givers in issues of childbirth.

*Item 2: How long a TBA had been living in the area*

Almost all (98%) TBAs have been residents in the area where they practice for more than 10 years. Only one TBA has been living in the area where she practises for a period less than 10 years. The longer the duration of stay within a community, denotes not only familiarity with the community but also assimilation of cultural values and beliefs of the community where a TBA lives.

*Item 3: Marital status*

*Item 4: Number of children*

Item 3 and item 4 have been grouped together to show the relationship between marriage and the number of children. All TBAs in the study are married. Forty-nine percent lives with partners while 51 percent are widowed. All TBAs have children of their own. Eighty-two percent have five or more children while 18 percent have two to four children.
Having children gives a woman a very important status in African societies. In Lesotho culturally a nulliparous woman cannot be permitted to assist in a delivery or become a TBA. Hence one criteria to become a TBA is the number of children one has (Clarke & Lephotso 1989:29).

**Item: 5 Occupation of TBAs**

![Bar chart showing occupation of TBAs](image)

Figure 4.2 Occupation of TBAs (trained) N= 36

(untained ) N= 24

According to figure 4.2 the majority (61%) of trained TBAs are housewives while more of the untrained TBAs are farmers (32%) and had more other alternative means (55%) of generating income than the trained TBAs. Clarke & Lephotso (1989:17) report that for TBAs in Lesotho, delivering women is not a full time occupation.
Other occupations mentioned were building, shop-keeping preaching, cooking and domestic cleaning. When asked about their source of income, 31.1 percent reported that they sold handicrafts and harvest, while 68.9 percent mentioned that they received money from their husbands and children. Selling of home made brew was mentioned more frequently as a source of income than selling fire wood, brooms, vegetables and poultry produce. Eades et al (1993:1505) found that for TBAs in Ghana attending to births was a part time activity, most of their primary income came from farming and trading.

**Item 6: Attendance of school by TBAs**

![Bar chart](#)

**Figure 4.3 Attendance of school by TBAs (trained) N=36 (Untrained) N=23**

Figure 4.3 shows that the majority of trained and untrained TBAs in the study attended school, only 14 percent of untrained TBAs had never attended school.
Item 7: Level of education attained by TBAs

Ninety-three percent of TBAs had obtained primary school level education. While only (6.6%) TBAs had obtained secondary level education. Formal education determines how trainable an individual can be, hence the selection of TBAs for training in Lesotho is based on the ability to read and write the local language (UNICEF & PHAL 1988:3).

4.2.2 Practice of TBAs

Item 1: Years of practice as a TBA

Sixty-six percent of TBAs both trained and untrained have been practising for more than 10 years while 34 percent have been practising for less than 10 years. This is confirmed by (WHO 1991:46) where TBAs were described as veterans in birth attendance because they had practised for at least 10 years.
Figure 4.4 illustrates that thirty-one percent of trained TBAs and 26 percent of untrained TBAs lived less than 5 kilometres from a health facility, while 69 percent of trained and 74 percent of untrained TBAs lived more than 5 kilometres from a health facility. This indicates that these TBAs and their clients travel long distances to reach health care facilities, hence women tend to be delivered at home by TBAs.

Long distances from health facilities do not only deter woman from using health facilities but are also an obstacle to timely referral during obstetric emergencies (Royston & Armstrong 1989:172).
Item 3: Place of practice of TBA

Table 4.1 Place of practice of TBAs (N=60)

<table>
<thead>
<tr>
<th>Place of practice</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>My village</td>
<td>56(93.3%)</td>
<td>4(6.7%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Neighbouring village</td>
<td>10 (16.7%)</td>
<td>50 (83.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Any where called</td>
<td>2 (3.3%)</td>
<td>58(96.7%)</td>
<td>60(100%)</td>
</tr>
</tbody>
</table>

The majority (93.3%) of TBAs practised in their own villages, 16.7 percent of TBAs practised in the neighbouring villages and 3.3 percent attended to deliveries any where they are called to assist. Singh (1994:122) indicates that TBAs have a well-defined area of operation because they provide culturally acceptable care and enjoy a position of trust and responsibility among local people.
Item 4: *Becoming a TBA*

Nearly 52 percent of the TBAs had learned the practice of midwifery from self-learning, through being asked to help or assist in a delivery, 13 percent had been taught by relatives particularly the mother and mother in law. Another 13 percent had been taught by an experienced TBA.

In addition to being taught by mother, mother-in-law and experienced TBAs, 22 percent was selected by their own communities for formal, ministry of health training because they were already providing the maternity service. Lefeber (1994:10) indicates that TBAs acquire skills through learning by doing, assisting in birth, and being taught by their mothers or grandmother and elderly TBAs. This indicates that TBA skills in Lesotho are still passed from generation to generation through apprenticeship.

Item 5: *Number of deliveries conducted by TBAs*

Most TBAs (78%) conducted less than five deliveries in a year while 12 percent conducted six to ten deliveries and 10 percent reported more than ten deliveries. To determine a difference between trained and untrained TBAs with regard the number of deliveries conducted when compared with years of experience, a chi-square was computed and $p=0.2$ which indicated that there was no significant difference. The number of deliveries attended to by TBAs differ from person to person. Successful TBAs who command great respect may have more clients than others WHO (1992) in Lefeber (1994:11).
4.2.3 Training of TBAs

Item 1: Initial training

There were 36 (60%) Trained TBAs and 24 (40%) untrained TBAs in the study.

Item 2: Duration of the initial training

Eighty percent of trained TBAs reported that they had been trained for the duration of two weeks. The remaining 20 percent mentioned that their training lasted from one to three weeks. Clarke and Lephotso in their study (1989: 16) indicated that a period of 2 weeks for initial training was not adequate, they therefore, recommended that the initial training be split into shorter periods and offered over a period of 3 to 6 months. Lefeber (1994: 100) also argues that practices and routines which are deeply rooted in the local culture cannot be changed by a few weeks of lectures and demonstrations. A further indication for the need to increase the period of initial training for TBAs.

Item 3: Place of training

According to the data, the health centre was frequently mentioned as a place for initial training by 80.6 percent of trained TBAs. The health service area hospital and a primary health centre were less utilised for training 11.1 percent and 8.3 percent respectively.
A clinic setting or arrangement is different from the home delivery setting therefore, if training is held in an environment different from the TBAs' own working conditions, TBAs are likely to reject what they learn as being inapplicable to their own work. Clarke and Lephotto (1989:18) argue that it is best to train them as close as possible to their homes. The room should be prepared to resemble a room or rondavel or a hut in which they will be working.

Item 4  A trainer for the initial training of TBAs

Two cadres of nurses conducted training of TBAs, namely public health nurses reported by 67 percent and nurse clinicians who were mentioned by 33 percent. Teachers of TBAs must be individuals of as similar a background to TBAs as possible. Nurse midwives and TBAs deliver and care for pregnant women therefore, they share the same goal of ensuring a healthy pregnancy and a live baby.
Item 5:  The content of initial training course for TBAs

Table 4.2  The content of initial training course for TBAs (N=36)

<table>
<thead>
<tr>
<th>Content</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care during ANC</td>
<td>34(94.5%)</td>
<td>2(5.5%)</td>
<td>36(100%)</td>
</tr>
<tr>
<td>Identify Risk Mothers</td>
<td>11(30.5%)</td>
<td>25(69.5%)</td>
<td>36(100%)</td>
</tr>
<tr>
<td>Safe Delivery</td>
<td>33(91.7%)</td>
<td>3(8.3%)</td>
<td>36(100%)</td>
</tr>
<tr>
<td>Reproductive Biology</td>
<td>3(8.3%)</td>
<td>33(91.7%)</td>
<td>36(100%)</td>
</tr>
<tr>
<td>Care of the baby</td>
<td>21(58.3%)</td>
<td>15(41.7%)</td>
<td>36(100%)</td>
</tr>
<tr>
<td>Postnatal</td>
<td>5(14%)</td>
<td>3(86%)</td>
<td>36(100%)</td>
</tr>
<tr>
<td>Other</td>
<td>14(39%)</td>
<td>22(61%)</td>
<td>36(100%)</td>
</tr>
</tbody>
</table>

Table 4.2 shows the content of training programs during the formal initial course. More TBAs responded positively to topics such as antenatal care (94.4%), safe delivery (91.7%) and to the care of the baby (58.3%). The explanation could be that they were able to recall what they understood better and could comprehend.
Other topics mentioned were:

- recognition of Tuberculosis
- avoidance of Medicinal herbs
- HIV/AIDS
- premature rupture of membranes and cord presentation

The course content of TBAs should be based on the prevalent obstetric problems, the knowledge and present practices of TBAs in the area. Many aspects of midwifery are too complex for TBAs to comprehend therefore, their training should be made simpler.

**Item 6: Attendance of a refresher training courses for TBAs**

**Item 7: Frequency of refresher courses for TBAs**

Item 6 and Item 7 were grouped together because they measure refresher training, 41 percent of the 36 trained TBAs had attended a refresher course. When asked how often these courses were held, 66 percent of the TBAs mentioned that the courses were held once a year, while 34 percent stated that refresher courses were held twice a year. Royston & Armstrong (1989:168) discussed a problem of regression among TBAs if there is no reinforcement of what they have learnt. If there is no follow up after training they soon revert to their old practices.
Item 8: Place of refresher training for TBAs

Eighty seven percent of TBAs who had refresher training were trained at health centres. Only 13 percent were trained at a health service area hospital and Primary Health Care Centre.

Item 9: Trainer for refresher training course.

In contrast with the initial training, the nurse clinician was frequently mentioned as the person who conducted the refresher training by 66.7 percent, followed by the public health nurse at 33.3 percent.
Item 10:  Content of the refresher training course for TBAs

Table 4.3 Content of the refresher training course for TBAs (N=15)

<table>
<thead>
<tr>
<th>Content</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Care</td>
<td>8(53%)</td>
<td>7(47%)</td>
<td>15(100%)</td>
</tr>
<tr>
<td>Identify risk mothers</td>
<td>5(33%)</td>
<td>10(67%)</td>
<td>15(100%)</td>
</tr>
<tr>
<td>Safe delivery</td>
<td>8(53%)</td>
<td>7(47%)</td>
<td>15(100%)</td>
</tr>
<tr>
<td>Reproductive biology</td>
<td>0</td>
<td>0(0)</td>
<td>0</td>
</tr>
<tr>
<td>Care of new born</td>
<td>7(47%)</td>
<td>8(53%)</td>
<td>(15(100%))</td>
</tr>
<tr>
<td>Postnatal Care</td>
<td>3(20%)</td>
<td>12(80%)</td>
<td>15(100%)</td>
</tr>
<tr>
<td>Other</td>
<td>4(26%)</td>
<td>11(74%)</td>
<td>15(100%)</td>
</tr>
</tbody>
</table>

Table 4.3 shows that the refresher course content does not differ from the initial training in terms of content reported by TBAs. The possible explanation could be that trainers do not consult with TBAs to assess the training needs before designing the refresher course.
**Item 11: Impact of training for TBAs**

The question was open in order to elicit the opinion of trained TBAs on the training. Ninety-six percent of trained TBAs who answered the question felt the training had been important, while 4 percent did not respond to the question.

The following were the ways TBAs felt the training had benefited them:

- they learned new techniques of delivery
- they learned which cases to refer to the clinic
- refresher training renewed the skills they had almost forgotten
- they learned how to protect themselves against HIV/AIDS
- training changed their old practices for better
- training helped them to understand the process of labour in terms of stages
- training had given them confidence in their practice
4.2.4 Antenatal care provided by TBAs

Item 1: Provision of antenatal care by TBAs

The study shows that out of 60 TBAs interviewed 55 percent (33 TBAs) provided antenatal care to pregnant mothers.

Item 2: Diagnosis of pregnancy by TBAs

Table 4.4 Diagnosis of pregnancy by TBAs trained (N=36) and Untrained (N=23)

<table>
<thead>
<tr>
<th>Signs</th>
<th>Trained N = 36</th>
<th>Untrained N=23</th>
<th>Significant Level (value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing Periods</td>
<td>20 (55%)</td>
<td>12 (52%)</td>
<td>0.79</td>
</tr>
<tr>
<td>Enlarged breast</td>
<td>17 (47%)</td>
<td>(30%)</td>
<td>0.2</td>
</tr>
<tr>
<td>Eating habits</td>
<td>15 (41%)</td>
<td>8 (34%)</td>
<td>0.59</td>
</tr>
</tbody>
</table>

As illustrated in table 4.4 missing of periods was mentioned by 55 percent of trained TBAs and 52 percent of untrained TBAs as a sign of pregnancy, followed by enlarged breasts (47%) by trained TBAs and 30% by untrained TBAs. Lastly change in eating habits was mentioned by 41.1 percent and 34 percent of trained and untrained TBAs respectively.
Other signs reported emphasised physical changes, such as:

- change of the complexion that is being fair
- being beautiful
- clear eyes
- nausea and vomiting
- an enlarged abdomen
- white teeth
- dark nipples

A chi-square was computed and level of significant (p) was more than 0.05 which confirmed that there was no significant difference between trained and untrained TBAs in their ability to diagnose pregnancy in as far as missing periods, enlarged breasts and eating habits were concerned.

Chalmers (1991:223) found that pregnancy in South Africa was kept as a secret from the community including some family members. She also found that cessation of menstruation and enlarged abdomen was regarded as signs of pregnancy. Pregnancy could be detected in the second trimester. This is further confirmed by (Sparks 1990:155).
Item 3:  *A place where antenatal care is provided by TBAs*

Table 4.5  *A place where antenatal care is provided by TBAs (N=33)*

<table>
<thead>
<tr>
<th>Place</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>My home</td>
<td>25(75.8%)</td>
<td>8(24.2%)</td>
<td>33(100%)</td>
</tr>
<tr>
<td>Woman's home</td>
<td>19(57.6%)</td>
<td>14(42.4%)</td>
<td>33 (100%)</td>
</tr>
<tr>
<td>Health centre</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Village health post</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table (4.5) shows that the majority (75.8%) of TBAs provided antenatal care in their homes, while 57.8 percent provided antenatal care in the pregnant mother’s home. There was no mention of health centre or health post as places where TBAs provided antenatal care.
**Item 4: First antenatal attendance by TBAs**

![Bar chart showing first antenatal attendance by TBAs](chart.png)

**Figure 4.5** First antenatal attendance by TBAs (trained) N=36

(Untrained) N=23

Figure 4.5 shows that half (50%) of the untrained TBAs saw their client for the first time in the first trimester compared to only 30 percent of the trained TBAs. The majority (56%) of trained TBAs saw their clients in the second trimester. This confirms findings of the Government of Lesotho and UNICEF (1994: 196) on the reluctance of women to utilise trained TBAs. Therefore, women present themselves to trained TBAs only during the second trimester.
Item 5: Antenatal care procedures done by TBAs

Table 4.6 Antenatal care procedures done by TBAs (N=33)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palpation</td>
<td>20(60.6%)</td>
<td>13(39.4%)</td>
<td>33(100%)</td>
</tr>
<tr>
<td>History Taking</td>
<td>3(9.1%)</td>
<td>30(90.9)</td>
<td>33(100%)</td>
</tr>
<tr>
<td>Abdominal Massage</td>
<td>5(15.2%)</td>
<td>28(84.8%)</td>
<td>33(100%)</td>
</tr>
<tr>
<td>Other</td>
<td>11(33.3%)</td>
<td>22(66.7%)</td>
<td>33(100%)</td>
</tr>
</tbody>
</table>

Table 4.6 shows that palpation (60.6%) is the activity most frequently performed by TBAs during antenatal visits. Abdominal massage performance in Lesotho has been reported by Clarke and Lephoto (1989:14) it is, however, interesting to note that many 84.8 percent of TBAs reported that they did not perform an abdominal massage. The possible explanation could be that, trained TBAs have been discouraged to perform a massage during pregnancy for fear of detaching the placenta in a vigorous massage. Ironically history taking is less done although it can provide information on potential risks among pregnant women. Other activities reported included external versions if the presentation was not a normal vertex.
Item 6: Health education given during pregnancy by TBAs

Table 4.7 Health education given during pregnancy by TBAs (N=33)

<table>
<thead>
<tr>
<th>Health Education</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>27 (81.8%)</td>
<td>6 (18.2%)</td>
<td>33(100)</td>
</tr>
<tr>
<td>Diet</td>
<td>29 (87.8%)</td>
<td>4 (12.2%)</td>
<td>33(100)</td>
</tr>
<tr>
<td>Exercise</td>
<td>5 (15.2%)</td>
<td>28 (84.8%)</td>
<td>33(100)</td>
</tr>
<tr>
<td>Rest</td>
<td>8 (24.3%)</td>
<td>25 (75.7%)</td>
<td>33(100)</td>
</tr>
</tbody>
</table>

The majority (87.8%) of TBAs offered various dietary recommendations while 81.8 percent advised women on cleanliness. Very few TBAs advised women to exercise and rest. In Sesotho custom a pregnant mother is not allowed to sleep during the day otherwise it is feared that she will experience difficult labour, hence women are not advised to rest (informal discussion with TBAs). The data indicates that TBAs play an important role in providing health information to pregnant mothers.
Item 7: *Determination of the baby’s lie by TBAs*

Sixty-three percent of the TBAs mentioned that they could identify the position or the lie of the baby through palpation and they said that the head felt hard and moved like a ball. They could also determine the lie by locating the back, which they said felt smooth on palpation, 37 percent stated that they could not determine the lie of a foetus. Nyasulu and Mzolo (1993:13) found that TBAs in Brazil could identify the foetal head as a hard substance that felt like a coconut on palpation. The ability to determine the position of a baby in utero is very crucial for prevention of complicated labour in cases of malpresentations.

