TBAs knowledge performance and relation with the formal health system in Lindi Region and the role of maternal waiting homes

Sebalda Leshabari,
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Abstract:

In Lindi region 110 active trained TBAs (10 or more deliveries per year) and 110 women who delivered with TBAs were interviewed about the role of these TBAs, their knowledge and practice and their relationship with the health facilities. In addition key informants in the communities, the districts and the health care system were interviewed.

The study showed that TBAs play a unique role in their respective communities as primary care giver for delivering mother and as principal advisor to families in all issues related to birth-giving. They are highly appreciated by their clients and the communities and often preferred to the health facilities, which are perceived as too expensive, hardly accessible and with staff often not friendly to the clients.

The training has increased the reputation of the TBAs in the community because they are perceived as comparable to the staff in the facility where they went for training. TBAs complained that in cases where the local government financed the training clients afterwards expect to get the service free of charge because it was the community who paid for training. In addition communities are sometimes suspicious that the trained TBA gets money from the government.

The TBAs do not play the expected role in referrals because referral to the health facilities is perceived as a professional failure on the side of the TBA and as a shame on the part of the woman. The communication between health services and the TBAs is not satisfactory. There is no supervision and no monitoring, no visits to the TBAs or any kind of meeting and no supply of gloves or other equipment. Proper records are not available especially regarding problems during delivery (death of a mother or the child).

It is recommended that working relation between formal health system and TBAs has to be improved.

Maternal waiting homes are not yet available in Lindi Region however a need is perceived by professionals and communities because many villages are too far from the nearest health facilities to make use of it for delivery. One church hospital offers a simple house for women and their relatives where they can stay while waiting. However it does not yet meet the criteria defined by the MoH for Maternal Waiting homes.
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acronyms</td>
<td>v</td>
</tr>
<tr>
<td>Acknowledgement</td>
<td>vi</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>vii</td>
</tr>
<tr>
<td><strong>CHAPTER ONE</strong></td>
<td></td>
</tr>
<tr>
<td>1.0. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.1. Background</td>
<td>1</td>
</tr>
<tr>
<td>1.2. Training of TBAs in Tanzania</td>
<td>4</td>
</tr>
<tr>
<td>1.3. Objectives of the study</td>
<td>5</td>
</tr>
<tr>
<td>1.3.1. Broad objectives</td>
<td>5</td>
</tr>
<tr>
<td>1.3.2. Study questions</td>
<td>5</td>
</tr>
<tr>
<td>1.3.3. Specific objectives</td>
<td>5</td>
</tr>
<tr>
<td>1.3.4. Significance of the study</td>
<td>6</td>
</tr>
<tr>
<td><strong>CHAPTER TWO – RESEARCH DESIGN AND METHODOLOGY</strong></td>
<td></td>
</tr>
<tr>
<td>2.0. Introduction</td>
<td>7</td>
</tr>
<tr>
<td>2.1. Study design</td>
<td>7</td>
</tr>
<tr>
<td>2.2. Study area</td>
<td>7</td>
</tr>
<tr>
<td>2.3. Study population</td>
<td>8</td>
</tr>
<tr>
<td>2.4. Sample size</td>
<td>8</td>
</tr>
<tr>
<td>2.5. Sampling procedure</td>
<td>9</td>
</tr>
<tr>
<td>2.6. Data Collection methods</td>
<td>9</td>
</tr>
<tr>
<td>2.7. Ethical consideration</td>
<td>12</td>
</tr>
<tr>
<td>2.8. Supervision and data quality control</td>
<td>12</td>
</tr>
<tr>
<td>2.9. Data processing and analysis</td>
<td>13</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>2.10. TBA training guidelines – Lindi region</td>
<td>13</td>
</tr>
<tr>
<td>CHAPTER THREE – THE RESEARCH FINDINGS AND DISCUSSION</td>
<td></td>
</tr>
<tr>
<td>3.0. Introduction</td>
<td>16</td>
</tr>
<tr>
<td>3.1. Socio-Demographic Characteristics</td>
<td>17</td>
</tr>
<tr>
<td>3.2. The role of TBAs</td>
<td>21</td>
</tr>
<tr>
<td>3.3. TBAs roles to the women with low and high risk pregnancies</td>
<td>24</td>
</tr>
<tr>
<td>3.4. TBAs role to a women with normal/abnormal labour</td>
<td>24</td>
</tr>
<tr>
<td>3.5. TBAs role to women during postnatal period</td>
<td>26</td>
</tr>
<tr>
<td>3.6. Knowledge and practices during pregnancy, labour and Postnatal periods</td>
<td>26</td>
</tr>
<tr>
<td>3.7. Knowledge about infection control</td>
<td>34</td>
</tr>
<tr>
<td>3.8. Client’s satisfaction</td>
<td>35</td>
</tr>
<tr>
<td>3.9. Working relations between TBAs and health facilities</td>
<td>37</td>
</tr>
<tr>
<td>3.10. Referrals</td>
<td>38</td>
</tr>
<tr>
<td>3.11. Reporting</td>
<td>40</td>
</tr>
<tr>
<td>3.12. Recording</td>
<td>40</td>
</tr>
<tr>
<td>3.13. Supervision</td>
<td>41</td>
</tr>
<tr>
<td>3.14. Basic equipment and supplies</td>
<td>42</td>
</tr>
<tr>
<td>3.15. TBAs with HSR, Poverty, Gender, HIV and Local Govt</td>
<td>42</td>
</tr>
<tr>
<td>CHAPTER FOUR</td>
<td></td>
</tr>
<tr>
<td>4.0. Evaluation existing maternity waiting homes</td>
<td>44</td>
</tr>
<tr>
<td>4.1. Maternity waiting homes in Lindi region</td>
<td>44</td>
</tr>
<tr>
<td>4.2. Observations made</td>
<td>45</td>
</tr>
<tr>
<td>4.3. Focus group discussions</td>
<td>46</td>
</tr>
<tr>
<td>4.4. Clients satisfaction</td>
<td>46</td>
</tr>
<tr>
<td>4.5. Suggestions</td>
<td>47</td>
</tr>
</tbody>
</table>
CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.0. Conclusion .................. 48
5.1. Recommendations .......... 51

BIBLIOGRAPHY .................. 54
APPENDICIES 1-16 ............... 57
ACRONYMS

TBAs - Traditional Birth Attendants
Active TBAs - Traditional Birth Attendants with >10 deliveries per year
PHC - Primary Health Care
MoH - Ministry of health
VHM - Village Health Workers
THS - Traditional healers
MCH - Maternal and Child Health
MCHA - Maternal and Child Health Aider
CORPS - Community owned resource persons
DHMT - District Health Management Team
GDS - German Development services
UNICEF - United Nations Children’s Fund
WHO - World Health Organization
SMI - Safe motherhood
ACKNOWLEDGEMENT

It is impossible to adequately thank all the people who made this report a reality. Simply listing their names does not do justice to the tremendous and generous contributions so many have made from my first day in Lindi.