Item 8: *Frequency of visits done by TBAs*

<table>
<thead>
<tr>
<th>Frequency of visits</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a month</td>
<td>4 (12.1%)</td>
</tr>
<tr>
<td>Every two weeks</td>
<td>0</td>
</tr>
<tr>
<td>Any time</td>
<td>29 (87.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>33 (100%)</td>
</tr>
</tbody>
</table>

Table 4.8 Frequency of visits done by TBAs (N=33)
The majority (87.9%) of TBAs saw their clients anytime when it was convenient for both the woman and the TBA, while 12.1 percent saw pregnant women once a month. Lang and Elkin (1997:27) also found that in Guatemala TBAs visited their clients during antenatal but the visits were not regularly scheduled and the visits began late in pregnancy.

**Item 9:** Conditions referred during antenatal care by TBAs (this is a multiple response question). Responses on each of the options were calculated on 100 percent basis and those who said no are not reflected.

To determine the ability of both trained and untrained TBAs to recognise a maternal risk during the antenatal, period they were asked to mention cases they would refer to a health facility.

**Table 4.9** Conditions referred during antenatal care by TBAs trained (N=36) vs untrained (N=23)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Trained N=36</th>
<th>Untrained N=23</th>
<th>Significance Level p</th>
</tr>
</thead>
<tbody>
<tr>
<td>During illness</td>
<td>23 (63.9%)</td>
<td>3 (13.0%)</td>
<td>0.00012</td>
</tr>
<tr>
<td>Antepartum haemorrhage</td>
<td>23 (63.0%)</td>
<td>2 (8.71%)</td>
<td>0.00003</td>
</tr>
<tr>
<td>Leaking Membranes</td>
<td>6 (16.7%)</td>
<td>1 (4.3%)</td>
<td>0.153</td>
</tr>
<tr>
<td>Previous Difficult Labour</td>
<td>6 (16.7%)</td>
<td>0</td>
<td>0.03</td>
</tr>
<tr>
<td>Others</td>
<td>17 (47.0%)</td>
<td>2 (8.71%)</td>
<td>0.021</td>
</tr>
</tbody>
</table>
Table 4.9 shows that trained TBAs referred patients with any illness (63.9%) and antepartum haemorrhage (63.9%) more frequently than untrained TBAs and there was high statistical difference for both conditions. Conditions such as leaking membranes and previous difficult labour were less reported. This confirms the findings of Sparks (1990:156) in Zimbabwe where trained TBAs were able to articulate specific reasons or indications for referral of cases such as primigravidae and haemorrhage better than the untrained TBAs.

One major objective of TBA's training programmes is to empower TBAs with skills to identify high-risk pregnancies and refer them to an appropriate health care facilities. Haemorrhage is one major cause of maternal mortality and morbidity (Myles 1996:32). It is therefore, important that TBAs should be able to identify such risks. It can be concluded therefore, that trained TBAs showed better knowledge of maternal risk cases they would refer than the untrained TBAs. The observed difference could be a result of training.

Other conditions reported as indications for referral were:

- primigravidae
- multiparous women
- absence of foetal heart beat
- vomiting
- vaginal discharges
The importance of identifying risks such as primigravidae and multiparous women is to ensure that such women are being prepared to deliver in a hospital not at home. Absence of a foetal heartbeat denotes intrauterine death and requires immediate attention to save the life of the mother. Vomiting and vaginal discharges cause discomfort to a pregnant woman and therefore, requires medical attention.

4.2.5 Treatment of illness during the antenatal period

Item 10: Use of herbs by TBAs for illness during pregnancy

Table 4.10 Use of herbs by TBAs for illness during pregnancy trained (N=25) untrained (N=6)

<table>
<thead>
<tr>
<th>Frequency of giving herbs</th>
<th>Trained N=25</th>
<th>Untrained N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>15 (60%)</td>
<td>1 (16.7%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>10 (40%)</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>Always</td>
<td>0</td>
<td>2 (33.3)</td>
</tr>
<tr>
<td>P. = 0.006</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.10 shows that untrained TBAs were giving medicinal herbs to pregnant mothers more frequently, than trained TBAs in the event of illness.

To determine the statistical difference between trained and untrained TBAs a chi-square was computed and P=0.006 which indicates that the difference observed is significant. It can be assumed from the few responses on the question that many TBAs did not answer because of secrecy in the utilisation of herbs. Use of herbs during antenatal care is not only common in Southern Africa (O’Mahony & Steinberg 1995:1170).
Use of herbs has also been reported in Latin America by Lefeber (1994:61). Clarke and Lephotso (1989:71) have documented use of herbs in Lesotho but these herbs have not been chemically analysed to determine their oxytocic and analgesic properties or their toxicity. UNICEF (1986:8) discourages the use of traditional plants or medications that may result in a pharmacologic reaction, unless clearly known or shown to be beneficial.

**Item 10.1: Calling of a traditional healer by TBAs**

The majority (92%) of TBAs reported that they never called a traditional healer in the event of illness during pregnancy, only 8 percent stated that they summoned a traditional healer. A P value of 0.5 shows that trained and untrained TBAs do not differ with regard to calling a traditional healer for treatment in pregnancy.

**Item 10.2: Referral to a health facility by TBAs**

Out of 33 TBAs who provided antenatal care 86.2 percent reported that they would refer pregnant women in the event of illness. A chi-square was computed and P = 0.1 which indicated that there was no significant difference between trained and untrained TBAs with regard to referring a woman to a health facility during illness. The data indicates that the status of training does not influence the health seeking behaviour of TBAs in the event of illness during pregnancy.
Item 11: Performance of a vaginal examination by TBAs

Item 12: How a vaginal examination is performed by TBAs

Out of 33 both trained and untrained TBAs, 91.4 percent reported that they never performed a vaginal examination during pregnancy. Only 8.6 percent reported that sometimes they performed a vaginal examination. They performed the examination, by inserting one, two or even three fingers of the right hand into the vagina. This is not done to determine the engagement of the head, as it is done at the 32-second week of pregnancy to assess the pelvic capacity. Vaginal examinations are usually not advisable during pregnancy.

Item 13: Methods used by TBAs to determine wellness of the foetus (multiple response question) Each option is calculated on 100 percent

All TBAs who provide antenatal care said they knew that a baby was well by kicks or movement felt by the pregnant mother. Fifty-five percent of TBAs said they were also able to determine the wellness when the foetal heart is normal. The study did not determine how TBAs knew if the foetal heart was normal, which is a limitation.
Item 14: How TBAs listen to foetal heart

Very few TBAs (8.3%) were able to monitor the foetal heart and they did that by placing the ear on the women’s abdomen and listened over the level of the umbilicus. Among the five TBAs who answered the question, 40 percent said they could differentiate maternal heartbeat from foetal heart, in that the maternal heartbeat was slower than the that of foetus.

This indicates that a very small percentage of TBAs have the skill to determine the foetal heart sound by abdominal palpation and this is cause for concern.

Item 15: Methods used by TBAs to determine health status of the pregnant mother.

(multiple response question) each option is calculated on 100 percent

Thirty percent of the TBAs who provided antenatal care reported that they could tell that a pregnant woman was well if she gained weight, 57 percent said a woman was well if there is no burning on micturition, 70 percent if there is no itching vaginal discharge and 45 percent said the absence of oedema was a good sign of health. This indicates that TBAs can identify problems during pregnancy.
4.2.6 Labour

4.2.6.1 First stage of labour

Item 1: Stage at which TBAs are called to assist a woman in labour

In this question the respondent could choose more than one response.

Every option is calculated on 100 percent

There were varying reports of when a TBA is usually called to assist with a delivery, 73 percent of TBAs stated that they are called when a woman is about to deliver while 89 percent mentioned that they are called at the onset of labour.

Clarke and Lephoto (1989:26) reported that in Lesotho the TBA is called at the onset of labour, a different finding from what this research found. Families determines who to call and when to call a TBA. Sometimes TBAs are called in an advanced stage of labour or late when there are complications or when labour is retarded. This has been reported in Zimbabwe, where a TBA is called to the pregnant woman’s hut during advanced labour (Sparks 1990:156).
Item 2:  *Length of time TBAs stayed with the woman during labour*

Ninety eight percent of interviewed TBAs said that once called to assist, they remain with the woman until the delivery process is complete.

Item 3:  *Signs used by TBAs to determine whether a woman is in labour (multiple response question)* each option is calculated on 100 percent

When questioned about how they knew if a woman was in true labour 72 percent of all TBAs in the study stated that true labour was characterised by abdominal pain. Twenty six percent said when a woman had an urge to bear down, 57 percent cited restlessness, and 13 percent recognised true labour by vomiting and 50 percent by sweating. All these signs are usually present during labour, but true labour is characterised by rhymic frequent contractions, dilatation of the cervix and the descent of the head (Myles 1996:161). These responses indicate that TBAs have limited knowledge of the physiology of the first stage of labour.

Item 4:  *Strategies used by TBAs if labour does not progress (Open-ended question)*

When TBAs were asked to mention what they would do if labour did not progress well, out of 56 TBAs who responded to the question the majority (82%) reported that they would refer the woman to a health care facility, that is a health centre or a hospital.
Seven percent stated that they would give medicinal herbs, while another 7 percent said that they had never experienced the problem, 1.7 percent waited for God's help, another 1.7 percent massaged the woman with warm water to stimulate contractions and the last 1.7 percent called other TBAs to help. The findings indicate that there is little that a TBA can do if labour does not progress well, however, their crucial role in the prevention of prolonged labour is to arrange for the timely transfer of the mother to a higher level of care before damage is done.

**Item 5: Duration of labour considered acceptable by TBAs**

Table 4.11 Duration of labour considered acceptable by TBAs trained (N=30)

<table>
<thead>
<tr>
<th>Duration</th>
<th>Trained N=30</th>
<th>Untrained N=22</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 hours</td>
<td>15 (50.5%)</td>
<td>16 (72.8%)</td>
</tr>
<tr>
<td>6-10</td>
<td>11 (36.6%)</td>
<td>3 (13.6%)</td>
</tr>
<tr>
<td>12 plus</td>
<td>2 (6.7%)</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2 (6.7%)</td>
<td>3 (13.6%)</td>
</tr>
</tbody>
</table>

Table 4.11 shows that the majority of both trained (50%) and untrained (72.8%) TBAs considered a period of 1 to 5 hours as an acceptable duration of labour but more untrained TBAs reported shorter duration of labour than trained TBAs.
It is important to note that some TBAs indicated that the length of labour differed from person to person. They said that women who are having a child for the first time took a longer period than a woman who has had more children. UNICEF (1986:32) reports that the only guide for the TBA to estimate duration of labour is the simple passage of time from what she considers to be the onset of labour. UNICEF further shows that the length of labour acceptable before referral to an appropriate health facility depends on ease of transfer and the distance to be travelled.

The acceptable period of labour is 8 hours in a multiparous woman and 12 hrs in a primigravida. TBAs have adopted guidelines of transferring a woman if one whole day or one whole night pass without progress. Williams et al (1994:105) have also reported this.

**Item 6: Fluids given by TBAs during labour**

**Table 4.12 Fluids given by TBAs during labour (N=59)**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Fluids intake during labour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Never</td>
<td>19</td>
</tr>
<tr>
<td>Sometimes</td>
<td>12</td>
</tr>
<tr>
<td>Always</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
</tr>
</tbody>
</table>
Table 4.12 shows that the majority (67.8) of TBAs give fluids to women in labour. This confirms the findings of Cook (1996:98) where she indicated that TBAs in Cambodia encouraged women to eat and drink in labour to keep up energy levels and to keep mobile. The 32.2 percent that does not give fluids, give rise to concern because if a woman is deprived of fluids when in labour, she may be exposed to dehydration and exhaustion.

**Item 7: Management of pain during labour by TBAs**

Out of 18 TBAs who responded to the question, 38.8 percent reported that they did not control pain because it is natural for a woman to experience pain in labour. Twenty seven percent (27.8%) of TBAs massaged the back with warm water, animal fat, Vaseline and red ochre to promote warmth or heat to relief pain. Another 27.8 percent administered boiled herbal mixtures like sekete, lesoko and selomi, 5.6 percent mentioned that avoidance of bearing down before the time and breathing in and out during a contraction relieved pain. Not all traditional practices are harmful; for instance, the practice of back massage for pain relief is strongly encouraged because of its effectiveness (Cook 1996: 98).
Item 8: Hygienic practices of TBAs

To determine TBAs’ hygienic practices during labour. They were asked if they shaved pubic hair, how often they cleaned the vulva and washed hands before delivery. Sixty-five percent of all TBAs never shaved the pubic hair while 11.7 percent sometimes shaved the pubic hair and 23 percent always shaved.

Item 8.1: Cleaning the vulva of the women in labour by TBAs

Table 4.13 Cleaning the vulva of the women in labour by TBAs trained (N=36)  

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Trained N=36</th>
<th>Untrained N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>7 (19.5%)</td>
<td>14 (60.9%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>4 (11.1%)</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Always</td>
<td>25 (69.4%)</td>
<td>8 (34.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

P = 0.005

Table 4.13 illustrates that trained TBAs cleaned the vulva during labour more often than the untrained TBAs and that the difference was highly significant. This could be attributable to the fact that hygiene was included in the training programme.
**Item 8.2: Washing of hands by TBAs during labour**

Table 4.14 Washing of hands by TBAs during labour

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Trained N=35</th>
<th>Untrained N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2 (5.7%)</td>
<td>7 (30.4%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2 (5.7%)</td>
<td>0</td>
</tr>
<tr>
<td>Always</td>
<td>31 (88.6%)</td>
<td>16 (69.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

*p = 0.003*

Table 4.14 indicates that there is a significant difference between trained and untrained TBAs, with regard to washing hands before delivery which is in line with item 8.1 cleaning the vulva. Trained TBAs reported improved hygienic practices when compared to their untrained colleagues, an indication that training had an influence on hygienic practices of trained TBAs. TBAs can help reduce tetanus and other infections by adopting hygienic measures (Williams et al 1994:220).
Item 12: Vaginal examination during labour by TBAs

Of all the TBAs, 81.7 percent in the study never performed a vaginal examination during the first stage of labour. This response is similar to that on the item on vaginal examination during pregnancy where 91.4 percent indicated that they do not perform vaginal examination. Only 18.3 percent did perform vaginal examination, and they did that by inserting one, two or even three fingers of the right hand into the vagina. This is not done to determine the degree of cervical dilatation but to feel for the head. A vaginal examination during labour is an aseptic procedure if it is done carelessly, there is a risk of introducing infection or organisms into the vagina (Myles 1996:159). It is encouraging therefore to note that few TBAs do vaginal examination.

Item 13: Stage at which the vaginal examinations are done by TBAs during labour

There was no significant difference observed in determining who often performed a vaginal examination between the trained and untrained TBAs. Out of 18 TBAs who performed a vaginal examination 33.3 percent reported that they did so when the woman showed signs of labour, another 33.3 percent said they conducted vaginal examination when the head is not visible at the vulva. The remaining 33.4 did not respond to the question. The possible explanation for the non-response could be that they truly did not know the stage at which vaginal examination is done during labour.
Item 14: Reasons given by TBA for performing a vaginal examination during labour

A vaginal examination during labour was performed to:

- determine the level of the foetus (50%) TBAs
- determine if the woman is indeed in labour (5.6%) TBAs
- determine dilatation of the cervix cited by (5.6%) TBAs

Of the respondents 38.8 percent did not respond. The possible explanation for the non-response could be that they did not know the purpose why vaginal examination is done during labour. UNICEF (1986:31) indicates that the only well established means of monitoring the progress of labour is by assessment of the dilatation of the cervix through a vaginal examination. But the risk of introducing infection by poor technique such as not washing hands makes it inappropriate to recommend vaginal examination to TBAs.

Item 14: The extend to which TBAs were involved in the measuring of the dilatation of the cervix during labour

One TBA who responded positively to measuring cervical dilatation said she did that by feeling for a ring of the cervix around the head, absence of the cervix or appearance of the head at the vulva indicated full dilatation of the cervix. One response to the question can be an indication of lack of knowledge of the first stage of labour, which is characterised by dilatation of the cervix; hence TBAs encourage women to bear down before the cervix is fully dilated.
4.2.6.2 *Second stage of labour*

**Item 1:** *The stage at which TBAs encourage women to bear down in labour*

Table 4.15  The stage at which TBAs encourage women to bear down in labour  
(N=60)

<table>
<thead>
<tr>
<th>The stage at which TBAs encourage women to bear down in labour</th>
<th>YES</th>
<th>NO</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>When bag of waters has rupture</td>
<td>10(16.7%)</td>
<td>50(83.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Once labour has started</td>
<td>3(5%)</td>
<td>57(95%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>At advanced stage of labour</td>
<td>42(70%)</td>
<td>18(30%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Before contractions start</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>27(45%)</td>
<td>33(55%)</td>
<td>60(100%)</td>
</tr>
</tbody>
</table>

The majority of TBAs (70%) said they encouraged a woman in labour to bear down when she is in an advanced stage of labour, that is when birth is eminent followed by other signs (45%) and when membranes have ruptured (16.7%).
Item 2: Maternal signs indicating that birth is eminent

This was a multiple response question each option is calculated on 100 percent.

Table 4.16 Maternal signs indicating that birth is eminent (N=60)

<table>
<thead>
<tr>
<th>Signs</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman feels hot</td>
<td>36(60%)</td>
<td>24(40%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Perspiring</td>
<td>44(73.3%)</td>
<td>16(26.7%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Cannot walk</td>
<td>7(11.7%)</td>
<td>53(88.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Urge to push</td>
<td>43(81.7%)</td>
<td>17(18.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Urge to defecate</td>
<td>26(43.3%)</td>
<td>34(56.7%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Other</td>
<td>(45%)</td>
<td>(55%)</td>
<td>60(100%)</td>
</tr>
</tbody>
</table>

Table 4.16 shows that 73.3 percent stated that they could tell that birth is eminent, when a woman is perspiring, 81.7 percent when there is an urge to push and 43.3 percent when there is an urge to defaecate. Other signs (45%) which indicated eminence of birth were:

- intense contractions,
- gaping vagina and the anus
- when the presenting part is visible
Mangay-Maglacas and Pizurki (1981:79) report that TBAs assess the advanced stage of labour externally by observing the women's state of agitation and frequency of contractions. Rupture of membranes is not considered to be a sign of impending birth.

**Item 3: Delivery positions recommended by TBAs during delivery**

![Pie chart showing delivery positions recommended by TBAs]

**Figure 4.6 Delivery positions recommended by TBAs (trained) N=36**

(Untressed) N=23

The position of delivery mentioned most frequently by TBAs was lithotomy (66.2%) squatting and other positions such as sitting and kneeling (34.8%) were less reported. Trained TBAs have been reported to use the lithotomy position because that is the position they are taught to use and the position also used in health care facilities.
UNICEF (1986:27) argues that traditional birth practices such as squatting, kneeling and standing positions during delivery are associated with a greater size of the pelvic outlet.

**Item 4: Methods used by TBAs to identify maternal risk during labour**

*(multiple response question) each Option is calculated on 100 percent*

To determine the ability to recognise maternal risk during labour TBAs were asked to say under which conditions they would refer a woman. Of both trained and untrained TBAs, 51.7 percent stated that they would refer a woman if labour is prolonged and 46.7 percent said they would refer in cases of haemorrhage. Forty-percent would refer when there is malpresentation and 36.7 percent for previous caesarean delivery.

Other conditions for which TBAs said they would refer were:

- multiparous women
- primigravidae
- premature labour
- cord prolapse

The ability to screen and refer can be effective in saving life if TBAs are capable of identifying certain categories of women in whom there is an increased risk of maternal or neonatal mortality and morbidity (Royston & Armstrong 1989:160). UNICEF (1986: 29) indicates that TBAs are very receptive to the idea of screening and referral of high risk mothers to appropriate facilities. They can readily recognise such risks as previous pregnancy mishaps, bleeding prior to labour or during labour.
4.2.6.3 Third stage of labour

Item 1: Care of the perineum by TBAs during labour (an open ended question)

Out of 48 TBAs who answered the question 67 percent said they supported the perineum by making a woman sits on a ring made of a clean cloth, a blanket or supported the perineum with cotton wool and also a hand to prevent tears during delivery. Of the TBAs 8.3 percent supported the perineum with heels when a woman delivers in a kneeling position. While 8.3 percent stated that if a woman opens her legs too far apart a tear will occur. Two percent lubricated the perineum with milk, cream and another two percent said a woman must have a tear particularly with the first child. Jacobs (1989:19) in the Northern Cape described how TBAs continually massaged the perineum with warm olive oil during the down bearing stage, a practice believed to make the perineum less liable to tears. Mapondera (1989) in (Lefeber 1994:25) reported that in Zimbabwe the perineum is prevented from tearing during second stage, by massaging with herbs throughout the first stage of labour.

Item 2: Care of a vaginal tear by TBAs (open ended question)

Both trained and untrained TBAs said if a woman sustained an extensive tear she is referred to a health centre for suturing, but if it is a snick or small laceration, they encouraged the woman to have warm sitz baths of salt and herbs such as moretele.
Use of herbs and warm sitz baths to hasten the healing of a perineum have been reported in Yemen (Williams et al 1994: 227) and among the Zulus where perineal tears are irrigated with a solution of salt or dettol (Lefeber 1994:34).

Item 3: Methods used by TBAs for clearing the airway of the baby

Immediately after the birth of the baby all TBAs (60) cleared the baby’s mouth by using an index finger to facilitate easy breathing.

Item 4: Procedures done by TBAs after delivery

Table 4.17 Procedures done by TBAs after delivery (N=60)

<table>
<thead>
<tr>
<th>Procedures done by TBAs after delivery</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tie the umbilical cord and cut</td>
<td>53(88.3%)</td>
<td>7(11.7%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Dried the baby with a towel</td>
<td>15(25%)</td>
<td>45(75%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Cover with a blanket</td>
<td>49(81.7%)</td>
<td>11(18.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Give the baby to the mother</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Initiate breast feeding</td>
<td>1(1.7%)</td>
<td>59(98.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Others</td>
<td>15(25%)</td>
<td>45(75%)</td>
<td>60(100%)</td>
</tr>
</tbody>
</table>
Table 4.17 shows that the majority (88.3%) of TBAs tied the umbilical cord after the delivery of the baby. Eighty two percent covered the baby with a blanket to keep it warm, while 15 percent dried the baby. Babies are born wet therefore, they can get cold very quickly. They must be dried with a dry cloth and covered with warm blanket immediately after birth.

UNICEF (1986:34) argues that home delivery although wrapped in rituals and magic have often resulted in the provision of a scientifically sound warm and humid environment in contrast to health centres and hospitals which are often open to breezes and have either inadequate or no source of heat. The majority of TBAs did not respond to breast feeding. This contradicted the finding of the item on initiation of breast feeding where 88.3% of TBAs stated that they encouraged mothers to breast feed immediately after delivery.

Other activities done included the following:

- the mother measured the cord and cut it at the level of the baby's knee. This is done after the delivery of the placenta
- sometimes an elderly woman, who is no longer sexually active or who does not indulge in sex, could cut a cord
- some TBAs used a clean razor to cut the cord other used a reed
**Item 6: Delivery of the placenta by TBAs**

Data shows that 98 percent of TBAs delivered the placenta immediately after the baby is born. Two percent waited for some time.

**Item 7: Methods used by TBAs to deliver the placenta (open ended question)**

Out of 20 trained TBAs who answered the question, 80 percent delivered the placenta by rubbing the abdomen, and by asking the woman to pass urine then to bear down or cough. Ten percent applied pressure on the abdomen, 5 percent tied the cord on the mother’s thigh. TBAs emphasised that tying the cord on the mother’s thigh acted as a traction and the placenta usually came out. Only 5 percent asked a woman to bear down after seeing a gush of blood, an indication that the placenta had separated from the uterus.

On the other hand 25 percent out of the 20 untrained TBAs asked a woman to bear down and 15 percent administered a herbal mixture *qobo*. 5 percent of TBAs gave a raw egg to facilitate separation from the uterus, 50 percent said the placenta came out spontaneously and only 5 percent believed that the placenta comes with the baby. UNICEF (1986:32) found that in traditional societies where women deliver in upright positions it is possible that the force of gravity and maternal effort to push help in placental expulsion.
**Item 8: Examination of the placenta by TBAs**

Figure 4.7 illustrates that trained TBAs always examined the placenta to ascertain complete expulsion, while the majority (70%) of the untrained never examined the placenta. Only one untrained TBA who was also a traditional healer reported that she examined the placenta to exclude cancer known as *mofetse* in Sesotho.

Examination of the placenta is important because if the placenta is not completely delivered the woman will continue to bleed vaginally and this is a serious condition, which requires immediate referral.
Table 4.18 Management of a retained placenta by TBAs (N=60)

<table>
<thead>
<tr>
<th>Management measures</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubbing the abdomen</td>
<td>11(18.3%)</td>
<td>49(81.7%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Blowing into a bottle</td>
<td>22(36.7%)</td>
<td>38(63.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Giving herbs</td>
<td>10(16.7%)</td>
<td>50(83.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Others</td>
<td>17(55%)</td>
<td>43(45%)</td>
<td>60(100%)</td>
</tr>
</tbody>
</table>

Table 4.18 illustrates various measures of management reported when the placenta is retained or when there are delays in the delivery of the placenta, 18.3 percent of TBAs rubbed the abdomen. Blowing into a bottle was reported by 36.7 percent of TBAs while giving herbs was mentioned by 16.7 percent, 55 percent used other ways, which included the following:

- stimulate sneezing
- stimulate vomiting
- give a herbal mixture
- give a mixture of soot
- give boiled horse placenta
- summon a traditional healer
Lefeber (1994:30) reports that in cases of retained placenta, massaging or rubbing the abdomen, blowing into a bottle and giving herbs have been reported from Kenya, Zimbabwe, Malawi and South Africa among the Zulus. Clarke and Lephoto (1989:68) have also reported the use of soot mixture and boiled horse’s placenta in Lesotho.

**Item 10: Views of TBAs regarding post partum haemorrhage (open ended question)**

TBAs were asked to state their views regarding bleeding after delivery of the 51 TBAs who answered the question, the majority (96%) believed that post partum haemorrhage endangered the woman’s health. However, 17 percent of the untrained TBAs stated that they managed haemorrhage by using a herbal mixture *Qobo* and applied red ochre in the vagina. Six percent believed that bleeding cleansed the uterus of the dirty blood that collected in the uterus during the nine months of pregnancy when a woman was not menstruating.

Lefeber (1994:74) shows that comparison of practices and beliefs of TBAs in Africa and Asia has revealed strikingly common practices or beliefs such as believing that postpartum haemorrhage is not alarming as it is considered to be the flow of bad blood.
Table 4.19 Methods used by TBAs to resuscitate the baby (N=60)

<table>
<thead>
<tr>
<th>Resuscitation methods by TBAs</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swing the baby in the air.</td>
<td>3(5.0%)</td>
<td>57(95.0%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Turn the baby upside down</td>
<td>12(20.0%)</td>
<td>48(80.0%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Apply alcohol to the baby’s body</td>
<td>1(1.7%)</td>
<td>59(89.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Splashing with cold water into the baby’s face</td>
<td>22(36.7%)</td>
<td>38(63.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Percussing the back</td>
<td>15(25%)</td>
<td>45(75.0%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Blow on the fontanel</td>
<td>1(1.7%)</td>
<td>59(89.3%)</td>
<td>60(100%)</td>
</tr>
<tr>
<td>Others</td>
<td>34(56.7%)</td>
<td>26(43.3%)</td>
<td>60(100%)</td>
</tr>
</tbody>
</table>

Table 4.19 displays that in cases where a baby did not breathe well at birth, splashing the baby’s face with cold water or blowing on the baby’s face, was done by 36.7 percent. Percussing the back of the baby was done by 25 percent. TBAs readily recognise asphyxia but they have limited resources e.g. (no mucous extractor) to tackle the problem (UNICEF 1986: 33).
Other measures included.

- applying alcohol or oil on the baby’s body
- startle the baby by throwing grains of millet on the baby’s body
- cover the baby with a washing basin and beat the top like a drum
- blow into the baby’s nose

These responses indicate that TBAs do not understand that sometimes the secretion may block the breathing passage of the newborn baby and prevent the baby from breathing or crying well, therefore, the solution is to remove the secretions from the baby’s mouth.

4.2.7 Post partum care carried out by TBAs

Item 1: Home visits done after delivery by TBAs

Nearly all TBAs (97 %) interviewed, stated that they visited a mother after delivery.

Item 2: Time at which first home visits are done by TBAs after delivery

Table 4.20 Time at which first home visits are done by TBAs after delivery (N=50)

<table>
<thead>
<tr>
<th>Time at which first home visits are done by TBAs after delivery</th>
<th>Frequency N=50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately after delivery</td>
<td>14(28%)</td>
</tr>
<tr>
<td>One day after delivery</td>
<td>31(62.0%)</td>
</tr>
<tr>
<td>More than a day</td>
<td>5(10.0%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50(100%)</td>
</tr>
</tbody>
</table>
In table 4.20, 62 percent of TBAs reported that postnatal visits began after one day, 28 percent said visits began immediately after delivery. Only 10 percent stated that the onset of visits was delayed by more than a day.

**Item 3: Duration of post partum care given by TBAs**

4.21 Duration of postpartum care given by TBAs

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Everyday N=34</th>
<th>Firstweek N=44</th>
<th>2weeks+ N=28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>20 (58.8%)</td>
<td>6 (13.6%)</td>
<td>21 (75%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1 (3%)</td>
<td>10 (22.8%)</td>
<td>3 (10.7%)</td>
</tr>
<tr>
<td>Always</td>
<td>13 (38.2%)</td>
<td>28 (63.6%)</td>
<td>4 (14.3%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>34 (100%)</td>
<td>44 (100%)</td>
<td>28 (100%)</td>
</tr>
</tbody>
</table>

According to table 4.21, when the TBAs were asked for how long they cared for a mother who has given birth, the majority (63.6%) of TBAs said that they always cared for the woman for a period lasting for a week, 14.3 percent cared for the woman for more than a week. Only 38.2 percent of TBAs visited women every day. It is desirable for a woman to be cared for a longer period to ensure that complications of pueperium such as infections and haemorrhage are not missed. It is alarming to note that 58.8 percent never visited the mother every day and 75 percent do not visit the mother for longer than a week.
Table 4.22 shows that checking the baby’s cord (63.3%), encouraging breast feeding (35%) and washing clothes (50%) are activities frequently performed during the post partum care visits. During the puerperium period the nursing mother is well looked after so that she can get a good rest, regain former strength and vigour so that she can provide the baby with sufficient breast milk. To keep fit she is expected to do light household chores such as washing napkins and the baby (UNICEF 1998: 23).
Other activities reported from open-ended questions

TBAs said following a delivery they examined the woman’s vulva, to rule out lacerations and oedema, they checked the lochia known as *malula* in Sesotho and encouraged the woman to breast-feed. They further reported that some families do not permit breast feeding until the cord has fallen off. This practice undermines the importance of nutrition in a baby and it is as a result of ignorance. Trained TBAs stated that during the post natal visits they checked if the baby passed stools, weighed the baby and covered the cord with a clean cloth. While the untrained reported that they applied cow dung or Vicks to the cord. When the cord fell off, they burned it in the house to protect the baby from witches.

**Item 5: Initiation of Breast Feeding by TBAs**

**Table 4.23  Initiation of breast feeding by TBAs (N=60)**

<table>
<thead>
<tr>
<th>Initiation of breast feeding by TBAs</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately after birth</td>
<td>53 (88.3%)</td>
<td>7 (11.7%)</td>
<td>60 (100%)</td>
</tr>
<tr>
<td>After 24 hours</td>
<td>4 (6.7%)</td>
<td>56 (93.3%)</td>
<td>60 (100%)</td>
</tr>
<tr>
<td>After 2 to 3 days</td>
<td>3 (5.0%)</td>
<td>57 (95.0%)</td>
<td>60 (100%)</td>
</tr>
</tbody>
</table>

The majority (88.3%) of TBAs according to table 4.23 encouraged mothers to breast feed their babies immediately after delivery.
It is believed that breast feeding helps the uterus to contract hence the practice is encouraged soon after delivery, this is confirmed by (UNICEF 1986: 32). When asked to give a reason for choice of time when they initiated breast feeding, some TBAs said that the onset of breast feeding is influenced or determined by the condition of the mother after delivery, if the mother is sick, breast feeding may be delayed.

**Item 6: Management of complicated obstetric cases by TBAs (open ended question)**

In cases of delivery complications such as obstructed labour, post partum haemorrhage, and a retained placenta, nearly all TBAs said that they used hired vehicles, to refer the mother to a health facility. Some carried a woman on a stretcher and others used a scotch cart. The importance of availability of transport for obstetric emergencies cannot be over emphasised. Distance and availability of transport determine how soon a woman can reach a health facility for help in an emergency (Royston & Armstrong 1989:170).
4. 2.8: Support and supervision of TBAs

Item 1: Availability of a delivery kits used by TBAs

Out of 36 trained TBAs 24 had delivery kits and the following items as listed in table 4.24 were found in the kits.

Item 2: Contents of a delivery kit used by TBAs

Table 4:24 Contents of a delivery kit used by TBAs (N=24)

<table>
<thead>
<tr>
<th>Items</th>
<th>Yes</th>
<th>No</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scissors</td>
<td>19 (79.2%)</td>
<td>5 (20.8%)</td>
<td>24(100%)</td>
</tr>
<tr>
<td>Gloves</td>
<td>22 (91.6%)</td>
<td>2 (8.4%)</td>
<td>24(100%)</td>
</tr>
<tr>
<td>Soap</td>
<td>19 (79.2%)</td>
<td>5 (20.8%)</td>
<td>24(100%)</td>
</tr>
<tr>
<td>Bowl</td>
<td>17 (70.8%)</td>
<td>7 (29.2%)</td>
<td>24(100%)</td>
</tr>
<tr>
<td>Tape</td>
<td>23 (95.8%)</td>
<td>1 (4.2%)</td>
<td>24(100%)</td>
</tr>
<tr>
<td>Cotton wool</td>
<td>22 (91.6%)</td>
<td>2 (8.4%)</td>
<td>24(100%)</td>
</tr>
<tr>
<td>Spirits</td>
<td>4 (16.7%)</td>
<td>20 (83.3%)</td>
<td>24(100%)</td>
</tr>
</tbody>
</table>

Table 4.24 shows that in general TBAs who owned delivery kits seemed to have adequate supplies at the time of the interview except for methylated spirits.
Item 3:  *Frequency that delivery kits of TBAs were refilled*

Refilling of supplies was not scheduled. Many TBAs (66.6%) did not know how often supplies were refilled. It is essential to establish a regular ongoing system of supply of equipment and materials for use by TBAs in their practice, because availability of material for use by TBAs would facilitate the continued knowledge and skills acquired during training (Cabral et al. 1992 (b): 27).