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EXECUTIVE SUMMARY

A cross-sectional exploratory study was conducted in five districts of Lindi region between June and July 2001. The study deployed both qualitative and quantitative methods in order to explore and validate issues related to the subject of investigation. Additionally, the study made use of existing secondary data in order to get to know what was on the ground and gain further insights into the study problem. The main goal of the study was to assess the role and practices of active TBAs in five district in Lindi as well as to evaluate the conditions of existing functional maternity waiting homes in Lindi Region as stipulated in the Lindi project plans of Operations developed on March 1999.

In the course of study a number of key respondents were interviewed. These included active trained TBAs, mothers who delivered at home, district leaders, health providers, community leaders, pregnant women and care-takers.

All sources of data and information elicited were analysed and triangulated in order to respond to the objectives of the commissioned tasks.

The following are the major findings emanating from the study.

1. TBAs play a unique role as a primary care giver to women for childbirth at home especially in rural communities. They are also multifunctional as consultants, counselors, educators etc.

2. TBAs do not give care during pregnancy and postnatal period. They mainly focus on delivery; they attend both normal and abnormal deliveries contrary to their expectations of only attending normal deliveries.

3. TBAs were found to delay some women who are for referral because they usually try local management before making decision for referral.
4. Referrals are associated with failure or lack of expertise on the side of the attendant and this contributed much on the knowledge-practice gap to most TBAs.

5. Practices on infection control were found to be low as some TBAs were conducting deliveries with bare-hands when gloves were not available.

6. Clients satisfaction on TBAs care provided was highly ranked and mothers revealed to perceive no difference between the care provided by TBAs and that of health providers in the health facilities.

7. Among the major factors that contribute for the mothers to deliver at home as perceived by both TBAs and mothers were; costs, sudden labour, bad attitude of midwives at the health facilities, good care at home, accessibility and affordability of TBAs and long distance to the health facilities.

8. The reporting system was found to be inadequate because of costs and lack of proper supervision from all levels. There were no reports for maternal deaths. Proper records from TBAs were observed. It was also found that, TBAs after training were left without any proper planned supervision from all levels. Most TBAs were also observed to have no delivery kits and not getting enough supplies of gloves from the health facilities.

9. It was also found from the study that there are no maternity waiting homes in all districts of Lindi region. It was found that St. Walburg’s hospital Nyangao had felt a need to assist those women who are coming from very far, by providing some place for rest but they disagreed to call it maternity waiting home because it doesn’t meet the standards needed for maternity waiting homes. However most of key informants from districts to community level felt a need for having at least one maternity waiting home in each district, to access more mothers to the health facilities.

In view of the above research findings the study report has come out with recommendations which are at the end of this report.
CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

The art of midwifery has been practised in one form or another, literally since the days of Adam and Eve (Genesis 4:1). So the history of midwifery is as old as mankind. In every culture special attendants have proffered aid to women in labour, assuaging their pains, assisting their deliveries and attending to their newborn. In most traditions, this was reserved to females. Different countries had a different name for the “traditional birth attendant”. In England she was known as “Midwife” (with woman), in France as “Sage Femme” (wise woman) (Wringley, 1961); in Kiswahili “Mkunga” (child-birth attendants) and in Kimwera “Bi-mkubwa” (The great woman).

Carvalho (1998) noted that TBAs are mostly elderly women who live in a community and are respected by the community. They have personal relationships with their clients families, speak the same language and share the local health beliefs and practices that are valued by woman and their families.

According to WHO, a traditional birth attendant (TBA) is a person who assist the mothers during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants. A family TBA is a TBA who has been designated by an extended family to attend births in the family. A trained TBA is a TBA or a family TBA who has received a short course of training (days, weeks, months etc.) through the modern health care sector to upgrade her skills (Joint WHO/UNFPA/UNICEF statement 1992).
While most pregnancies and births are uneventful, all pregnancies are at risk. Around 15% of all pregnant women develop a potentially life-threatening complication that calls for skilled care and some will require a major obstetrical intervention to survive.

Besides the problem of acceptability of health staff, inadequate delivery health facilities, lack of personnel in the few available health facilities, poor transport and communication systems in Tanzania and many others together force many women to deliver at home. In Tanzania it is estimated that only 40% of the deliveries are institutional (health facilities) while 60% of them are home deliveries. The question is “who attends to these home deliveries?” Most probably are TBAs, relatives and friends.

The Government of Tanzania through the Ministry of Health, adopted the Primary Health Care (PHC) strategy since the Alma Ata Conference in 1978. The PHC implementation recognized the strong linkage between the community based health care services using community own resource person (CORPS) e.g. TBAs, VHW, THS with health institutions. The Ministry of Health began a national program of maternal and Child health Services (MCH) in 1974. Administratively MCH services are divided into Zones, Regions and District which are manned by Coordinators. During the implementation of MCH services it became increasingly evident that there were a lot of home deliveries at a range of 50%, particularly in areas where health facilities were far from communities. In addition the level of maternal mortality was high ranging between 400 – 700 maternal deaths per 100,000 livebirths. In-order to meet the objectives in the Primary Health Care Strategy, the Ministry of Health saw the need to integrate TBAs into the health system through training.

The first curriculum was developed in 1989, the 2nd and 3rd editions were produced in 1992 and 1996 respectively.
In 1987, at an International Conference in Nairobi, the Safe Motherhood Initiative was launched. The goal of the initiative is to reduce maternal mortality by at least 50% by the year 2000. The initiative advocates a 4 pronged approach to improving women’s health.

i. Raising the status of women
ii. Ensuring access to family planning services and family life education.
iii. Strengthening community based maternal health services.
iv. Providing backup and support services at the first referral level (district).

In 1992, a task force was formed which came up with the Safe Motherhood Strategy for Tanzania under the guidance of Ministry of Health as follows:

A  Improving routine maternal health services.

This strategy had the following objectives:

i. To improve skills of service providers (including TBAs and VHWs) in the identification and management of high risk pregnancies.
ii. To establish community based pregnancy monitoring system – through training of TBAs and VHWs.
iii. To improve quality of PHC at dispensary and health centre level inorder to provide backup support to community based PHC.

B. Improving emergency care and referral.

This strategy had the objective:

Of training personnel in risk screening (during pregnancy and labour) and in management of complications before transport to referral facility.

In 1997 following the International Conference on Population and Development which was conducted in Cairo in 1994, the Ministry of Health came up with the Reproductive and Child
Health Strategy (1977 – 2001) of which Safe Motherhood is an integral part of it along with Family Planning, Prevention of STD/HIV/AIDS and Child care.

During the same year, SMI convened a global meeting in October 1997 in Colombia, Sri-Lanka to review the key lessons learned of the past 10 years. Some of the lessons learnt were that, the critical pathways to reduce maternal mortality is improving the accessibility, utilization and quality of services for treatment of complications during pregnancy and childbirth. Another lesson is that, worldwide, it has revealed, at least 40% of women who become pregnant experience some complications during pregnancy, childbirth and the postpartum period and about 15% develop life threatening complications mostly at the time of birth. At least 5% require a caesarean section. Therefore all women need access to quality maternal services including a skilled attendant during birth.

1.2 Training of TBAs in Tanzania

In recognition of an essential role played by TBAs in improving Maternal and Child Health Services in the country, the Ministry of Health started a training programme for TBAs in 1983 which later was assisted by non governmental organizations such as German Development Services (GDS) Ireland Aid and Missionary hospitals.

The main goal of the programme is to reduce complications and deaths caused by childbirth through:

- Identification of risk cases
- Prompt referrals
- Hygienic procedures and Infection Control
- Advocacy on Family Planning Methods
• Proper reporting system
• Promotion of Cooperation and good relationship between TBAs and providers in the health facilities
• Encouraging mothers to make use of the MCH services.

1.3 OBJECTIVES OF THE STUDY

1.3.1 The Broad Objective

The main goal of the study was to assess the role and practices of active TBAs in five districts in Lindi as well as to evaluate the conditions of existing functional maternity waiting homes in Lindi Region as stipulated in the Lindi project plans of Operations developed on March 1999.

1.3.2 The Study Questions

The questions in mind were:

• What are specific activities performed by TBAs in Lindi region?
• How significant are TBAs and Maternity waiting homes in Lindi region.

In order to have answers for the questions; the following objectives were to accomplished:

1.3.3 Specific Objectives

1. To conduct baseline survey in five districts of Lindi region to assess the role of active TBAs and the conditions of existing functional maternity waiting homes.
2. To examine the functions of TBAs and maternity waiting homes including strength, weaknesses challenges.
3. To assess the working relations with the nearby health facilities of the referral system.
4. To review TBAs service in the community and linkage with the health sector reform, local government, poverty reduction and HIV/AIDS.

5. To examine infrastructure, quality of services, basic equipment and supplies in the maternity waiting homes.

6. To determine user satisfaction for both TBAs services and maternity waiting homes based on perceived quality of care.

7. To examine the current reporting, recording and monitoring system for both TBAs and in maternity waiting homes.

8. To make recommendations for future support.

1.3.4. THE SIGNIFICANCE OF THE STUDY
The significance of the study lies in the fact that very little is know about the roles and practices of active trained TBAs and existence of functional maternity homes in Lindi region. Therefore, findings from this study will reveal the existing situation as a basis for future support in improving quality care for Maternal and Child Health services in Lindi region.
CHAPTER TWO
RESEARCH DESIGN AND METHODOLOGY

2.0 INTRODUCTION

This chapter discusses the methodology of the study under nine main headings namely:

Study Design
Study Areas
Study Population
Sample Size
Sampling Procedure
Data Collection Methods
Ethical consideration
Field Work Management
Supervision and Data Quality
Data processing and Analysis
Dissemination

2.1 STUDY DESIGN

The design of this study was a cross sectional exploratory survey.

2.2 STUDY AREAS

This study was conducted in all districts with trained TBAs in Lindi region namely Lindi Rural, Ruangwa, Nachingwea, Liwale and Kilwa. Only Lindi Urban was left because they didn’t have trained TBAs as there was no training programme conducted in this district. The region has total population of 868,969 (RRCH report, 2000). This region was chosen because it is among the focal regions for German Development Support Programme.
The region has a total of 134 health facilities. The government is the main provider of health facilities. The dispensaries and health centers constitute the first level of care. The hospitals constitute the referral level of care.

The local government has initiated a training programme for TBAs 5 years before. The overall objectives of the governmental training was: To exchange ideas between midwives (with formal training) and TBAs about the best and safe ways of caring for pregnant women during pregnancy until delivery; so as to reduce complications and deaths caused by child birth. Also to promote a good relationship between TBAs and MCH Aiders.

Some other training has been conducted in the region by different providers such as Missionaries hospitals and NGO’s e.g. GDS.

2.3. STUDY POPULATION

The study sought to collect information from the trained TBAs having an average of 10 or more deliveries per year.

2.4. SAMPLE SIZE

The sample size of 110 active TBAs out of a total of 275 was found adequate for establishment of the roles of trained active TBAs in Lindi region.
2.5 . SAMPLING PROCEDURE

A list of the trained TBAs reporting having more than 10 deliveries per year was obtained from the regional RCH Office. A list was arranged according to districts, ward and villages. Systematic random sampling using random number tables was employed to select the study population.

2.6 . DATA COLLECTION METHODS

Given the nature of the study, the researcher used quantitative and qualitative approaches to data collection, from both primary and secondary sources, for the purpose of collecting reliable and valid information. This include:-

- Questionnaire
  - Unstructured
- Individual indepth interviews
- Documentation review
  - TBAs Training Guidelines
  - Delivery books
  - Report
    - Health facilities
    - Regional RRCH Coordinator
    - District RRCH Coordinator.
- Observation checklists
  - Delivery kits
  - Maternity waiting homes.
- Focus Group Discussions (FGDs)
Questionnaires
The questionnaires were semi-structured and in “Kiswahili” because it is a media of communication in this communities. The surveyors administered the questionnaire in order to give proper clarification where the need arise and also to ensure high rate of return.

The questionnaires were expected to give information on views of the trained TBAs concerning their demographic characteristics, roles, quality of care, and working relations with health facilities (See appendix 1). The data collection from the TBAs was done during home visits the health worker in the respective dispensary/health centre were informed in advance by the DRCH – Coordinator to send a message to the selected TBAs about the date of interview.

However, the above information was supplemented by the insight information from the semi-structured questionnaire which were administered to 100 mothers who delivered by TBAs who were attending MCH clinic during survey 4 mothers in each health facility surveyed were interviewed (See appendix 2).

In-depth Interviews (Key informants)
This technique involved a face to face contact between the interviewer and the interviewee. In this study, semi-structured interview using an interview guide was used to explore knowledge, feelings and opinions from key informants concerning the role of TBAs in their respective districts and also quality of care provided by TBAs.