Item 4:  *Reasons as to why delivery kits were not filled*

Of the 24 TBAs, 66.7 percent said that they did not know why kits were not refilled or delayed to be replenished. Twenty-one percent of TBAs mentioned that delivery kits were not refilled in time because supplies are not available while 12.3 did not respond to the question. Troskie (1997:19) showed in her study in South Africa that with current strict economic measures, refilling of delivery kits used by TBAs might not be possible.

Item 5:  *Support/supervision of TBAs*

When asked if they received support or were supervised, the majority of trained TBAs (70%) responded positively.
**Item 6: Supervision and support of TBAs**

*(This is a multiple response question each option is calculated on 100%).*

The majority (90%) of TBAs mentioned that the health centre nurse was the individual who supported and supervised them. Then followed the community support, which was stated by both trained and untrained TBAs. Chiefs were mentioned by 41 percent. Regular supervision of TBAs can help to identify the constraints in the implementation of the program of training and in the practices of trained TBAs.

**Item 7: Frequency at which TBAs were supervised**

Eighty-seven percent of trained TBAs stated that supervision was conducted mostly once a month while 13 percent said supervision was never done.

**Item 8: Place in which TBAs were supervised**

Fourteen percent of trained TBAs reported that the health centre nurse was supervising them at home. Monthly supervision was done by calling TBAs to the clinic to discuss their problems, submit lists of deliveries, and give a report on other activities they are engaged in within their community. Periodic contact with TBAs is essential as it can be used to refresh the TBA's memory on some points taught during training. If possible TBAs should be provided transport expenses to attend meetings (Cabral et al 1992 (b): 27)
**Item 9 and Item 9.1: Problems reported by trained TBAs**

Both trained and untrained TBAs (73.3%) stated that they had problems in their practice.

Problems identified were as follows:

- lack of incentives from government and community and working without pay
- lack of supplies
- training is costly in that they pay for their own transport and food whilst attending training including attendance of monthly meeting
- lack of refresher courses
- women refuse to go to health centres when referred
- nurses sometimes are not objective when resolving conflict or misunderstandings among TBAs

**Item 9.2: Problems reported by the untrained TBAs**

The main problem reported by untrained TBAs is lack of support from the chiefs and the community. Some TBAs mentioned that they are no longer thanked in kind for the work they do. Some felt they were too old and sickly to do the work meanwhile the community expects them to continue providing services.
4.2.9 Informal discussions with TBAs

During informal discussion TBAs mentioned various taboos that a pregnant mother had to observe.

Item 1: Taboos identified by TBAs

A pregnant mother should not:

- travel very early in the morning because she will get in contact with evil spirits o tla tlola mehlala
- take milk and potatoes as the baby will be too big and predispose her too difficult labour
- eat eggs as she will experience difficult labour
- have sex after the seventh month of pregnancy, as the baby will be covered with sperms at birth
- sleep during the day because the baby will sleep during delivery
- peep through the windows and doors because the baby will recede and not proceed out through the vagina
- drink a lot of water, as the baby will be hydrocephalus
- practise unacceptable positions like making love from behind as it could result in conjoined twins
**Item 2: Beliefs of TBAs' associated with difficult labour**

The majority (78%) of TBAs believed that difficult labour was a result of witches and jealousy. Some believed that jealous women could render delivery difficult or prolong the labour by hiding stones in their underwear or placing stones behind a hut where the labouring mother is.

Bulging membranes are considered a bad sign because they are regarded as an egg preceding the presentation and therefore, believed to delay delivery and a woman will experience burning pain.

These beliefs indicate lack of understanding of the physiology of labour. Lefeber (1994:17) reports that people believe in witches and bad influences from a supernatural world and certain precautions must be taken to protect the mother and the foetus against these forces.

Leininger in (George 1995:375) indicates that cultural care values, beliefs and practices are influenced and embedded in the worldview and the cultural and social structure dimensions of a particular culture. Therefore, beliefs and taboos observed in pregnancy and birth are deeply rooted into the TBAs culture, which they share with their clients and which cannot be easily eliminated.
Item 3: Herbal medicines used in pregnancy and labour

Providing herbs is an important part of treatment during pregnancy, delivery and postpartum care. When TBAs were asked to give names of herbs they used, some TBAs did not know the names but knew the indications as shown below.

Table 4.25 Herbal medicines used during pregnancy and labour

<table>
<thead>
<tr>
<th>Period</th>
<th>Name of the herbal medicine</th>
<th>Use of the medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy:</td>
<td>Lekhalana “Aloe”</td>
<td>Used for cleansing and to prevent abortion in early pregnancy.</td>
</tr>
<tr>
<td></td>
<td>Phetola, tikamotse, sehlapetso</td>
<td>These are given at the end of the 7th month of pregnancy they make the foetus assume a cephalic presentation, if the lie was not normal.</td>
</tr>
<tr>
<td></td>
<td>Khamane</td>
<td>Used for treatment of warts</td>
</tr>
<tr>
<td></td>
<td>Mosisili and tee ea baroa</td>
<td>Used for abnormal vaginal discharge seso</td>
</tr>
<tr>
<td></td>
<td>Lephelephele</td>
<td>Used for constipation</td>
</tr>
<tr>
<td>Pre -delivery</td>
<td>Theletsi</td>
<td>Stimulate strong uterine contractions</td>
</tr>
<tr>
<td></td>
<td>Senyarela</td>
<td>Stimulastes strong uterine contractions</td>
</tr>
<tr>
<td>Labour&amp;delivery</td>
<td>Phakisane</td>
<td>Controls pain during labour</td>
</tr>
<tr>
<td>Third stage.</td>
<td>Lesoko and selomi</td>
<td>Control pain during labour</td>
</tr>
<tr>
<td></td>
<td>Qobo</td>
<td>Controls bleeding</td>
</tr>
<tr>
<td></td>
<td>Khokhotsi</td>
<td>Controls bleeding</td>
</tr>
</tbody>
</table>
Sometimes the same medicines are used throughout pregnancy and delivery although there are some that are used for specific ailments or purposes. As indicated earlier chemical analysis of these medicinal plants has not been undertaken in Lesotho.

4.10 SUMMARY

Chapter four presented findings from data obtained from TBAs.
The analysis provided information on the role and practices of TBAs in the provision of antenatal care, delivery and post partum care. The study shows that:

- The main role of TBAs in the provision of antenatal care is to provide care, health education on diet and cleanliness and to refer women when there are problems.
- During labour TBAs assist and play an important role in monitoring the process of labour, delivering the mother, and providing care to the newborn.
- TBAs assists the mother during the peuperium period by cooking, washing clothes, they examine the mother and the baby and provide the necessary care if there are complications.
- The study also provided information on the training of TBAs, support and supervision given to TBAs by nurses and community leaders.

In Chapter 5 the findings from the analysis of the nurses' questionnaire are discussed.
CHAPTER FIVE

FINDINGS FROM THE NURSES QUESTIONNAIRE

5.1 INTRODUCTION

The nurses formed a subgroup in the study. They participated in the study to provide information on the role played by the health care system in support of the TBAs in their practice. Nurses play an important role in the training and supervision of TBAs, hence their participation in the study was crucial.

Nine nurse-midwives were recruited from 12 health centres, which trained TBAs. Three nurse assistants were excluded from the study even though they were in-charge of the clinics and expected to supervise TBAs. The reason for their exclusion was that they lacked the capacity to train and supervise TBAs.

Because of the few nurses only frequencies were employed for analysis of data from their questionnaire.
5.2 ANALYSIS OF DATA OBTAINED FROM NURSES

5.2.1 Involvement of community leaders in the selection of TBAs

*Item 4: Involvement of community leaders in the selection of TBAs*

*Reasons given by the nurse for the involvement of community leaders in the selection of TBAs*

When nurses were asked if they involved community leaders in the selection of TBAs, 78 percent said they involved them because, community leaders are an entry point to any community, as

- they assist in organising and calling meetings *pitsos* for the selection, because leaders like the members of the community know individuals who could be selected for training as TBAs, through their qualities and their involvement in maternity care
- after training the TBAs need the support of the chiefs and have to work hand in hand with them in the community

Pedersen (1985:46) stresses the importance of contacting community leaders in organising the program of training TBAs, because success of the training is a result of the support of community leaders.
The two nurses (22%) who did not involve community leaders in the selection of TBAs did so because they felt that it was the community that selected the TBAs so they did not see why chiefs should be involved. Secondly they did not involve community leaders because they had no time to meet with them because of shortage of personnel at the health centre.

**Item 5: Duration nurse had worked within the community**

The majority of nurses (78%) had worked within the community for a period of more than 6 years, while 22 percent had worked in the health centres for less than 5 years.

**Item 6: Building community trust by nurses**

Nurses reported that they built trust with the community by being part of the community, through holding regular meetings, discussing community problems, solving problems with them and referring those issues that the community cannot handle to appropriate departments. They also built trust by being open, respecting the community, by being a good role model in behaviour and by exercising objectivity in conflict resolution. WHO (1991:31) indicates that an essential first step in building trust is respect and understanding between members of the modern and traditional health sector.
To create the climate of trust a mechanism must be established where activities such as informal meetings, seminars and workshops are planned, where key people representing both the modern and traditional sectors can come together in a supportive atmosphere to hear each others complaints, state their own ideas and suggestions and agree on a common goal and create solutions for using TBAs as part of PHC team.

**Item 7: The frequency nurses met with community leaders**

Nurses reported that they met with community leaders yearly to discuss the TBA programme. Meeting yearly with community leaders is not adequate, it allows problems and complaints of the TBAs, community and the nurses to go on for a long period without being solved or given attention. Frequent meeting with community leaders ensures support for TBAs and indicates co-operation between the nurses and TBAs.

**Item 8 and Item 9: Support of TBAs by nurses and how they are supported**

*(multiple response question) Each option is calculated on 100 percent*

All nurses stated that they supported TBAs, 67 percent of nurses said they did so by holding monthly meetings for supervision and reviewing problems TBAs encounter in their practice and by, holding refresher courses. Eighty nine percent of the nurses said that they supported TBAs by supplying the commodities TBAs use in their work. Only one nurse supported TBAs in her area through an income-generating project of gardening and poultry.
**Item 10: Visits done by nurses to the homes of TBAs**

Sixty seven percent of nurses said that they visited TBAs in their homes to monitor how they worked with the communities. Thirty three percent of nurses reported that they were not able to visit TBAs. Visiting a TBAs where she practices gives the nurse-midwife the opportunity to evaluate the TBAs delivery techniques, and to assess the conditions under which she practices.

**Item 11: Means of contact with the clinic nurse if a TBA has a problem**

Table 5.1  Means of contact with the clinic nurse if a TBA has a problem (N = 9)

<table>
<thead>
<tr>
<th>Means of contact</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post</td>
<td>1(1.1%)</td>
<td>8(98.9%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Messenger</td>
<td>6(67%)</td>
<td>3(33%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Other</td>
<td>2(22%)</td>
<td>7(78%)</td>
<td>9(100%)</td>
</tr>
</tbody>
</table>

Table 5.1 shows that the commonly used means of contacting a nurse if a TBA had a problem was sending a messenger to the clinic (67%). Williams et al (1994:105) found that in Sudan messages about childbirth and emergencies, between the village midwife in the remote areas and health facility were transmitted by a runner who carried a token to indicate the condition for which help was needed.
Royston and Armstrong (1989:173) reports that in Ethiopia a maternal health scheme makes use of messengers who run and walk up to three hours on request of the TBA in cases of an emergency. Other means included bringing a woman with a delivery problem to the clinic. Royston and Armstrong (1989:160) further indicates that referral can be effective in life saving, if links in the chain of referral such as transport are considered. A weak link can render the whole system ineffective.

5.2.2 Training of TBAs by nurses

**Item 1: Number of trained TBAs admitted in a year for initial training**

The majority (78%) of nurses trained between 11 and 15 TBAs a year for initial training. It would seem that numbers of TBAs being trained are large, given the shortage of nurse-midwives and inadequate supervision of TBAs reported (MOH & WHO: 1997:3)

**Item 2: Number of trained TBAs attending refresher course in a year**

Fifty five percent of nurses, trained 11 to 15 TBAs for refresher courses, not all conducted refresher training because of financial constraints. This confirms findings on TBA training in chapter 4 where only 15 TBAs out of 36 received a refresher course
Table 5.2  Course content of the initial training programme for TBAs (N=9)

<table>
<thead>
<tr>
<th>Content of initial training programme</th>
<th>Yes</th>
<th>NO</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of risk during pregnancy</td>
<td>8(89.9%)</td>
<td>1(11.1%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Safe clean delivery</td>
<td>8(89.9%)</td>
<td>1(11.1%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Timely referral</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Care of the newborn</td>
<td>8(89.9%)</td>
<td>1(11.1%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Others</td>
<td>4(44.4%)</td>
<td>5(55.6%)</td>
<td>9(100%)</td>
</tr>
</tbody>
</table>

Table 5.2 shows that emphasis of training was placed mainly on identification of risks during pregnancy (89.9%), safe and clean delivery (89.9%) and care of the new born (89.9%). The topics reported by nurses do not differ from topics reported by TBAs in chapter four. Timely referral of emergencies seems to be given less importance. Timely referral is crucial for life saving in an emergency particularly if there is timely intervention in health facilities.

Other topics mentioned were:

- nutrition for a nursing mother
- immunisation
- family planning services
- post natal care
- use and effects of traditional medicine in pregnancy
Cabral et al (1992 (a): 16) argue that training of TBAs is most effective when it is directed at upgrading skills for simple well-focused tasks to tackle a particular problem.

Experience has not yet shown that TBAs’ efforts are as effective or sustained when they have taken over a broad array of primary health care functions. Cabral et al (1992 (a): 16) further indicates that success is most likely when TBAs are given training on a small number of topics and when the content builds upon the skills which they already have.

Item 4: Methods of teaching used for TBAs

All nurses used a participatory method of teaching and practical where they observed TBAs conducting a delivery. Since TBAs may be illiterate or semiliterate their training should not involve lecturing or the use of a blackboard. Training methods such as role playing, demonstration, discussions and practice should be adopted (Cabral 1992 (a): 21).

Item 5: Duration of training offered by nurses for TBAs

Training for initial and refresher courses lasted for a period of 2 weeks, other periods were less frequently reported. This confirms findings of TBAs on duration of training in chapter four.
5.2.3 Management of TBA programme

Item 7: Records kept by nurses on the training of TBAs

All nurses claimed to keep the following records in the management of a TBA programme.

- a list of trained TBAs
- a list of active and non active TBAs
- a record of deliveries conducted by TBAs
- a record of outcomes of TBAs deliveries (not kept by all nurses).

It was not possible to ascertain the availability of all the mentioned records because of the nature of data collection. Only the register of trained TBAs could be validated because it was used as a sampling frame. Record keeping is important because it provides information necessary for monitoring and evaluating the training programme of TBAs.

Item 8: Evaluation of care given by TBAs by nurses (multiple response question)

*each option is calculated on 100 percent*

Nurses did not seem to understand how care given by TBAs could be evaluated. Three (33%) nurses out of 9 assessed delivery techniques of TBAs and 5 (56%) assessed care through reviewing outcomes of delivery and intervention during emergencies.
**Item 9: Methods used by nurses to ensure standards of care provided by TBAs**

*(multiple response questions) each option is calculated on 100 percent*

When asked how they maintained standards of care provided by TBAs, all said they did so by calling the TBAs to the clinic for monthly meetings. Five (56%) held refresher courses; none mentioned the importance of visiting TBAs in their work places or where they practiced and lived.

**Item 10: Availability of teaching material used by nurses**

When asked if they had the necessary teaching material the majority (78%) reported that they did not have teaching material, only 22 percent had teaching material. Training without teaching material cannot be successful. Cabral et al (1992 (b): 20) stress that teaching material needs to be acceptable, and suitable for the culture in which TBAs practice and need to be as close to reality as possible. For instance showing a pregnant woman with swollen feet and face is better than using a picture or telling a story.
Item 11 and Item 12: Problems encountered by a nurse in refilling delivery kits

Almost all (78%) nurses said they encountered problems with the refilling of delivery kits. Royston and Armstrong (1989: 168) points out that problems with replenishing of delivery kits are very common. They recommend that adequate replenishing is very vital if TBAs have to provide maternity care. Trainers should discuss possible substitutes for items in the kits that can be readily available locally.

Item 13: Availability of transport for referring patients with obstetric complications

Only 33.0 percent of nurses stated that transport was available for referring patients. All clinics in Lesotho do not have transport. Therefore, transportation of clients from health centres to HSA hospitals is a problem hence, sometimes TBAs and their clients by pass health centres. This also deters TBAs from referring their clients to nurses (MOH & WHO 1997:32).