The informants were purposely selected and asked for their willingness to give information.

This was done in each district to the:-

- DED
- DPLO
- DMO
- DNO
- DRCH Coordinator
- DVHW Coordinator
- Village Leaders
- Health personnel (l/c or MCHA or PHN in the dispensary or health centre),
- Incharge maternity waiting home.

Permission to be recorded was sought and tapes were transcribed and reported every after the interview.

**DOCUMENTARY REVIEWS**
Documentation review included a list of all trained active TBAs in the region; arranged according to districts, wards and villages. This was used to select a study sample. The list was obtained from the RRCH Coordinator.

TBAs Training Guidelines (MOH) was also examined for what was supposed to be taught concerning roles, quality of care and relationship with health facilities. Delivery books were also reviewed for number of deliveries, referrals, reporting, recording and supervision. Finally, report from health facilities RRCH and DRCH Coordinators were also reviewed for number of deliveries, interpersonal relations, referrals and supervision. This set of secondary data was used to check for consistence of data gathered through questionnaires and interviews.

**OBSERVATION CHECKLIST:**
Delivery kits were checked for equipment and their conditions. Again maternity waiting home was to be check for care given, working relations with other health facilities and standard according to (MoH 1999) checklist (see appendix 3)

**FOCUS GROUP DISCUSSION (FGDS)**
Two FGDs were held at St. Walburg’s Hospital Nyangao. One group of pregnant women and the second group was of women care takers. These were meant to obtain their views about the care given and the need for maternity waiting homes.
2.7 ETHICAL CONSIDERATION

The situation analysis whose results are discussed in this report was conducted during the months of June and July 2001. Permission was sought from authorities at regional to grass root levels. The purpose of the study was explained to the respondents and their consent was obtained before being interviewed.

Participants of focus group discussion (FGDs) were told about the procedure and that they would be tape-recorded if they agree. The same information was given to those individuals who participated in the in-depth interviews. Confidentiality, anonymity and privacy were the practice in the study. The tapes were stored to a place accessible to interviewers only. They would be erased at the end of the study.

2.8 SUPERVISION AND DATA QUALITY CONTROL

Every after one complete day the researchers discussed the interviews together with the research assistant and pointed out the strengths and weaknesses so as to improve in the subsequent questionnaires.

2.9 DATA PROCESSING AND ANALYSIS

After the fieldwork, all questionnaires were coded and data was entered into the computer using EPI-Info software. Data was cleaned and analyzed using the same program. Data from in-depth interviews and focus group discussions were transcribed and content analysis applied.

2.10 TBA Training Guidelines in Lindi Region

Before assessing the roles and quality care provided by TBAs, I had to review the TBAs training guidelines to know the expected output. This was as follows:

The TBA training in Lindi region was based on MoH 1992 curriculum for training of TBAs. Currently the latest curriculum is of 1998.

The goal of the training is to reduce maternal and child mortality.
The specific objectives of the training is to:

- Enable TBAs to recognize and refer women who are at risk during pregnancy, delivery and post delivery to the nearest health facility.
- To be able to assist delivery in a safe and clean atmosphere
- To be able to record births and deaths of mothers and children in their communities.
- To cooperate and collaborate with fellow TBAs.
- To increase awareness in the community on the use of MCH services – particularly for pregnant women.
- To be able to provide non-prescriptive contraceptives e.g. condoms.
- To sensitize mothers on the importance of exclusive breastfeeding after delivery.

**Methodology**

The duration of the training according to the MoH curriculum is 30 days.

The venue should be within the village setting preferably at a nearby facility where they can have practical training.

The sessions are in theory and practice.

The training program should be timed to suit with the TBAs availability.

The training of TBAs is mainly conducted by doctors, midwives and Public Health Nurses. After the original training it is advised to have regular refresher course at least once in every 2 years.

**The Content**

Expectation of TBA, Fertilization and puberty, Care of antenatal mothers, Pregnancy and problem related, Signs and symptoms of labour and Identification of at risk pregnant mothers

The updated curriculum also includes reproductive health and prevention of STD/HIV/AIDS.
**Expected Outputs:**

A trained TBA is expected to perform the following tasks:

- Provide counselling to pregnant women
- To recognise risk factors in pregnant women and provide referral
- To assist mothers during delivery
- Provide care after delivery
- Prevent transmission of STDs/HIV/AIDS to the baby, mother or herself during delivery
- To educate youth and families on reproductive health
- Promote community development
- Advice families on vaccination and family planning
- Proper keeping of records.

**TBA Kit**

The trained TBA is supposed to be provided with the following:

- IEC materials
- Doll model with cord and placenta and female pelvic model
- Reals of thread – used by TBA for recording data.
  - White thread indicating a (live baby).
  - Black thread indicating a (still birth).
  - Mackintosh.
  - Piece of soap.
  - 150 cm long stick for measuring mothers’ height.
  - Razor blade.
  - Cod tie.
  - Exercise books for record keeping.
• Pieces of clothes.
• Cooking pots.
• Water containers.
CHAPTER THREE
THE RESEARCH FINDINGS AND DISCUSSIONS

3.0. INTRODUCTION

This chapter presents results obtained through documentary reviews, questionnaires, individual indepth interview observation checklist and focus group discussions conducted with TBAs, and key informants in Lindi region on June-July 2001.

The chapter is divided into six sections. 4.2 shows the socio-demographic characteristics of the study population, while section 4.3 presents the roles and practices of TBAs including their strengths weaknesses and challenges. Section 4.4 examines working relations with health facilities including infrastructure, reporting recording, monitoring and referral systems. 4.5 will explored the user satisfaction and this will include how are the services perceived by clients communities and health care providers at the health facility and 4.6 will also explore the factors that influencing home deliveries including causes for not complying to referrals and client's perceptions of the effect of home deliveries.

3.1. SOCIO-DEMONOGRAPHIC CHARACTERISTICS

The Socio-demographic characteristics of the study population is as displayed in table 1 below. As can be seen Ruangwa district is having more trained and active TBAs than other four districts. A total of 110 trained active TBAs were interviewed and all (100%) were female mostly (89%) muslim, over 40 years of age except only one who had 37 years (the youngest). Sixty eight of them (62%) were aged 40-60 years. All of them had at some time been married, their current marital status vary; (53%) were married, (32%) widowed and (15%) were divorced.
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<thead>
<tr>
<th>Characteristic</th>
<th>Categories</th>
<th>NUMBER</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>District</td>
<td>Lindi Rural</td>
<td>20</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>Ruangwa</td>
<td>55</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Nachingwea</td>
<td>13</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Liwale</td>
<td>10</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Kilwa</td>
<td>12</td>
<td>11%</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>110</td>
<td>100%</td>
</tr>
<tr>
<td>Marital status</td>
<td>Single</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>58</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>35</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>17</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Religion</td>
<td>Muslim</td>
<td>98</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>Christian</td>
<td>12</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Age</td>
<td>20 – 40</td>
<td>6</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>40 – 60</td>
<td>68</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>&gt;60</td>
<td>36</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Youngest</td>
<td>37</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Oldest</td>
<td>75</td>
<td>72%</td>
</tr>
<tr>
<td></td>
<td>Mean age</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Educational level</td>
<td>No formal education</td>
<td>87</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td>Primary education</td>
<td>22</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Secondary education</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Ability to read and write Kiswahili</td>
<td>Easily</td>
<td>23</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>With difficult</td>
<td>8</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Not able</td>
<td>79</td>
<td>72%</td>
</tr>
<tr>
<td>Number of deliveries last year (2000)</td>
<td>Less than 10</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>10- 15</td>
<td>88</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>More than 15</td>
<td>18</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Mean age</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Client selection</td>
<td>Every woman who need assistance</td>
<td>103</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>Only relatives and friends</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Any who can pay</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Place of delivery</td>
<td>Home of TBA</td>
<td>5</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Home of the mother</td>
<td>46</td>
<td>42%</td>
</tr>
<tr>
<td>Both TBAs and Mothers</td>
<td>59</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>----</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>Payment</td>
<td>44</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td>32</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Inkind</td>
<td>34</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Place of initial learning how to deliver</td>
<td>22</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Health worker</td>
<td>67</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>An older relative TBA</td>
<td>24</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>or a friend and H/W</td>
<td>7</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>On my own and H/W</td>
<td>24</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>7</td>
<td>6%</td>
<td></td>
</tr>
</tbody>
</table>

This results support the comment made by one of the key informants that;

"The position of a TBA in this rural society is an important one. To be accepted as a TBA, it is necessary to be a relatively older individual who has lived as a married person and should have at least one living child."

79% had no formal education and only (20%) had primary education. This justify why only (21%) could read and write without problems. The large majority (93%) claimed that they assist any woman who comes for the service. Only few (4%) said they attend most deliveries to relatives and friends and (3%) agreed that they don’t do it for free therefore, they always assist mothers who can pay. 105(95%) had more than 10 deliveries per year. When asked how they came to acquire the skills of attending birth, there were 4 types of response to the question and all show they had some training from a health worker 67(61%) said they were trained by a relative (mother, grand mother aunt) or a friend and later in the health facility by a health worker. 22(20%) said they had initially watched a health worker 14(13%) claimed to have acquired their skills on their own as it is a tradition within their extended family. The rest 7(6%) claimed to have
acquired their skills from God through a dream. For place of delivery, 59(54%) said to attend births on both their homes and sometimes at the mother’s home. Only (4%) insisted that they do it at their home only. These were the very old ones with more than 68 years of age and they give reasons that they can’t walk long distance. 46(42%) they reported to attend births at women’s home. 44(40%) claimed to have no payment and they complained bitterly that before government select them to go for training at least clients were showing a kind of appreciation as they could give them cash or something inkind for compensation for their services but now after training they are given mere words of appreciation. The following comment was noted from one of the key informants;

“Our village government pay some money (15,000/=) from our deposits for their living when attending the training. They are supposed to come back to save the community free of charge: we are very poor and we don’t have to pay them double. After all government should pay them”.

Most of the comments given by the TBAs on remuneration and rewards were that; traditionally the TBAs provided their services on voluntary basis no fees were charged. However, African tradition demands that anyone who received kindness or help from another should demonstrate his/her gratitude in appropriate way. So in the past, after a successful delivery the mother showed her appreciation by giving the TBAs basket full of flour and a pair of black calico (KANIKI) and some produce from the farm. In more recent times some grateful clients have offered cash rewards ranging from 1,200-1,500 Tanzanian shillings or mere words of thanks. The main reward for the TBAs was the gratitude and prestige they had from the community.
Table 2 shows that about a half (49%) of women delivered at home are between 19 and 35 years of age. About one third (31%) are under 18 years of age. (64%) had not formal education and (88%) had attended Antenatal Clinic because most of them (63%) were advised by TBAs. (48%) had at risk pregnancies as they were more than 6 pregnancies (multigravida). (78%) were delivered by TBAs and the rest by relatives or alone. Only few (2%) reported to be assisted by health workers. The outcome mostly (88%) were live births and the most payment were (50%) in cash and the rest (35%) were in kind and (15%) nothing.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Categories</th>
<th>N=110</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>15 – 18</td>
<td>31</td>
<td>31%</td>
</tr>
<tr>
<td></td>
<td>19 – 35</td>
<td>49</td>
<td>49%</td>
</tr>
<tr>
<td></td>
<td>&gt;35</td>
<td>20</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>Muslim</td>
<td>95</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Christian</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Schooling</td>
<td>None</td>
<td>64</td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td>Primary education</td>
<td>36</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Ante-natal clinic</td>
<td>Attended</td>
<td>88</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>N of attended</td>
<td>12</td>
<td>12%</td>
</tr>
<tr>
<td>Advice to attend ANC given by</td>
<td>Health worker</td>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Herself</td>
<td>14</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
<td>63</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>17</td>
<td>17%</td>
</tr>
<tr>
<td>Number of pregnancies</td>
<td>1 – 5</td>
<td>52</td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>6 – 10</td>
<td>34</td>
<td>34%</td>
</tr>
<tr>
<td></td>
<td>&gt;10</td>
<td>14</td>
<td>14%</td>
</tr>
<tr>
<td>Number of deliveries</td>
<td>1 – 5</td>
<td>48</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td>6 – 10</td>
<td>34</td>
<td>34%</td>
</tr>
<tr>
<td></td>
<td>&gt;10</td>
<td>14</td>
<td>14%</td>
</tr>
</tbody>
</table>
3.2. THE ROLES OF TBAs

The key issues explored here were; their specific activities; their role to a woman with low risk pregnancy; a woman with normal labour; a woman with abnormal labour; and a woman after delivery and during postnatal period.