Item 14 and Item 15: Types of cases referred to nurses by TBAs

Eighty eight percent of nurses reported that TBAs referred cases to them. Table 5.3 shows conditions referred to nurses by TBAs
Table 5.3  Types of cases referred to nurses by TBAs (N=9)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained placenta</td>
<td>7(78%)</td>
<td>2(22%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Malpresentation</td>
<td>6(67%)</td>
<td>3(33%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Haemorrhage</td>
<td>6(67%)</td>
<td>3(33%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Prolonged labour</td>
<td>8(89.9%)</td>
<td>1(11.1%)</td>
<td>9(100%)</td>
</tr>
</tbody>
</table>

Prolonged labour (89.9%) and retained placenta (78%) were conditions frequently referred by TBAs to nurses. Identification of women at risk and referral is one major function of antenatal care. TBAs' findings as displayed in chapter 4 show that sometimes there is a delay in referring cases such as retained placenta, prolonged labour and haemorrhage, because TBAs attempt various options to manage some of the mentioned conditions. They refer only when there is no progress.

Item 16:  Follow up visits made by nurses to patients with complications

All nurses (100%) followed up women who had complications by recalling a woman to the clinic after a specified period of time. Forty four percent visited the woman at her home 56 percent mentioned that they never visited the woman at her home.
Item 17: *Methods of communication used by nurses if contacted by a TBA with a problem (multiple response question) each option is calculated on 100 percent*

Sixty percent of nurses reported that in the event of an emergency or if a TBA has a problem the available means by which they could be contacted were by a TBA sending a messenger (66%) and coming to the clinic (78%).

Item 18: *Action taken by the nurse in resolving the problem*

Nurses responded to the problems by waiting for women with problems to be brought to the clinic. Thirty three percent of nurses who said that they had transport available for referral also visited the TBA. Given a situation where clinics have no transport it is clear that clinic nurses are not able to visit TBAs in cases of emergencies.

Item 19 and item 20: *Record keeping and types of records kept by TBAs*

All nurses reported that TBAs kept records of their activities as shown below

- list of deliveries was reported by 89.1 percent of nurses
- maternal deaths reported by 78 percent of nurses
- births reported by 89.9 percent of nurses
- other records included weight of babies
5.2.4 Support from the health service area

Item 1: Support given to the nurse by the health service area

Available data showed that all nurses had support from their respective health service areas (HSAs), in a form of attending meetings at the central level and visitation by the health service area team.

Item 2 How often is a nurse visited

Fifty six percent of nurses reported that they were visited once every month, 11 percent once in 6 months and 11 percent was visited yearly, 22 percent did not respond to the question.

Item 3: Supervisors of nurses

Table 5.4 Supervisors of nurses (N=9)

<table>
<thead>
<tr>
<th>Supervisor</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>District medical officer</td>
<td>8(89.9%)</td>
<td>1(11.1%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>District public health nurse</td>
<td>7(78%)</td>
<td>2(22%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Central level staff</td>
<td>2(22%)</td>
<td>7(78%)</td>
<td>9(100%)</td>
</tr>
<tr>
<td>Other specify</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
According to table 5.4 the majority of nurses (89.9%) reported that they were supervised by the district medical officer and 78% by the public health nurse.

**Item 4: Holding of meetings at the district level**

Eight (88.9%) nurses said regular meetings were held every three months. The findings indicate that nurses have adequate support, from their health service area. The support however, needs to be translated to funding and provision of adequate staff in order to sustain the TBA program. Only 11.1 percent said that regular meetings were being held monthly.

**Item 5: The frequency with which the nurse is called to attend.**

All nurses mentioned that they are called every time to attend meetings at the HSA. There were no responses to other options.

5.3 **SUMMARY**

Chapter 5 presented the role nurses play in the training and management of TBA programmes. The chapter outlined the working relationship between TBAs and nurses in terms of support, supervision, maintaining standards of care provided by TBAs and communication when TBAs encounter problems. The Chapter also presented the support given to nurses by their health service areas.

In chapter 6 conclusions are discussed and recommendations are made.
CHAPTER SIX

FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS OF
THE STUDY

6.1 INTRODUCTION

Chapter 6 gives the conclusions of the analysed data of TBAs’ and nurses. Recommendations are made based on the findings. The objectives and research questions of the study within the framework of Leininger’s sunrise model as described in Chapter two will be used to come to conclusions and to make recommendations. Limitations of the study will be highlighted.

The discussion is presented according to the research questions in order to provide a clear picture of what the research set to answer. Namely:

- what is the role and practices of TBAs in the provision of maternal health at community level?
- what are the problems TBAs experience in their practice?
- what role does the health care system play in supporting the practice of the Traditional Birth Attendants?
6.2 WHAT IS THE ROLE AND PRACTICES OF TBAs IN THE PROVISION OF MATERNAL HEALTH AT COMMUNITY LEVEL?

6.2.1 Characteristics of TBAs

From the data it is clear that the majority of TBAs are in the middle to elderly age group. All are married and have children of their own, 80 percent have five and more children. For these TBAs delivery is a part time occupation, the majority (61%) of trained TBAs are housewives while 32 percent of untrained TBAs are farmers. Ninety-eight percent have been resident in the areas they practice for more than ten years. Singh (1994:120), Conway-Turner (1997:567) and Troskie (1997:17) have described similar characteristics that indicate that TBAs are both experienced as TBAs, mothers and are accepted as authorities in the issues of pregnancy and childbirth in their communities.

Feyi-Wabaso (1989:162) is of the opinion that TBAs are creating more problems than not. He described them as illiterate and lacking knowledge of aseptic techniques. He further blamed them for infertility from unsterile delivery and history of poor obstetric care. He claimed that developed countries have been able to reduce childbirth mortality to less than 0-1 per thousand live births, by moving away from the use of TBAs. The TBAs in the present study all had at least primary school education, which indicates that they are not illiterate, also those trained did practice under more hygienic conditions.
Lefeber (1994:4) sees a TBA as an individual who provides a sense of psychological security for the mother, since she participates in the cultural matrix of the social ethnic group to which the mother belongs. This results in the performance of certain protective ceremonies or rituals during pregnancy, delivery and after delivery. Being elderly and having lived in the community for a long period result in TBAs being aware of the cultural beliefs, values and practices of the people.

6.2.2 Practice of TBAs

The majority (66%) of TBAs have been practising as TBAs for more than 10 years and 93.3 percent practised in their villages. Fifty-two percent became TBAs through self-learning that is, by being asked to assist in a delivery. Twenty six percent had been taught by relatives and experienced TBAs and 22 percent were selected by their communities to train as TBAs. Cabral et al (1992 (a): 9) describe TBAs as members of the communities where they live and they speak the local language and are an integral part of the cultural system.

The finding indicates that TBAs acquired and developed their skills over time and therefore, plays an important role in transmitting the skill and knowledge of caring for pregnant mothers. Leininger in George (1995:376) describes this role as cultural care preservation also known as maintenance and includes “assistive, supportive, facilitative, actions and decisions that help people of a particular culture to retain and preserve relevant care practices values so that they can maintain their wellbeing.”
Vansingenjan (1984:36) argues that women deliver at home despite availability of hospitals and clinics because they prefer to be delivered by someone who is familiar with their customs and habits sometimes someone from their own ethnic group. Culture therefore, gives one an identity and a sense of belonging. Knowledge of client's culture enables TBAs to use the assistive, supporting, facilitative notions to make decisions that can maintain the client's well being (Fitzpatrick & Whall 1996:185).

The environment according to Leininger in Fitzpatrick & Whall (1996:186) is an important influence on health and care patterns. The environment refers to the totality of an event, situation, or particular experiences. It is therefore, understandable that women prefer to deliver at home where meaning is given to human expressions, interpretations and social interaction. The relevant care values of the particular culture is retained and preserved to recover from illness.

6.2.2.1 Number of Deliveries

The majority of TBAs (78%) conducted less than five deliveries in a year while 12 percent conducted six to ten deliveries and 10 percent reported more than ten deliveries. Cabral et al (1992 (a): 9) indicate that the number of births attended to by TBAs each year varies widely. In large communities with many families TBAs may deliver up to twenty-four babies, per year. In smaller families they may attend to only one or two births in a year.
The findings imply that trainers of TBAs have to assess TBAs’ case load and monitor changes in trends before they can decide to introduce TBA training. When case loads are very small, for instance one delivery a year, it is questionable whether TBAs can retain knowledge and skill taught by the time she attends to the next delivery which may occur once a year.

6.2.2.2 Travelling distance by TBAs

The majority (69%) trained and (74%) untrained TBAs in the study reside far from health care facilities. The finding is consistent with what was reported by Clarke and Lephot (1989:55), their report indicated that the majority of deliveries occur at night when there is usually no public transport to take a woman to a health centre. This indicates that TBAs are potentially more accessible to the mother because they live within their communities.
6.2.3 **Antenatal care**

From the findings it is clear that of the 60 TBAs, 55 percent provided antenatal care to pregnant mothers. Antenatal care was provided in the TBAs own homes (75.8%) and at the mother's home (57%). Their care was limited mainly to palpation as reported by 60.6 percent and health education on diet and cleanliness, while history taking and abdominal massage were less reported.

TBAs also do not monitor the foetal heart, which is of concern. Eades at al (1993:1504) showed that in Ghana the role of TBAs in antenatal care included obstetric history taking and giving of nutritional advice. Lang and Elkin (1997:27) have reported similar findings. Eades at al further indicate that the role of TBAs in the provision of antenatal care differs from community to community but similarities can be identified.

In Botswana, Ramotswa health workers had a successful experience with a TBA who was operating a maternity clinic from her home. Given the influence the woman had among many of the clients in the village health centre, health workers used her position to disseminate information on nutrition, postnatal care immunisation and family planning. This is a testimony of the influence, respect and the role TBAs play in the provision maternal health information (Kewakae 1985:114).
6.2.3.1 First attendance of antenatal care

Item 4 of 4.2.4. Page 112 (antenatal care) shows that 50 percent of trained TBAs saw their clients in the second trimester while untrained TBAs saw their clients earlier, that is, in the first trimester. Sparks (1990:156) reports that in Zimbabwe there is a delay in the announcement of pregnancy, it is believed the practice protects the woman from evil forces. Only primigravidae have formalised prenatal care from TBAs, which begins only after seven months of pregnancy. This may encourage women to show up late for antenatal care.

6.2.3.2 Use of herbs during antenatal care

Twenty five percent of trained and untrained TBAs administered herbs for illness during pregnancy. The findings of Lefeber (1994:15) and Sparks (1990:155) are confirmed by this information. They indicate that providing herbal medicines in an important part of antenatal care, these herbal medicines are used for several treatments and purposes. Some of these herbs have been described as teratogenic if taken very early in pregnancy. The practice should be slowly eliminated through training.
6.2.3.3 Traditional beliefs and taboos identified by TBAs

From informal discussions held with TBAs, it is clear that TBAs play a crucial role in observing traditional beliefs and adhering to taboos for instance a pregnant mother is advised not to:

- travel very early in the morning because she will get in contact with evil spirits *o tla tlola mehlala*
- take milk and potatoes the baby will be too big and predispose her to a difficult labour
- eat eggs otherwise she will experience difficult labour. Have sex after the seventh month of pregnancy the baby will be born covered with sperms
- sleep during the day the baby will sleep during delivery
- Peep through the windows and doors as the baby will recede and not proceed out through the vagina

Similarly Chalmers (1991:16) Ntoane (1989:21) and Lefeber (1994:17) have reported these taboos. Lefeber reports that people believe in witches and bad influences from a supernatural world and certain precautions must be taken to protect the mother and the baby against these forces.
Leininger in (Fitzpatric & Whall 1996:118) indicates that cultural care values beliefs and practices are influenced and embedded in the worldview and the cultural and social structure dimensions of a particular culture. Therefore, beliefs and taboos observed in pregnancy and birth are deeply rooted into the TBAs culture, which they share with their clients and cannot be easily eliminated.

6.2.3.4 Conditions referred during antenatal care

Item 9 of 4.2.4 page 116 (antenatal care) shows that TBAs frequently referred conditions such as haemorrhage (63.9%), any type of illness (63.9%) that occurred during antenatal care and other conditions such as multiparous and nulliparous women and absence of foetal heart sound. Trained TBAs in the study showed reasonable ability to screen for risk among pregnant mothers. The ability could be assumed to be a result of exposure to upgrading and new knowledge. Sparks (1990:156) in Zimbabwe found that trained TBAs articulated reasons or indications for referral better than the untrained TBAs, the indications included referral of conditions such as haemorrhage, and nulliparous women.
6.2.4  Labour

6.2.4.1  First stage of labour

Eighty nine percent of the TBAs said they were called to assist with delivery at the onset of labour while 73 percent was called during an advanced stage of labour. Clarke and Lephoto (1989:30) found that TBAs were called at the onset of labour. The majority (92%) of the respondents diagnosed true labour by abdominal pains, 26 percent by an urge to bear down and 57 percent by restlessness and sweating. Signs such as an urge to bear down, restlessness and sweating show limited knowledge with regard to the physiology of the stages of labour among both trained and untrained TBAs. First stage of labour represent a period from the onset of rhythmic contractions to full dilation of the cervix and the progress during the period is determined by the descent of the head and dilation of the cervix through a vaginal examination (Myles 1996:151).

Like in other African communities it has been found that in Lesotho there is little preparation for the impending delivery. A hut is cleaned and a fire made to ensure that the baby is received in a warm environment. A woman sits on a ring made of a cloth or old blanket to prevent tears and leans against the wall. All assistants should be half-naked, to ensure that labour is not retarded (Clarke and Lephoto 1989:34). The practice to warm the hut is to be recommended as it protects the baby from hypothermia.
Signs of true labour

TBAs determined true labour by physical expression such as perspiring, anxiety, and the urge to bear down. They encouraged the woman to bear down without evidence of dilation of the cervix. Some TBAs encouraged bearing down at the onset of labour while others waited for the head to be seen at the vulva. Jepson (1988) in Lefeber (1994:23) found a similar practice where TBAs were unsure of when to encourage the woman to bear down because of ignorance of the physiology of the first stage of labour. This may cause exhaustion and exanguination of the mother, resulting in foetal distress, asphyxia and stillbirth. The inability to determine progress of labour may result in failure to recognise obstructed labour and consequently loss of life of the mother or the baby. Hence it is necessary to train TBAs in many countries to reduce maternal morbidity and mortality.

Internal examination

Vaginal examinations although performed by only 8.3 percent, were done to feel for the presentation and not to determine the dilation of the cervix. And this is a dangerous practice. Untrained TBAs performed vaginal examination more frequently than the trained TBAs but the difference was not statistically significant. This is a matter that needs to be brought to the attention of all TBAs, as doing vaginal examination can be harmful to the mother if not done correctly.
6.2.4.2 Second stage of labour (delivery)

Signs of eminent birth

TBAs identified the behaviour of the mother such as perspiring, anxiety, urge to bear down and to defecate to diagnose eminent birth. Few said appearance of the head or gaping vagina were signs of eminent birth, an indication once more, of lack of understanding of the physiology of the second stage of labour described by Sleep in Myles (1996:197) as the period from full dilation of the cervix the baby is born.

Positions during delivery

The result indicates that 66 percent of deliveries are conducted with a woman in the dorsal lithotomy position, a position encouraged by health professionals in health facilities. The traditional squatting, sitting and standing positions were reported by only 34 percent of TBAs. These positions are recently being encouraged in the western world. Sleep in Myles (1996:207) indicates that it has been proven scientifically that there is an overall 28 percent increase of the pelvic outlet when squatting is used compared to the supine position, because the transverse diameter increases by one centimetre and the antero-posterior increases by two centimetres.
Squatting is easier for the mother because it is said that the weight of the baby helps her push, while lithotomy position is easier for the midwife and not the mother. There is evidence that if a mother lies flat on her back during delivery, vena cava compression is increased resulting in hypertension leading to reduced placental perfusion and consequently diminished foetal oxygenation (Myles 1996:207).

Chalmers (1991:225) found that among Pedi speaking women lithotomy was reported by the majority, when asked why they preferred the position they stated that the supine position was used in health facilities. She argues that it is ironical that the supine position is still preferred among black women when the west is rejecting the position. Ntoane (1989:21) found that TBAs (Bo-mmabotsetse) in Bophuthatswana in South Africa expressed that some women felt threatened by the position adopted in health centres during delivery, as women felt more comfortable in a squatting position.

Although the trained TBAs seemed more able to recognise risk during labour, management of the actual birth did not differ between the two groups. The exception was that the trained TBAs had better understanding of hygiene evidenced through comparison of their hygienic practices.
6.2.4.3  Third stage of labour

It was found that immediately after birth the baby is put beside the mother, 98 percent delivered the placenta immediately while 2 percent waited. Some TBAs did not cut the cord immediately some waited until the placenta was expelled. The placenta was delivered by asking the mother to push or pressure was applied without evidence of separation of the placenta from the uterus, which is indicated by a gush of blood and elongation of the cord. Pushing is believed to stimulate the expulsion of the placenta but if the placenta is not detached this may encourage post partum haemorrhage.

If there was a delay in the delivery of the placenta, various measures were undertaken as in item 9 (treatment of retained placenta) in 4.2.5 on labour. The study did not, however, determine a period that the TBAs considered as a delay. Third stage in a normal delivery takes 30 minutes but deliveries differ, some women can take five minutes and others more. Some TBAs embraced the importance of supporting the perineum to prevent tears.