Table 3: Distribution of respondents views on their roles to women in the community

<table>
<thead>
<tr>
<th>Roles</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attend deliveries</td>
<td>110</td>
<td>100%</td>
</tr>
<tr>
<td>Consultants</td>
<td>58</td>
<td>53%</td>
</tr>
<tr>
<td>Counselors</td>
<td>69</td>
<td>63%</td>
</tr>
<tr>
<td>Health promoters</td>
<td>73</td>
<td>66%</td>
</tr>
<tr>
<td>Traditional healers</td>
<td>8</td>
<td>7%</td>
</tr>
<tr>
<td>Educators</td>
<td>52</td>
<td>47%</td>
</tr>
<tr>
<td>Advisers</td>
<td>61</td>
<td>55%</td>
</tr>
<tr>
<td>Coordinators</td>
<td>54</td>
<td>49%</td>
</tr>
</tbody>
</table>
**Conduct Deliveries**

The major role mentioned by all 110 (100%) TBAs was conducting deliveries. This was also reflected in the curriculum for TBAs. Most of the content emphasize on how to conduct deliveries. It was also supported by the answers from almost all key informants who reported that; “The major role of TBAs is to conduct deliveries at home.” This also was reported the same by the health care providers in the health facility when interviewed as key informants. The same, response was reflected in the record of total number of deliveries in the study districts as in table 4.

**Table 4: Total number of deliveries in the 5 Districts Lindi region Jan – Dec. 2000**

<table>
<thead>
<tr>
<th>District</th>
<th>Health facility delivery</th>
<th>TBAs delivery at home</th>
<th>Total No of deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lindi Rural</td>
<td>3,639</td>
<td>1,240</td>
<td>4,879</td>
</tr>
<tr>
<td>Ruangwa</td>
<td>1,191</td>
<td>922</td>
<td>2,113</td>
</tr>
<tr>
<td>Nachingwea</td>
<td>3,460</td>
<td>1,780</td>
<td>5,240</td>
</tr>
<tr>
<td>Liwale</td>
<td>2,389</td>
<td>1,361</td>
<td>3,750</td>
</tr>
<tr>
<td>Kilwa</td>
<td>2,263</td>
<td>2,174</td>
<td>4,437</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12,942</td>
<td>7,477</td>
<td>20,419</td>
</tr>
</tbody>
</table>

The Health facilities records show that about (37%) of all deliveries recorded are assisted by TBAs, however some TBAs claimed to conduct some deliveries in the health facility with or without the presence of MCHA and are not recorded as deliveries conducted by TBAs. This means that not all recorded under health facilities were conducted by health care provider and the percentage of TBAs may be higher.

58(53%) of the respondents said after training now they act as consultants they claimed that when relatives or untrained TBAs have any problem when attending deliveries in their villages they always consult them of what to do. This strengthens the specific objective for the training which is to cooperate and collaborate with fellow TBAs but looking at the side, the process of consultation may prolong time for referral and may cause more harm to the life of the mother and babies.

69(63%) said they act as counselors for those who do not comply with referrals although during indepth interviews with mothers who were delivered by a TBA one of them said;

“I was told from a health facility to go to Mnero hospital because I am only 15 years old and they suspected some problems during delivery. But when I went to consult our neighbour who is a TBA she advised..."
The above statement contradict the MoH expected outputs for a trained TBA which are:

- To provide counseling to pregnant women to comply with suggestions given.
- To recognize risk factors in pregnant women and provide referral.

**Counselors**

They also said that they counsel mothers on immunizations and sometimes they take the babies to the clinics for immunization if the mothers do not feel well. This also shows that instead of encouraging mothers for postnatal check-up they encourage them to rest at home. All of them claimed to counsel mothers to attend antenatal services during pregnancy. This was supported by all mothers interviewed because they agreed that they all attended antenatal clinic.

**Health Promoters**

As health promoters they claimed that they give escort to the mothers when problem arise and need to go to the health facility. They said they do so because they feel that they are responsible to go and give the details of the problem for proper management. They also said that they sensitize the communities on the matters affecting health in general 8(7%) agreed that they also treat some people in the community using traditional medicine. It was also noted from most key informants that TBAs are viewed as the key professional worker for all women having home births taking the primary management role in labour.

**Educators:**

52(47%) agreed that they are “Nyaloangas” or “Walombe” the traditional names used to refer to educators of youth group during rite of passage period and they are highly respected in the communities they can even given advice to some major decisions in the village authorities.
When asked of any other task performed besides the roles mentioned above; almost all 106(96%) said they are also farmers. These other few 4(4%) were the very old ones who can not walk properly.

3.3. TBAs ROLES TO THE WOMEN WITH LOW AND HIGH RISK PREGNANCIES

When asked about their roles to the women with low and high risk pregnancies; they all 110(100%) responded that they advice them to go to the health facility (dispensary/health center) for Antenatal check-up. They also said that antenatal care is not their role and they don’t examine mothers during antenatal period until the time of delivery.

3.4. TBAs ROLES TO THE WOMEN WITH NORMAL/ABNORMAL LABOUR

When asked about their roles to the women with normal/abnormal labour; the responses were more than one and of four types as shown in table 5.

| Table 5: Respondents views on their roles to the women with normal/abnormal labour |
|-------------------------------|-----------------|-----------------|
| Responses | Normal labour | Abnormal labour |
| N | % | N | % |
It was found that TBAs view their role in intrapartum care as very important in both normal and abnormal labour. This is in contrary to the training objectives of early detection and referral for the abnormal conditions.

This was also supported by key informant from the community who commented that;

“These people (TBAs) are very competent them even those incompetent young providers at the health facilities because they usually manage well the difficulty conditions that have been referred by our health facilities. They very much understand our real situations that we all villagers don’t have money.”

### 3.5. TBAs ROLES TO WOMEN DURING POSTNATAL PERIOD

The study noted that TBAs view on their role during postnatal period was not important. Most of them (87%) said two to three hours after delivery if there is no sign of only problem they usually go back home and if they are not called for any reasons they don’t see why they should go back to see mothers after delivery. Others complained that if they are seen to visit matters frequently even mothers themselves and husbands may think that they are going there for payment and
3.6. KNOWLEDGE AND PRACTICES DURING PREGNANCY, LABOUR AND POSTNATAL PERIOD

Knowledge and practices during pregnancy

While most pregnancies and births are uneventful, all pregnancies are at risk. Around 15% of all pregnant women develop a potentially life-threatening complications that calls for skilled care and some will require a major obstetrical intervention to survive knowledge of the danger signs that may occur to a woman during pregnancy is critical to all those who play a unique role in caring for pregnant women e.g. TBAs.

In order to understand the level of knowledge among the study population, a scale was constructed. Each danger sign mentioned was given a score of one and for each respondent a total knowledge score was obtained by counting the number of danger signs mentioned. The score ranged from zero to a maximum of eight points. Those who score less than three points were classified as having a low level of knowledge on danger signs, while those with three to five points were classified among TBAs with moderate knowledge. High level of knowledge was reflected by scores of six or more points. The variation of the level of knowledge is summarized in figure 1.
The findings show that most (56%) of trained TBAs had moderate level of knowledge of danger signs during pregnancy, while 36(33%) had low level of knowledge about the danger signs and only 12(11%) had high level of knowledge on danger sings. When cross-checked with age those with high level of knowledge were younger than those with low level of knowledge whose age ranged from 60 years onwards.