Jacobs (1989:18) from the Northern Cape in South Africa described an alarming sight of post delivery cases arriving in the hospital with retained placenta and long dangling lengths of partially dried severed cords tied to the woman's leg. Sometimes the new born came lying between the mothers legs with a gray paste made of fire ash smeared carelessly over the remains of the cord.
She further mentions that under such conditions puerperal sepsis became too common a diagnosis hence they had to locate TBAs conducting deliveries in the area and intervened with training. This is a description of a mismanaged third stage combined with unhygienic practices and delayed referral. Failure to refer a woman immediately to a health facility when complications occur during the third stage may result in sepsis and loss of life.

6.2.5 Post partum care

Post partum or puerperium is a period of six weeks, which begins as soon as the placenta is expelled. During this time a number of physiological changes take place such as the return of reproductive organs to a non-pregnant state. The mother recovers from the stress of pregnancy and delivery, and assumes the responsibility of caring for and nurturing her infant (Myles 1996:233).

Post partum period in the study was characterized by TBA's visits to the mother and performance of various activities from drawing water, cooking and washing clothes used for delivery to examining the woman and the baby and managing tears with sitz baths. In South Africa among Zulus, Larsen (1983) in Lefeber (1994:37) reports that perineal tears are washed regularly with a solution of salt or dettol in water. This seems a common practice, which is effective for small laceration or perineal snicks, which need no suturing.
Ntoane (1989:22) emphasized the importance of seclusion in that although it is meant to protect the mother from evil spirits, it protects the mother from infections she can get from too many social contacts. Seclusion has been reported by Clarke and Lephotso in Lesotho (1989:56)

6.2.5.1 Use of herbs in post partum period

Administration of herbs was found to be part of post partum care for purposes of both cleansing the baby and stimulating the uterus to contract. Post partum haemorrhage is managed by use of herbs if this fail only then can a woman be referred to a health facility. Troskie (1997:18) also reports that in South Africa, after the baby is born the mother is given a herbal mixture to drink to help the uterus contract. In Malawi herbal medicines are given to the mother after delivery to expel retained products, encourage the flow of lochia and to control bleeding (Lefeber 1994:37).

Puerperal sepsis is still a cause of maternal death in the developing world, which must be prevented by strict cleanliness. The study did not establish hygienic practices performed at this period. Lang and Elkin (1997:28) found that in Guatemala bathing by the mother who has just delivered is delayed for 1 to 3 days, because it is believed that bathing soon would cause abdominal pains or a prolapsed uterus. Lack of cleanliness during this period can predispose a mother to infection. In Lesotho a practice where a woman used to sit on cow dung or the application of cow dung on the cord after deliveries is disappearing slowly. The practice is associated with neonatal tetanus (Clarke & Lephotso 1989:4).
6.3 WHAT ARE THE PROBLEMS TBAs EXPERIENCE IN THEIR PRACTICE?

Both trained and untrained TBAs (73.3%) stated that they had problems in their practice. These included lack of incentives from government and community and working without pay. Costs of transport and food incurred whilst attending training and attendance of monthly meeting.

Some problems were:

- lack of refresher courses
- women refuse to go to health centres when referred
- sometimes nurses are not objective when there are conflicts or misunderstanding among TBAs. This may be an indication of inadequate preparation of nurses in conflict management.

Main problems reported by untrained TBAs were lack of support from the chiefs and the communities. Some TBAs mentioned that they are no longer thanked in kind for their work; some felt they were too old and sickly to do the work but the community expect them to continue providing services. The study further showed that TBAs lived far from health facilities this indicated that TBAs do meet problems when they have to refer women with delivery complications.
Lefeber (1994:161) indicates that there is a fundamental difference between traditional midwifery and western obstetrics. Western obstetrics is focused on the biological birth processes and less dependent on the social and cultural surrounding as compared to the work of TBAs. The difference between the two systems of care have been described by Leininger (1991) in George (1995:378) as a source of conflict.

Clarke and Lephoto (1989:59) found that in Lesotho TBAs saw their biggest problem as heavy demands on their time by the community and lack of payment. In order to perform the task efficiently TBAs need support and acceptance of the village community, in which they live and work.

Non payment of TBAs is a universal problem. In other countries such as Honduras, Colombia and Ecuador TBAs fees are charged according to the difficulty of the delivery, the sex of the child, length of time spend with the mother and types of chores performed such as washing of clothes, cooking and cleaning. Some TBAs are rewarded either by food, clothes or gifts (Lefeber 1994:71). Mangay-Maglacas & Pizurki (1981:207) describe some problems of TBAs, which include unsuitability of training programmes for certain characteristics of TBAs and their dissonance with the cultural values and economic situations of the members of the community. Other problems are lack of adequate referral systems and inadequate supervision. In many developing countries including Lesotho it may be a long time before problems that surround the role practice, and training of TBAs will be resolved.
6.4 WHAT ROLE DOES THE HEALTH CARE SYSTEM PLAY IN SUPPORTING THE PRACTICE OF TBAs

6.4.1 Training of TBAs

There were 36 trained TBAs in the study. The majority (80%) of TBAs had been trained for a period of two weeks at health centres, by public health nurses and nurse clinicians. The duration of training should be given careful consideration. A period of two weeks for training as found in this study seems inadequate particularly given that few TBAs were offered refresher courses. Some countries like Ghana have offered a course content of six to 12 weeks.

In Thailand training courses lasts for 35 hours confined to one or two weeks since they believed that TBAs already had previous experience in delivering babies (Lefeber 1994:106). Clarke and Lephoto (1989:18) indicate that if training is held in a different environment from the TBAs' place of practice they are likely to reject what they learn as being inapplicable to their work. Health centres have been reported as places used for training, in Zimbabwe and Malawi. Galloway (1984:7) argues that training should take place in their own villages because it does not remove them from the context in which they practice. This indicates that trainers of TBAs need to review places where TBAs are trained.
This is the phase where cultural care accommodation or negotiation takes place. The TBAs are assisted by the professional actions and decisions of the nurse "to adapt or to negotiate with, others for the beneficial or satisfying health outcomes" (Fitzpatrick & Whall 1996:185). Nurses should therefore, ensure that the environment in which they train TBAs are conducive to accommodation and negotiation.

6.4.2 Content of training course for TBAs

Topics such as antenatal care, (94.4%) safe delivery (91.7%) including the care of the baby were frequently taught during the initial training. Nurses also reported similar topics in item 3 of 5.2.2 training of TBAs in chapter 5 page 162. Other topics reported by both TBAs and nurses indicate that the role of TBAs has expanded to include a role in family planning and immunization. There are various opinions on what TBAs should be taught. Training of TBAs should aim at upgrading skills and gradually eliminating harmful practices to ensure safe and hygienic deliveries (Singh 1994:121).

Another goal of training has been seen to preserve the rituals and cultural beliefs around birth that maintain the culture tapestry of the community while modifying those that are seen as unhealthy by medical authorities (Conway-Turner 1997:572).

Trainers need to avoid trying to teach a TBA what they themselves were taught in school, instead the trainer must learn to transmit what a TBA needs to know. Leininger in her theory of transcultural care confirms training or culture care repatterning as one of the crucial nursing action that can result in a cultural congruent care.
Culture care repatterning or restructuring care refers to those actions and decisions which assist the TBAs to "reorder, change or greatly modify their lifeways for new, different and beneficial health care patterns" at the same time valuing their own cultural values and beliefs (Fitzpatrick & Whall 1996:185).

6.4.3 Refresher courses

Out of 36 trained TBAs only 15 (41%) had attended refresher courses. Follow up after training cannot be over emphasized. Singh (1994:121) in India found that after initial training there is no refresher training or follow ups. Therefore, TBAs continue to practice on their own. Occasional visits by nurses to various villages where TBAs practice is one of the best methods of follow up. It can also influence the villagers credibility for the trainee TBAs.

Nurses' responses in item 8 visiting TBAs in their homes in chapter 5 showed that nurses do not visit TBAs in their villages, the reason cited was that they had other responsibilities in the health centres and therefore unable to carry out the visits. Royston & Armstrong (1989:154) report that follow up immediately after training is crucial in motivating TBAs to put their new knowledge into practice. This is the time when TBAs are making the adjustment from former roles to the new ones and they particularly need support. Refresher courses were a vital element in cultural care preservation to retain healthier lifeways than before the changes.
6.4.4 Number of TBAs trained

Item 1 number of trained TBAs in a year for initial training and Item 2 on refresher training in chapter 5 on training of TBAs show that 78% of nurses trained and gave refresher courses to between 11 and 15 TBAs. These numbers are unmanageable for supervision and follow-ups if a nurse midwife is alone in a health centre, as is the situation in Lesotho (MOH & WHO 1997:3).

6.4.5 Methods of training TBAs

Item 4 of 5.2.2 (training of TBAs) in chapter 5 page 163 shows that all nurses in the study reported that they used a participatory method of teaching, which includes a lecture and discussion. They also used practical sessions to observe TBAs conducting a delivery. Seventy-eight percent of nurses reported that they did not have teaching materials.

Clarke and Lephotso (1989:18) argue that the teaching method used in schools and colleges are likely to be ineffective in teaching semiliterate adults from traditional societies. Problem solving approach and group discussions are the appropriate methods of teaching TBAs. It is more realistic to train TBAs with clear methods and materials agreed upon and acceptable to those that use them and those on whom they are used (Galloway 1984:7).
6.4.6 Selection of TBAs for training

Item 1 involvement of community leaders and item 2 reasons for the involvement of community leaders in the selection of TBAs in chapter 5 page 157 show that 78 percent of nurses involved community leaders in the selection of TBAs for training. They involve community leaders because they believe that the leaders are an entry point to any village in Lesotho and they support TBAs after training. Leininger (1978) in George (1995:381) speaks with concern about the possibility of the nurse being involved in cultural imposition or culture shock, which may happen if the community leaders and their communities are not involved in the planning and organization of training programmes of TBAs.

Leininger (1978) in George (1995: 381) describes cultural imposition as “efforts of the outsider both subtle or not so subtle, to impose his or her own cultural values, beliefs, behaviours upon an individual, family or a group from another culture”. She indicates that culture shock may lead to anger and this can be reduced by seeking knowledge of the culture before encountering that culture.

In Zimbabwe Sparks (1990:153) found that their village community choose TBAs selected for formal government upgrading courses. The basis for selection were experience and long reputation as a successful birth attendant. Practical attribute mentioned several times, were the ability of a midwife to travel to a local clinic to attend the weekly classes. This implied availability of money for bus fare or willingness to walk many kilometers.
This attribute definitely deterred many TBAs from participating in the training, particularly if they were poor elderly women.

Item 8 (support and supervision of TBAs) in chapter 4 page 150 and item 8 (ensuring standards of care provided by TBAs) in chapter 5 page 160 show that TBAs are called by nurses to monthly meetings as a form of supervision and ensuring standards of care given by TBAs. This implies that selected TBAs should be strong or able to walk long distances, or pay for the transport, which obviously exclude the old and poor TBAs.

Generally most programmes of training require that a TBA be literate so that they can read manuals and keep records of their activities. The majority of TBAs in the study were literate although the majority of older TBAs had little formal education, which makes them untrainable according to the criteria based on the ability to read and write.

These criteria exclude individuals with a good long history of being TBAs and trusted by their communities. Cabral et al (1992 (b):15) argue that imposing literacy as a criterion for selection of TBAs for training may severely limit the number of active TBAs who could be trained, who are well accepted and respected in their communities.

Government of Lesotho and UNICEF (1994:191) found that in Lesotho trained TBAs are less utilized than untrained TBAs who included mothers, grandmothers and relatives. Reasons for this are not clearly understood but the assumption is that the criteria for selection of TBAs has not been sensitive enough.
The selection of TBAs varies from country to country based on the criteria established by health professionals and the members of the community.

6.4.7 Supervision of trained TBAs

Nurses in item 8 of chapter 5 page 160 reported that they supervised TBAs by calling them to the health centre monthly, where they discussed problems TBAs encounter in their practice. Visits to the TBAs home were not done and nurses did not review delivery techniques as a way of evaluating care given by TBAs. The data indicates that supervision of trained TBAs in Lesotho is inadequate.

Clarke and Lephotso (1989:14) have also reported this. Mangay- Maglacas and Pizurki (1981:9) observed that information available on supervision of TBAs is only on the work of supervisors, for instance, number of TBAs observed, number of monthly meetings and not the actual work of TBAs. They argue that there is no evidence to show either quantity or quality of work performed by TBAs. Lack of evidence is due not only to underreporting but also resources for supervision of TBAs are not sufficient to permit systematic direct observation of their performance. Lack of supervision demoralizes TBAs and has a negative effect on the standards of maternity care provided.
6.4.8 **Availability of delivery kits**

Out of 36 TBAs in the study only 24 had delivery kits; the reason cited by nurses was that the TBA programme did not have a budget from the ministry of health since it has always been a programme supported by UNICEF. Although inadequacies in refilling delivery kits were not reported by many TBAs, 78 percent of nurses reported that they had problems with the refilling of delivery kits. It has been shown that when UNICEF kits are depleted TBAs may resort to their old medicines and implements especially when visits to hospital or clinic are fruitless because the health facility itself is short of supplies (Lefeber 1994:99).

6.5 **CONCLUSIONS ON THE ROLE AND PRACTICE OF TBAs IN THE PROVISION OF MATERNAL HEALTH**

The following conclusions can be made:

- the study has provided information on the role and practices of trained and untrained TBAs in Lesotho that can be used as a basis for their curriculum.
- trained TBAs played an important role in the prevention of infection by practicing better hygienic practices than untrained TBAs.
- TBAs played a role in the prevention of complication of pregnancy and delivery by referring of risk conditions more than untrained TBA.
- TBAs played a role of agents of referral during obstetric emergencies.
6.6 CONCLUSIONS ON PROBLEMS TBAs EXPERIENCE IN THEIR PRACTICE

The findings of the study show that:

- TBAs are not paid, and received no incentives for the work they do
- TBAs and the communities they serve live very far from health care facilities, which suggest that there are problems when women with delivery complications have to be referred.
- Nurses do not adequately supervise TBAs
- TBAs lack knowledge of the physiology of labour.
- TBAs are not capable of monitoring foetal heart during pregnancy and labour.
- Chiefs do not provide adequate support to TBA.

6.7 CONCLUSIONS ON THE ROLE OF THE HEALTH CARE SYSTEM IN SUPPORTING TBAs' PRACTICE

- Training programme in Lesotho has been implemented without specific knowledge about TBAs' practices. Assumptions were made and continue to be made about their practice and the knowledge they have.
- TBAs' programme has not been evaluated and therefore, it is difficult to show what impact the programme has had on maternal health.
- It is assumed that nurses because of the nature of their training are appropriate persons to train and supervise TBAs, without them being trained.
training methods seem inappropriate for TBAs, training takes place in an unfamiliar environment from their own and the curriculum is based on a midwifery course for nurses.

- many TBAs are still left out for training because they do not meet the criteria, meanwhile they continue delivering even more women than the trained.

- the commitment is not adequate on support of TBAs from the ministry of health, evidenced by absence of budgets for TBA programmes and dependency on donors to fund the programmes.

6.8 RECOMMENDATIONS ON THE ROLE OF TBAs IN THE PROVISION OF MATERNAL HEALTH

- Because women still prefer to visit untrained TBAs during pregnancy, there is need for trainers of TBAs to adopt a culturally relevant view on the provision of maternity care by learning culture, values and traditional beliefs of the clientele served. This will assist trainers to give more cultural sensitive training to TBAs, resulting in improved trust between trained TBAs and their clients.

- Consultation with traditional healers and modern medical practitioners is essential to discuss the use of herbal mixtures given to pregnant women as that may put a woman in danger: if not consulted they may not realize the dangers of medicinal herbs in pregnancy and labour.
To determine the effect of the herbs used by TBAs a study by pharmaceutical companies or laboratories on chemical components of these herbs used in pregnancy and delivery is being recommended. Once this has been done it can be determined what the effects are on the pregnant women, and what the possible side effects can be.

As the study was only conducted in two districts of Lesotho, further investigation by health care practitioners need to be done on TBAs practices and how best their skills can be upgraded.

6.9 RECOMMENDATIONS ON SOME PROBLEMS TBAs EXPERIENCE IN THEIR PRACTICE

- chiefs need to organise communities to provide transport for obstetric emergencies
- chiefs have to be approached and requested to support TBAs in their communities
- communities need to select TBAs that they can utilise
- traditional healers need to be involved and consulted on training of TBAs

6.10 RECOMMENDATIONS ON THE ROLE OF THE HEALTH CARE SYSTEM IN SUPPORT OF TBAs’ PRACTICE.

The study recommends the following:

- training of TBAs should be continued and encouraged in Lesotho
- the selection criteria need to be revised to include even illiterate TBAs
- the curriculum for TBAs needs to be reviewed to make it simpler and easier to understand
the ministry of health needs to increase support and commitment for the TBA programme in Lesotho, provide material and equipment for practice and supervision of the TBAs

• nurses need further training to be able to train, supervise and follow up trained TBAs

• nurses in the clinics are alone and over worked therefore, they are unable to give more attention to the programme. It is recommended that public health nurses should run the programmes for TBAs and staffing levels at clinics be reviewed.

6.11 LIMITATIONS OF THE STUDY

• only two HSA i.e., the Leribe and Butha-buthe were included in the study, the findings can therefore, not be generalised to other HSA in Lesotho.

• the number of nurses who participated was small, because only one nurse per clinic was included in the study.