The most mentioned danger signs by almost all respondents were vaginal bleeding and anaemia. The possible explanation for this may be that because they are seen frequently in their daily practice is more easy to recall. This was supported by the RRCH report (2000) which show Antepartum haemorrhage, anaemia and malaria as the leading cause of maternal mortality in Lindi region.

The same scale was used to measure the level of knowledge for danger signs during pregnancy that would require TBAs to refer to a health facility. The variation of knowledge is summarized in fig. 2
The findings had no difference from the previous ones because they couldn’t recall more signs and when asked about the management of specific problems during pregnancy they all claimed that they don’t manage any woman during pregnancy. They said that usually they advice mothers to go for antenatal care in the clinics, whereby those problems will be better managed. This also corresponds with their responses when asked about their roles to women during pregnancy.

**KNOWLEDGE AND PRACTICES DURING LABOUR**

The same measurement was used to score the level of knowledge of danger signs during labour. The responses were as summarized below in fig 3:
92 (83%) of the respondents had moderate level of knowledge of danger signs that my occur to a woman at the time of delivery. Very few (4%) who had low knowledge said they don’t recall because they have never had problems when attending deliveries and it was very long since they attended the training.

For the danger signs that require immediate referral; the knowledge of the responds were as summarized in table 6:

Table 6: Distribution of Responses of Knowledge of Danger Signs that Require Immediate Referral
96 (87%) of all respondents had good knowledge of danger signs for referral during labour. The problems which were not mentioned were malpositions and malpresentations and twins delivery. In the interview with mothers who delivered at home one of them said

“I was told to go to deliver at Nangao hospital because of breech presentation. My husband advised me to go and consult our neighbour TBA first because he didn’t have money for transport and payments at the hospital. This TBA admitted me in her house and she managed to deliver my live baby, although with difficulties which I don’t want to recall.”

78 (71%) claimed that they had attended some women who got problems during delivery. The most common problems mentioned and action taken were as summarized in table.

Table 7: Distribution of Responses of Management for Problems during Labour

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>N</th>
<th>%</th>
<th>LOCAL MANAGEMENT</th>
<th>IMMEDIATE REFERRAL</th>
<th>LOCAL MANAGE THEN REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>14</td>
<td>13%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>61</td>
<td>55%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>35</td>
<td>32%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In general, these findings show that most trained TBAs have encountered several problems on the process of performing their roles. 83 (75%) had faced a problem of a woman with vaginal bleeding and 38(46%) managed the problem locally. The most management described was to squeeze the mothers uterus by hand externally. Only 12(14%) reported to refer the women to the health facilities immediately while 33(40%) tried local management first and after observing failure of the management then decided to transfer these women to the health facility. These findings reflect much of the gap between knowledge and practice. This is because, although most of them have good knowledge of risk factors and the need for early identification and referral, but in practice they have been found not to comply with what are expected from them practically.

Most (72%) of the mothers interviewed found to have low knowledge about the danger signs that, may occur to a woman during pregnancy as well as danger signs that would require a mother to deliver in a health facility. The mothers responses supported well the TBAs results because (67%) of these mothers have undergone through some problems during pregnancy and labour. Among them (70%) revealed that the problems were handled locally by a TBA and (66%) reported positive results with these kind of management at home. Only (4%) reported to have been transferred to the hospital after failure of the management. Those who reported

<table>
<thead>
<tr>
<th>Condition</th>
<th>TBAs Encountered</th>
<th>TBAs Local Management</th>
<th>TBAs Refer</th>
<th>Total Problems Encountered</th>
<th>TBAs Local Management</th>
<th>TBAs Refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal bleeding</td>
<td>83</td>
<td>75%</td>
<td>38</td>
<td>465</td>
<td>12</td>
<td>14%</td>
</tr>
<tr>
<td>Malpresentation</td>
<td>51</td>
<td>46%</td>
<td>31</td>
<td>61%</td>
<td>9</td>
<td>18%</td>
</tr>
<tr>
<td>Multiple deliveries</td>
<td>24</td>
<td>22%</td>
<td>20</td>
<td>83%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Convulsions (Eclampsia)</td>
<td>32</td>
<td>29%</td>
<td>4</td>
<td>12%</td>
<td>7</td>
<td>22%</td>
</tr>
<tr>
<td>Prolonged labour</td>
<td>65</td>
<td>59%</td>
<td>24</td>
<td>37%</td>
<td>5</td>
<td>8%</td>
</tr>
<tr>
<td>Tears</td>
<td>39</td>
<td>35%</td>
<td>26</td>
<td>67%</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Cord prolapse</td>
<td>28</td>
<td>25%</td>
<td>18</td>
<td>64%</td>
<td>4</td>
<td>14%</td>
</tr>
</tbody>
</table>
positive results after TBAs management said there was no different between the service given by a TBA at home during delivery and those services given by a midwife at the health facility.

During indepth interviews, the following comments were made by some community leaders;

“TBAs are very close to our families, they know us very well that most of our people in this community cannot afford whatever the suggestion given to these women from those health providers in the health facilities. They are trying their best to smoothen the poverty around by doing all the efforts to deliver mothers at home; as is abit more cheap.”

Again, another comments was;

“TBAs are very useful, cost effective and provides cultural sensitive management to our women. They work with confidence even when there are some problems, they will try their level best to solve it without an additional burden of more costs to refer the woman to these very costful hospitals.”

Different leaders interviewed claimed to have trained TBA experts in their communities who are consulted every time for any delivery problem, and they usually never fail to get the baby out. Even some district leaders (key informants) concurred with the claims; that some TBAs are very expert in their areas in such a way that, there are no referrals from their respective areas. There comments gave us a clue that most of the people in the communities perceive referral as failure or lack of expertise to the attendant. One mother during interview said;

“It's a shame infront of your friends and neighbours if you go to deliver at the hospital that you are a coward; unable to deliver at home"
KNOWLEDGE AND PRACTICES DURING PUERPERIUM PERIOD

The same measurement was used to score the level of knowledge of danger signs that may happen to a woman after delivery. There were no much difference between the responses which were given when asked again about the danger signs during postnatal period, which will require immediate referral. The responses were as summarized in table 8.