• it was a quantitative study and probing during interviews to get feelings, and attitudes was not always possible.
6.12 APPLICATION OF THE FINDINGS OF THE STUDY TO LEININGER'S SUNRISE MODEL

Leininger's sunrise model depicts dimensions of culture care diversity and universality. She predicts that "different cultures perceive, know and practice care in different ways yet there are commonalities about care among all cultures". (George 1995:376)

The findings show that TBAs continue to play a significant role in caring for pregnant mothers, by providing health education, referring risk mothers to health facilities and assisting women during delivery, and puerperium.

These TBAs provide care, which is described by Leininger in Fitzpatric and Whall (1996:188) as "culturally learned and transmitted, lay indigenous (traditional) or folk, knowledge and skills used to provide assistive, supportive enabling facilitative acts (or phenomena) towards or for another individual, group or institution with evident or anticipated needs to ameliorate or improve a human condition (or well-being), disability, lifeway, or to face death."

The decision and action of TBAs are influenced by their cultural values, beliefs and practices, which are embedded in their world view and social structure features as displayed in figure 6.1.
Nurses therefore, can assist and support TBAs to achieve culturally congruent care to the pregnant women. However, for the nurse to be able to play such a role, she requires knowledge of the cultural worldview of TBAs, their social structure and language (George 1995:375).

Cultural congruent care is the main goal of Leininger’s sunrise model. She defines cultural congruent care as "those cognitively based assistive, supportive facilitative or enabling acts or decisions that are tailor made to fit with individuals, group or institutional cultural values, beliefs and lifeway in order to provide or support meaningful beneficial and satisfying health care or well being services (Leininger in Fitzpatric & Whall 1996:185). Nursing actions and decision can assist TBAs to achieve cultural congruent care through three modes namely.

- Cultural care preservation or maintenance
- Cultural care accommodation or negotiation
- Cultural care repatterning
APPLICATION OF SUNRISE MODEL TO THE FINDINGS OF THE STUDY

KINGSHIP FACTORS
CULTURAL VALUES
TRADITIONAL BELIEFS

EDUCATIONAL
ECONOMICAL
TECHNOLOGICAL
FACTORS

TBA ROLE & PRACTICES

NURSING ACTIONS

TRAINING
CULTURAL CARE/
RESTRUCTURING
REPATERNING

SUPERVISION
REFRESHER
COURSES
SUPPORT

CULTURAL CARE
PRESERVATION

ADAPTATION
NEGOTIATION
AND
COLLABORATION

CULTURAL CARE
ACCOMODATION

CULTURAL CONGRUENT CARE
TO MOTHERS & CHILDREN

Figure 6.1 Application of the sunrise model to the role of TBAs

The model shown in figure 6.1 suggests how nursing can assist TBAs to achieve culturally congruent care in their role as midwives.
6.12.1 Cultural care preservation

The role played by TBAs in retaining relevant care values is very important. There is a variety of traditional practices that affect the health of women some of which are beneficial, some neutral and some harmful.

The role of the health care system is to:

- Support and retain those practices that are positive like encouraging women to breast feed immediately after birth. This stimulates uterine contraction, which encourages the expulsion of the placenta.
- Respect those that are neutral like burying of the placenta.
- Replace or abolish those that are negative like unhygienic practices of not washing hands and cutting the baby's cord with an unsafe instruments (Royston & Armstrong 1989:156)

Nurses should also maintain TBAs skills and knowledge that they were taught in their training programme. Nurses can achieve this by holding refresher courses for TBAs and follow up visits and supervision. Supervision assist TBAs to appreciate their new role after training and prevent reverting to old practices.
6.12.2 Cultural care accommodation

TBAs and professional midwifery represent two different systems of care, which have commonalities and differences. TBAs and nurses have a common goal of providing safe care to pregnant mothers. For them to achieve satisfying beneficial care they need to collaborate and respect each other's cultural care values, beliefs and practices. The findings indicate that TBAs are trained in an unfamiliar environment, the training content is complex and the duration of training is very short. To achieve beneficial or satisfying health outcomes from training of TBAs, there is a need to understand TBAs care patterns and lifeways. The knowledge of which will assist the trainers of TBAs to adapt the training to the needs of TBAs and their clients.

Collaboration with the TBAs, the community and their leaders in training of TBAs lead to trust and support for the programme. Non use of trained TBAs may be a reflection of lack if involvement of community leaders in the planning for the TBA training programme.

In chapter 5 item 7 page 159 nurses reported that they met once a year with community leaders to discuss the TBA programme. The frequency of meeting with community leader is not adequate, this may lead to culmination of problems and dissatisfaction among the TBAs, nurses and the members, of the community.
6.12.3 Cultural care repatterning or restructuring

The findings of the study show that the health care system plays an important role in modifying or changing negative practices and upgrading the skills of TBAs in the provision of maternal health. Leininger in Fitzpatrick & Whall (1996:185) define cultural care repatterning as "those actions and decisions which assist the TBAs to reorder, change or greatly modify their lifeways for new different and beneficial health care patterns at the same time valuing their own cultural values and beliefs." Training of TBAs therefore, is a crucial nursing action that can assist TBAs to provide culturally congruent care.

The study has revealed weaknesses in the practices of TBAs such as:

- the inability to monitor foetal heart
- use of herbs in pregnancy and labour
- lack of hygienic practices such as hand washing before delivery, mostly by untrained TBAs
- inadequate knowledge on the stages of labour which results in encouraging women to bear down before the cervix is fully dilated

These are some of the weaknesses that could be eliminated if stressed during the training of TBAs because some are dangerous to the health of the mother.
6.12.4 Assumptions linked to Leininger's theory

The role of the traditional birth attendant was assessed based upon some assumptions described by Leininger in her theory of cultural care diversity and universality.

Assumptions

- TBAs can be viewed as a social cultural institution, which has survived within a culture through time. The findings of the research indicated that women visit TBAs because they are from the same cultural background and have an understanding of clients' values and beliefs. Because of long distances from modern health care facilities this made TBAs more accessible, available and affordable to the community.

- TBAs represent a generic system or indigenous, traditional system, based on" the values, beliefs and life-style of people from diverse cultures” (Fitzpatric & Whall 1996:184). According to the findings TBAs see themselves as providing culturally based care to enable health and wellbeing to mothers and babies in two districts where the research was conducted. They base their care on the values, beliefs and life-style of the people they serve.

- From understanding the cultural beliefs, practices and values (cultural and social structure dimensions embedded in their worldview) of the TBAs in maternal health provision, nursing can ensure that TBAs provide cultural congruent care.
Cultural congruent care can be provided through the three modes of nursing care decisions and activities namely cultural care repatterning, cultural care accommodation and cultural care preservation. This is the central goal of Leininger's theory of culture care diversity and universality as depicted in the sunrise model (George 1995:376-7). As given in the discussion in 6.12.1, 6.12.2, and 6.12.3 cultural congruent care can be provided through the three modes of nursing care decisions.

The role of a nurse as link between the two health care systems namely the traditional midwifery and professional midwifery. The need for support of the TBAs practice from the health care system was discussed in section 6.4 (the selection of TBAs for training). The training and use of refresher course and supervision of TBAs can be a link between traditional midwifery and professional midwifery systems. To do this effectively nurses who are involved in these activities must have a cultural sensitive approach.
6.13 CONTRIBUTION OF THE STUDY TO NURSING

The following contributions were made. The study

- will provide information on maternal health, cultural aspects that are the basis for TBAs practice, knowledge and skills
- has covered an area of cultural care that is often lacking in the nurses curriculum
- will assist the health care system to review their contribution and support in the practice of TBAs
- will assist nurses to adapt the TBAs curriculum based on the needs identified in the study

6.14 RECOMMENDATIONS FOR FURTHER RESEARCH

The following recommendations are made for further research:

- A qualitative research that can elicit opinion and feelings of TBAs regarding their practice.
- A more extensive study to include a more representative population of TBAs and nurses should be conducted.
- Further research need to be done on the utilisation of TBAs.
- There is a need to evaluate TBA programme in Lesotho.
6.15 FINAL CONCLUSION

As we have moved into the new millennium the year 2000 holds many challenges. Various health and social trends will demand our attention. We will respond to these needs by taking into account our client's cultural heritage, recognising their diversity and render cultural sensitive care. The TBAs in Lesotho holds great potential to assist in rendering holistic quality maternal health to the communities. It is the responsibility of the health care system to provide the necessary support to assist the TBAs to face their challenges.

The parting of ways be African and modern medical ideas lies very deep: very near to man's experience with plants and other substances. Once the traditional African has decided that similarity forms a basis for arguing towards causality, and the man in the white coat insists that causality should first be proved experimentally before any further deductions can be made, what possibility is there of reconciling them? (Kriel 1989:209-210)
LIST OF REFERENCES:


Kinoti, N. & Mpanju, MV. 1993. *Implications of reproductive health, research results in East, Central and Southern Africa*. Arusha: Commonwealth Regional Health Secretariat.


APPENDIX I
TBA QUESTIONNAIRE
# TRADITIONAL BIRTH ATTENDANT QUESTIONNAIRE IN LESOTHO

## PERSONAL DETAILS

1. **The TBA number**

2. **Age**
   - <20
   - 21 - 30
   - 31 - 40
   - 41 - 50
   - 51 - 60
   - 61 - 70
   - 70 +

3. **The village where the TBAs lives number**

4. **Health Centre which serves the village**

5. **How long you been living in this village**
   - <1 year
   - 2 - 4
   - 5 - 9
   - 10 +

6. **What is your marital status**
   - Married
   - Divorced
   - Single
   - Widowed

7. **Do you have children**
   - Yes
   - No

8. **If yes, how many**
   - <1
   - 2 - 4
   - 5 +

9. **What is your occupation**
   - House wife
   - Farmer
   - Seems dresser
   - Herbalist
   - Others, specify
10. What is your source of income
1. Selling harvest 
2. Handicraft 
3. Others, specify

11. Have you attended school
1. Yes
2. No

TRAINING OF A TBA

1. Have you received any training
1. Yes
2. No

2. If yes, how long was the training
1. 1 week
2. 2 weeks
3. 3 weeks
4. 3+

3. Where did you train
1. Health service area hospital
2. Health centres
3. Primary health care centre
4. Others, specify

4. Who trained you
1. District public health nurse
2. Nurse clinician
3. Health centre nurse

5. What was the content
1. Care during antenatal care
   1. Yes
   2. No
2. Identification of risk
   1. Yes
   2. No
3. Safe delivery
   1. Yes
   2. No
4. Reproductive biology
   1. Yes
   2. No
5. Care of the new baby
   1. Yes
   2. No
6. Postnatal care
   1. Yes
   2. No
**REFRESHER COURSE**

1. Do you attend refresher course
   - 1. Yes
   - 2. No

2. If yes, how often
   - 1. Once a year
   - 2. Twice a year
   - 3. Never

3. Where was the refresher held
   - 1. Health service area hospital
   - 2. Health centre
   - 3. Primary health care centre
   - 4. Others, specify ............................................

4. Who was involved in the training ........................................

5. What was the content of the refresher course
   - 1. Care during antenatal care
     - 1. Yes
     - 2. No
   - 2. Identification of risk
     - 1. Yes
     - 2. No
   - 3. Safe delivery
     - 1. Yes
     - 2. No
   - 4. Reproductive biology
     - 1. Yes
     - 2. No
   - 5. Care of the new baby
     - 1. Yes
     - 2. No
   - 6. Postnatal care
     - 1. Yes
     - 2. No

**EVALUATION**

1. Do you feel the training has prepared you adequately
   - 1. Yes
   - 2. No

   Explain ................................................................................................
   ......................................................................................................
   ......................................................................................................
   ......................................................................................................
### TBA PRACTICE

1. How long have you been practising as a midwife? 
   
2. Do you know the Health service area that supervises you?
   - Yes
   - No

3. What distance do you have to travel to your health centre?
   - < 5 km
   - > 5 km

4. What area do you practice in?
   - My Village
   - Neighbouring village
   - Any where called by relatives
   - Other, specify

5. How did you become a TBA?
   - Being asked to help
   - Taught by mother
   - Taught by an experienced TBAs
   - A divine calling
   - Having birth related dreams
   - Other, specify

### PRENATAL CARE

1. How do you know when a woman is pregnant?
   - When a woman misses her period
   - Through dreams
   - When the breasts are enlarged
   - When eating habits change

2. Do you provide ANC services to pregnant mothers?
   - Yes
   - No
3. Where do you provide the services
   1. My home 1. Yes 2. No 1 54
   2. Woman's home 1. Yes 2. No 2 55
   3. Health centre 1. Yes 2. No 3 56
   4. Village Health Post 1. Yes 2. No 4 57

4. At what period during pregnancy do you often see your clients for the first time
   1. 1st trimester 1 58
   2. Second trimester 2
   3. Last trimester 3

5. What activities are performed during ANC visits.
   1. Palpation 1. Yes 1 59
     2. No 2
   2. History taking to determine previous complications 1. Yes 1 60
     2. No 2
   3. Massage the abdomen 1. Yes 1 61
     2. No 2
   4. Other, specify ........................................................................ 62

6. Do you give Health education on the following
   1. Cleanliness 1. Yes 2. No 1 63
   2. Diet 1. Yes 2. No 2 64
   3. Exercise 1. Yes 2. No 3 65
   4. Rest 1. Yes 2. No 4 66
   5. Foetal monitoring 1. Yes 2. No 5 67

7. Are you able to determine the lie of the baby
   1. Yes 1 68
   2. No 2

8. How often do you see your clients during antenal care
   1. Once a month 1 69
   2. Every two weeks 2
   3. Any time 3

9. When (During ANC) do you refer client to a facility
   1. During an illness 1. Yes 1 70
     2. No 2
   2. When there is bleeding (anteprtum haemorrhage) 1. Yes 1 71
     2. No 2
   3. Rupture of membranes (leaking membranes) 1. Yes 1 72
     2. No 2
   4. Previous difficult labour 1. Yes 1 73
     2. No 2
   5. Other, specify ........................................................................ 74
10. During the event of illness what care do you give to a pregnant mother

1. Nothing
   1. Yes 1
   2. No 2
2. Herbs
   1. Yes 1
   2. No 2
3. Call for assistance from traditional healer
   1. Yes 1
   2. No 2
4. Refer to a health facility
   1. Yes 1
   2. No 2
5. Others, specify...........................................................

If yes to medicinal herbs, which.........................................

11. Do you perform a vaginal exam during ANC
1. Yes 1
2. No 2

12. How?..........................................................................

13. How do you know when a woman is at risk
1. When there is bleeding (antepartum haemorrhage)
   1. Yes 1
   2. No 2
2. Rupture of membranes (leaking membranes)
   1. Yes 1
   2. No 2
3. Previous difficult labour
   1. Yes 1
   2. No 2
4. Primigravida
   1. Yes 1
   2. No 2

14. How do you know the baby is well
1. When the baby is kicking
   1. Yes 1
   2. No 2
2. Foetal heart Normal
   1. Yes 1
   2. No 2
3. Others, specify.........................................................

.............................................................................
15. How do you know that a pregnant mother is well
   If the woman
   1. Gains weight gradually
      1. Yes 1 86
      2. No 2
   2. Has no burning micturition
      1. Yes 1
      2. No 2
   3. No itching vaginal discharge
      1. Yes 1
      2. No 2
   4. No oedema
      1. Yes 1
      2. No 2
   5. Other, specify............................................

DELIVERY

1. How many deliveries do you conduct in a year
   1. <5 1 87
   2. 6 - 10 2
   3. 10 + 3

FIRST STAGE OF LABOUR

1. When are you called to assist with delivery
   1. When labour starts
      1. Yes 1 88
      2. No 2
   2. When the woman is about to deliver
      1. Yes 1 89
      2. No 2
   3. Other, specify.............................................

2. Do you stay with the mother all the time during labour
   1. Yes 1 90
   2. No 2

3. How do you know when a woman is in labour
   1. Abdominal pain
      1. Yes 1 91
      2. No 2
   2. When she has the urge to bear down
      1. Yes 1 92
      2. No 2
   3. When she is restless
      1. Yes 1 93
      2. No 2
   4. When she is vomiting
      1. Yes 1 94
      2. No 2
   5. When she is sweating
   6. Others, specify.............................................
      ..........................................................
4. What would you do if the woman's labour is not progressing well
   .................................................................................................................................

5. What would you consider to be a normal period of time for a
   woman to be in labour...............................................................................................  
   .................................................................................................................................

6. Do you encourage fluid taking during labour
   
<p>| |
|   |</p>
<table>
<thead>
<tr>
<th>1. Yes</th>
<th>2. No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

96 |

7. How do you control pain during labour.................................  
   .................................................................................................................................

8. Do you shave the pubic
   
<p>| |
|   |</p>
<table>
<thead>
<tr>
<th>1. Yes</th>
<th>2. No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

97 |

9. Do you clean the vulval area during labour and delivery
   
<p>| |
|   |</p>
<table>
<thead>
<tr>
<th>1. Yes</th>
<th>2. No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

98 |

10. Do you wash hands before delivery
    
    |   |  
    | 1. Yes | 2. No |
    |---|---|
    | 1 | 2 |

99 |

11. Where do woman deliver
    
    |   |  
    | 1. At the woman's home | 2. Birth attendants home |
    |---|---|
    | 1 | 2 |

100 |

101 |

12. Do you perform a vaginal examination During labour
    
    |   |  
    | 1. Yes | 2. No |
    |---|---|
    | 1 | 2 |

103 |

13. If yes, when
    
    |   |  
    | 1. Membranes have ruptured | 2. When a women shows sign of labour | 3. When the head is not visible at the vulva |
    |---|---|---|
    | 1 | 2 | 2 | 2 | 2 |

104 |

105 |

106 |
14. For what purpose

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To determine the level of the head</td>
<td>1. Yes</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2. Feel if the woman is indeed in labour</td>
<td>1. Yes</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3. Determine the dilation of the cervix</td>
<td>1. Yes</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4. Other, specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. If yes how do you perform vaginal examination

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inserting one or two fingers</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2. Feel for the head</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3. Feel for the ischial spines (litaloane)</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4. Other, specify</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

16. Do you measure the dilation of the cervix

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yes</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2. No</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

17. If yes, how do you measure the dilation of the cervix

SECOND STAGE OF LABOUR

1. When do you encourage a woman to bear down.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When bag of waters has ruptured</td>
<td>1. Yes</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2. Once labour has started</td>
<td>1. Yes</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3. At advanced stage of labour</td>
<td>1. Yes</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4. Before contractions start</td>
<td>1. Yes</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>5. Others, specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. What maternal signs show that birth is eminent

1. When the woman feels hot
   1. Yes 1
   2. No 2 118

2. Perspiring
   1. Yes 1
   2. No 2

3. Can't walk
   1. Yes 1
   2. No 2 120

4. Urge to push
   1. Yes 1
   2. No 2

5. Urge to defecate
   1. Yes 1
   2. No 2

6. Others, specify..........................................................

3. What position is a woman encouraged to take

1. Squatting
   1. Yes 1
   2. No 2 123

2. Semi reclining
   1. Yes 1
   2. No 2

3. Lithotomy
   1. Yes 1
   2. No 2

4. Others, specify.........................................................

4. When do you refer a woman to a health facility during labour

1. When there is bleeding
   1. Yes 1
   2. No 2 126

2. Malpresentation
   1. Yes 1
   2. No 2

3. Prolonged labour
   1. Yes 1
   2. No 2

4. Previous cesarean section
   1. Yes 1
   2. No 2

5. Other, specify..........................................................

THIRD STAGE OF LABOUR

1. What care do you give to the perineum during labour

2. What do you do when a woman sustain a tear

.................................................................
.................................................................
4. How are the mucous removed from the baby's mouth to facilitate easy breathing

1. Use a finger to remove
   1. Yes 1
   2. No 2
2. Remove the mucous by mouth
   1. Yes 1
   2. No 2
3. Others, specify

5. What is done once the baby is born

1. Tie the umbilical cord and cut
   1. Yes 1
   2. No 2
2. Dried up with a towel
   1. Yes 1
   2. No 2
3. Covered with a blanket to keep it warm
   1. Yes 1
   2. No 2
4. Give to the mother
   1. Yes 1
   2. No 2
5. Initiate breast feeding
   1. Yes 1
   2. No 2
6. Others, specify

6. When do you deliver the placenta

1. Immediately after the baby
   1. Yes 1
   2. No 2
2. Others, specify

7. How do you deliver a placenta

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   

   


8. Do you examine the placenta
   1. Yes 1
   2. No 2

9. If the placenta is retained what do you do?
   1. Rub the abdomen
      1. Yes 1
      2. No 2
   2. Encourage a woman to bow into a bottle
      1. Yes 1
      2. No 2
   3. Give medicinal herbs
      1. Yes 1
      2. No 2
   4. Others, specify

10. What are your views regarding bleeding after delivery

11. If the baby is born with a low apgar score what resuscitation measures are taken
   1. Swing the baby in the air
      1. Yes 1
      2. No 2
   2. Turn the baby upside down and shake
      1. Yes 1
      2. No 2
   3. Apply alcohol to the baby's body
      1. Yes 1
      2. No 2
   4. Spatting / blowing into the baby's face
      1. Yes 1
      2. No 2
   5. Percussing the back
      1. Yes 1
      2. No 2
   6. Blow on the fontanelle
      1. Yes 1
      2. No 2
   7. Others, specify

12. What are the beliefs associated with difficult delivery?
# POST PARTUM CARE

1. **Do you visit the mother after delivery**
   1. Yes  
   2. No  

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>148</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

2. **If yes, how soon after the delivery**
   
<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>One day after delivery</td>
<td>149</td>
</tr>
<tr>
<td>Immediately after delivery</td>
<td>150</td>
</tr>
</tbody>
</table>

3. **For how long is the mother taken care of by a TBA after delivery**
   
<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every day until post partum period is over</td>
<td>151</td>
</tr>
<tr>
<td>For the first two weeks</td>
<td>152</td>
</tr>
<tr>
<td>For the first week</td>
<td>153</td>
</tr>
</tbody>
</table>

4. **What activities are performed during Post Natal Care**
   
<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massage the uterus</td>
<td>154</td>
</tr>
<tr>
<td>Check the baby's cord</td>
<td>155</td>
</tr>
<tr>
<td>Encourage the mother to breast feed</td>
<td>156</td>
</tr>
<tr>
<td>Examination of the baby's condition</td>
<td>157</td>
</tr>
<tr>
<td>Wash the mother and baby's clothes</td>
<td>158</td>
</tr>
<tr>
<td>Others, specify</td>
<td></td>
</tr>
</tbody>
</table>

5. **When is breast feeding initiated**
   
<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately after birth</td>
<td>159</td>
</tr>
<tr>
<td>After 24 hours</td>
<td>160</td>
</tr>
<tr>
<td>After 2 to 3 days</td>
<td>161</td>
</tr>
</tbody>
</table>
6. How do you transfer complicated cases

SUPPORT AND SUPERVISION

1. Do you have a delivery kit
   1. Yes
   2. No

2. If yes does it have the following
   1. Scissors
      1. Yes
      2. No
   2. Gloves
      1. Yes
      2. No
   3. Soap
      1. Yes
      2. No
   4. Bowl
      1. Yes
      2. No
   5. Umbilical tape
      1. Yes
      2. No
   6. Sanitary pads / cotton wool
      1. Yes
      2. No
   7. Spirit
      1. Yes
      2. No

3. How often is your kit refilled
   1. Often
      1. Yes
      2. No
   2. Less often
      1. Yes
      2. No
   3. Not refilled
      1. Yes
      2. No
4. What are the reasons for non refilling

<table>
<thead>
<tr>
<th>Reason</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don't know</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Less frequent contact with the nurse</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Too far we have to travel to the clinic</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nurses not available at health centres</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Commodities often out of stock at health facilities</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Others, specify</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

5. Do you get any support / supervision in your practice

<table>
<thead>
<tr>
<th>Support</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yes</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>2. No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Who gives the support

<table>
<thead>
<tr>
<th>Support</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The community</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Chiefs</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. District public health nurse</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Health centre nurse</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Other, specify</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

7. How often are you supervised

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once a month</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Every 4 months</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Yearly</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

8. Where does the supervision take place

<table>
<thead>
<tr>
<th>Location</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>At my house</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>At the clinic</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Others, specify</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>
9. Do you have any problems as a TBA

1. Yes
2. No

10. If yes, explain........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
APPENDIX II
NURSES QUESTIONNAIRE
NURSES QUESTIONNAIRE (TBA TRAINER)

1. Facility No. 
   
2. The health service area number
   1
   2

3. Is it in the urban area
   1 Yes
   2 No

4. Are you involved with the community leaders in the selection of TBA trainees in your area
   1 Yes
   2 No

Give reasons for your answer ....................................................... 
.......................................................................................................... 
.......................................................................................................... 

5. How long have you been working with the community
   1. <1 year
   2. 1 - 5 yrs
   3. 6 + yrs

6. How do you build trust with community, explain ....................... 
.......................................................................................................... 
.......................................................................................................... 

7. How often do you meet with the community leaders to discuss the program of TBAs
   1. Every month
   2. Every 6 months
   3. Once a year

8. Do you support TBAs in their practice
   1 Yes
   2 No
9. If yes, how do you support TBAs

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

1. Supervisory visits

2. Holding refresher courses

3. Providing them with necessary supplies

4. Assist to produce vegetables (gardening / poultry)

5. Others, specify

10. Do you visit Traditional Birth Attendants

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

11. If a TBA has a problem how do they contact you

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

1. By post

2. Sending a messenger

3. Others, specify

TRAINING OF TBAs

1. How many TBAs do you train in a year

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>1</td>
</tr>
<tr>
<td>6-10</td>
<td>2</td>
</tr>
<tr>
<td>11-15</td>
<td>3</td>
</tr>
</tbody>
</table>

2. How many TBAs do you train in a year for refresher Courses

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>1</td>
</tr>
<tr>
<td>6-10</td>
<td>2</td>
</tr>
<tr>
<td>11-15</td>
<td>3</td>
</tr>
</tbody>
</table>

3. What is the content of the training

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

1. Identification of risk in pregnancy

2. Clean safe delivery

3. Timely referral of complications

4. Care of the newborn

5. Others, specify
4. What methods of teaching are used

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

1. Participatory (lectures and discussions)
2. Use of pictures
3. Practical (hands on)

5. How long is the training

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1. 1 week
2. 2 weeks
3. 3 weeks +

6. How do you teach illiterate TBA? Explain..........................

7. What training records do you keep

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

1. List of trained TBAs
2. List of TBAs who are active and those inactive
3. Deliveries by TBAs and the outcome
4. Others, specify...............................................

8. How do you evaluate the care provided by TBAs

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

1. Assessment of their delivery techniques
2. Assessing outcomes of their deliveries
3. Other, specify.............................................
9. How do you ensure that standards of care provided by TBAs are maintained

<table>
<thead>
<tr>
<th></th>
<th>Supervisory visitations</th>
<th>1</th>
<th>2</th>
<th>38</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Refresher courses</td>
<td>1</td>
<td>2</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Calling TBAs to the health center for meetings</td>
<td>1</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Other, specify</td>
<td>1</td>
<td>2</td>
<td>41</td>
</tr>
</tbody>
</table>

10. Do you have necessary material for teaching

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>42</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

11. Do you encounter problems with refilling of TBA kits

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>43</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

12. If yes, what problems, explain

<table>
<thead>
<tr>
<th></th>
<th>44</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Do you have transport for referring patients?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>44</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

14. Do TBAs refer patients to you?

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>3</td>
</tr>
</tbody>
</table>
15. What type of cases are referred to you

<table>
<thead>
<tr>
<th>Types of Cases</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Retained placenta</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Malpresentations</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Haemorrhage</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Prolonged labour</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Other, specify</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

16. What follow up do you do for the complications

1. Recall a woman to the health centre after a specified time
   1. Always
   2. Sometimes
   3. Never

2. Visit the woman at her home
   1. Always
   2. Sometimes
   3. Never

3. Ask the TBA to follow
   1. Always
   2. Sometimes
   3. Never

4. Other, specify

17. What are the means of communication if contacted by a TBA with a problem and she wishes to transfer a client to your centre

1. Sending a messenger to a clinic
   1. Yes
   2. No

2. No means
   1. Yes
   2. No

3. Bringing a woman with problems to the clinic
   1. Yes
   2. No

4. Other, specify
   1. Yes
   2. No
18. What action do you take

1. Visit the TBA
2. Inform the TBA to bring the woman
3. Organise transport to bring the woman to the clinic
4. Other, specify

Yes | No | Page
---|---|---
1 | 2 | 58
1 | 2 | 59
1 | 2 | 60
1 | 2 | 61

19. Do TBAs keep records

Yes | No
---|---
1 | 2 | 62

20. If yes, what records are kept by the TBAs

Yes | No
---|---
1 | 2 | 63
1 | 2 | 64
1 | 2 | 65
1 | 2 | 66
**SUPPORT FROM THE HEALTH SERVICE AREA**

1. Is the nurse given support from the Health service area
   - Yes: 1
   - No: 2

2. How often are you visited by your Health service area
   1. Once a month: 1
   2. Every six months: 2
   3. Once a year: 3
   4. Other, specify: 4

3. Who supervises you
   1. District medical office
   2. District public health nurse
   3. Central level staff
   4. Other, specify

4. How often are regular meetings held at district level
   1. Once a month: 1
   2. Once every 3 months: 2
   3. Once every 6 months: 3
   4. Once a year: 4

5. How often are you called to attend this meeting
   1. Never: 1
   2. Every time: 2
   3. Sporadic invitations: 3
   4. Other, specify: 4
APPENDIX III
REQUEST TO THE MINISTRY OF HEALTH TO CONDUCT THE STUDY
RE: PERMISSION TO CONDUCT A STUDY ON THE ROLE OF TRADITION BIRTH ATTENDANTS IN THE PROVISION OF MATERNAL HEALTH IN LESOTHO BY L.N. MAKOAE

A request is hereby made by Ms. L.N. Makoae to conduct a study on the role of TBAs in the provision of Maternal Health in Northern Districts of Leribe and Butha-Buthe.

Ms. L.N. Makoae is pursuing her doctoral studies with the University of South Africa and in fulfilment of a doctoral degree she has to conduct research that is expected to make a contribution in the area of maternal health.

The study aims at providing information on the role of TBAs, for the purpose of improving their practices.

The study will provide the Ministry of Health with information that can assist in adapting the training of TBAs accordingly if results indicates so.

The study population comprises of TBAs. Nurses form a population subgroup that will be investigated to provide information on the role played by the health care system in support of TBAs’ practice.

To ensure that individuals are not cohersed into participating in the study, informed concern will be assured. Names of persons and facilities will not be recorded, only codes will be used to ensure anonimity and confidentiality.

Yours sincerely,

L.N. MAKOAE
APPENDIX IV
REQUEST TO PHAL
TO CONDUCT THE STUDY
19 March 1999

Hi PROJ40

EXECUTIVE SECRETARY
CHAL
P.O. BOX 1632
MASERU

Dear Madam,

**RE: REQUEST FOR PERMISSION TO CONDUCT A SURVEY ON TRADITIONAL BIRTH ATTENDANTS IN BUTHA-BUTHE AND LERIBE DISTRICTS**

The above mentioned activity will take place in the above mentioned districts. We therefore request for permission since CHAL facilities are also included in the survey.

The aim of the survey is:

- to assess practice among the trained and untrained TBAs and the support they get from the supervisors and the communities.

Your usual support is anticipated.

YOURS SINCERELY,

DR. T. RAMATLAPENG

**ACTING DIRECTOR GENERAL**

**OF HEALTH SERVICES**
APPENDIX V
REQUEST TO HSAs
TO CONDUCT THE STUDY
THE DISTRICT MEDICAL OFFICER
BUTHA-BUTHE

DEAR SIR,

RE: Permission to conduct a study on the role of TBAs in the provision of maternal health in Butha-buthe HSA

A request is here made to conduct a study in your health service area. The study aims at providing information on the role and practices of TBAs, and the information can be used to adapt the training of TBAs accordingly if the results indicates so. The study will further assess the role played by the health care system and communities in support of TBAs’ practice.

The study population comprises of TBAs and nurses who are incharge of health centres that are involved in training of TBAs.

The study will take a period of two months to cover HSAs in Leribe and Butha-buthe districts namely Seboche, Butha-buthe and Leribe.

Please find enclosed a copy of a permission to conduct the study from the Ministry of Health.

Yours sincerely,

[Signature]

L.N Makoae
THE SUPERINTENDENT
ST CHARLES
SEBOCHE
BUTHA-BUTHE

DEAR SIR,

RE: Permission to conduct a study on the role of TBAs in the provision of maternal health in Seboche HSA

A request is here made to conduct a study in your health service area. The study aims at providing information on the role and practices of TBAs, and the information can be used to adapt the training of TBAs accordingly if the results indicates so. The study will further assess the role played by the health care system and communities in support of TBAs' practice.

The study population comprises of TBAs and nurses who are incharge of health centres that are involved in training of TBAs.

The study will take a period of two months to cover HSAs in Leribe and Butha-buthe districts namely Seboche, Butha-buthe and Leribe.

Please find enclosed a copy of a permission to conduct the study from the Ministry of Health.

Yours sincerely

L.N Makoae
THE DISTRICT MEDICAL OFFICER
LERIBE
DEAR SIR,

RE: Permission to conduct a study on the role of TBAs in the provision of maternal health in Leribe HSA

A request is here made to conduct a study in your health service area. The study aims at providing information on the role and practices of TBAs, and the information can be used to adapt the training of TBAs accordingly if the results indicates so. The study will further assess the role played by the health care system and communities in support of TBAs' practice.

The study population comprises of TBAs and nurses who are incharge of health centres that are involved in training of TBAs.

The study will take a period of two months to cover HSAs in Leribe and Butha-buthe districts namely Seboche, Butha-buthe and Leribe.

Please find enclosed a copy of a permission to conduct the study from the Ministry of Health.

Yours sincerely

L.N Makoae
APPENDIX VI
PERMISSION TO CONDUCT THE STUDY
Dear Ms. Makoae,

**RE: PERMISSION TO CONDUCT RESEARCH IN LERIBE AND BUTHA-BUTHE**

The Ministry of Health is pleased to inform you that the Advisory Research Committee has approved your request to conduct a study in Leribe and Butha-Butha. Since the inception of a Community Health Program, only one study of 1988 looked into the practices of trained and untrained TBAs.

The committee find your endeavour to review TBA role an essential one. The Ministry of Health and UNICEF have provided funding for training of TBAs but it is not clear if training has changed or improved TBAs practice. It is therefore hoped that your study can be able to elicit an improved picture.

You are also advised to contact the authorities in the HSAs where you will be conducting the research.

Yours sincerely,

[Signature]

**DIRECTOR GENERAL FOR HEALTH SERVICES**