Table 8: Distribution of responses for those who had danger signs that require immediate referral

<table>
<thead>
<tr>
<th>Danger signs</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>62</td>
<td>56%</td>
</tr>
<tr>
<td>MODERATE</td>
<td>36</td>
<td>33%</td>
</tr>
<tr>
<td>HIGH</td>
<td>12</td>
<td>11%</td>
</tr>
</tbody>
</table>

These findings show that most (56%) of the trained TBAs had low knowledge about danger signs during pueperium period. The same results were found to the mothers interviewed. 82% of the mothers had low knowledge about the danger during puerperium. These results also supported the responses of the TBAs when asked about their role during antenatal, intranatal and postnatal period.

Generally the TBAs were concerned with childbirth, they did not give antenatal or postnatal care to their clients. They were consulted when labour is thought to have started. This shows us that women’s health services often focus on reproductive health and a woman is referred as a “wife” or “a mother”.

3.7. KNOWLEDGE ABOUT INFECTION CONTROL
Again the same measurement was used to score the level of knowledge about infection control to both TBAs and the mothers who were delivered by TBAs. This was mainly because the topic about infection control was reflected in their curriculum and as HIV infections are present in a considerable number of pregnant women the knowledge of infection control is very vital to TBAs as well as to mothers. Most (82%) TBAs were aware that they are at risk of getting infections due to their roles. Very few (5%) said they don’t know. The rest (13%) disagree to get infections through delivery practice. They also gave reasons that, usually they attend deliveries to the women in their areas and they have never heard of a person drying of AIDS from in their villages. Those who die usually they come from towns and returned back home for burrial. The mothers interviewed had no much difference as (76%) were aware that TBAs may get infections through assisting deliveries. Only (3%) were unaware and (21%) said they can not get infections and the same reason as of TBAs was given. A comment from a community leader during interviews was as follows;

“There is no HIV infection in our village although there are some people there are some people with extra marital relations. It may be because they run around with the people around the village only. This is to assure you that TBAs can not have infections.

This shows that most people do not link TBAs functions with infections like HIV etc. The findings also showed most (63%) of TBAS to have moderate knowledge of infection control when attending deliveries and again most (80%) of mothers interviewed found to have low knowledge of infection control during delivery.

The same findings revealed that all (100%) TBAs agreed that gloves are necessary for infection control during delivery. But on the question of how many times do they put on the same gloves before discarding, it was found that about (23%) said they put them more than once although
the rest (77%) said only once. Some TBAs revealed that they usually wash the used gloves with soap and dry them out on the sun in order to be used again and again until when they show signs of being torn.

83% of the respondents said that they usually deliver mothers with bare-hands if the mother is in labour and gloves are not available.

3.8. CLIENTS SATISFACTION

The level of mothers satisfaction for the care provided by the TBAs and the perception of TBAs on the clients satisfaction with their care they provide was among the variables to be measured.

The responses were as listed below:-

Table 9: Distribution of the Responses on Levels of Satisfaction

<table>
<thead>
<tr>
<th></th>
<th>HIGHLY</th>
<th>FAIRLY</th>
<th>POORLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>TBAs</td>
<td>107</td>
<td>97</td>
<td>3</td>
</tr>
<tr>
<td>Mothers delivered by TBAs</td>
<td>84</td>
<td>84</td>
<td>16</td>
</tr>
</tbody>
</table>

These findings shows that, the level of satisfaction by the care provided by the TBAs were highly ranked by most mothers who were delivered by TBAs. The same level of satisfaction was also perceived by the TBAs on their care provided to the mothers during delivery.

The following were the most factors mentioned by both mothers and TBAs for the mothers to deliver at home.

Table 10: Factors that make mothers deliver at home
The frequent mentioned factors were; costs for traveling and hospital costs mentioned by all (100%) mothers as well as (84%) of TBAs. Sudden labour by (79%) of TBAs as compared to (69%) of the mothers. Attitudes of Midwives by (95%) of TBAs as compared to (71%) of mothers. Good care at home by (89%) of TBAs as compared to (87%) of mothers. accessibility and Affordability of TBAs mentioned by (96%) of mothers as compared to (69%) of TBAs. Long distance to health facility by (98%) of mothers as compared to (95%) of TBAs.

In assessing the quality of health services, it is important to take into consideration the fact that quality is related not only to the physical structures and clinical services provided, but also to the relationships between health care providers and users as well as the perceptions that users have of the services.

**3.9. WORKING RELATIONS BETWEEN TBAs AND HEALTH FACILITIES**
The good interpersonal relationship between health workers and the communities they serve as well as with CORPS in their locality is of foremost important in reducing obstetrical, complications in the communities. (73%) of health providers mostly MCHA who were
interviewed knew the number of trained TBAs available in their area. Only few (8%) complained of having no good relationship with the TBAs in their areas. The reason mainly given was that TBAs were telling the mothers not to deliver in the health facility; They should consult them first because they are trained like those in the health facilities, so there is no need to go to be delivered by a younger person with very few years of experience. This was also supported by complains made by one mother who was delivered by a TBA and she had the following to tell;

“A TBA who assisted my delivery wanted me to pay 2,500/= and unfortunately I couldn’t pay that amount of money. It was until when I started to take my child to the MCH Clinic when she came and took the child’s card with argument that I should go for that card when I pay the money. It was hard for me because for about two months I couldn’t take my child to the clinic until when I got the money and went for the card”.

This shows indirectly that there is hindrance of access to health care from the TBAs to both mothers and children in the community.

(96%) of all facilities visited had a good record of deliveries conducted by TBAs in their communities. Most (72%) of TBAs interviewed reported to have good relations with the neighbour health facility. Many of them argued that they were very free in the health facilities to the extent that whenever they escort a woman for referral, they were allowed to assist that delivery at the health facility in absence of the health provider.

This concurred also with an answer given by most MCHAs (Key informant) when asked what do they think are the roles of TBAs; and almost all said is to deliver mothers in the community. But
when they were asked, how many time they have visited TBAs or conducted deliveries at home; very few about 4% reported to have this kind of relationship.

3.10. REFERRALS

Among the main objectives for the TBAs training programme is to improve the number of referrals of the risk pregnancies and complicated labour. The TBAs were asked if they had referred mothers to deliver in hospital and only 42%) agree to have done so. On the other side; 67% of TBAs interviewed claimed to deliver at risk mothers because they were called when mothers were in second stage of labour. Only (12%) of TBAs, claimed not to assist deliveries if they learn that the mother was advised to deliver at the health facility.

In the interview with community leaders (Key informant) some were commenting as follows;

“*These ladies (TBAs) feel prestigious whenever they deliver babies at home and they are mostly proud when assisting a difficult labour; Is where they show their expertise*”.

Another one said also that;

“*Sometimes they show enmity and even don’t speak to any woman who goes to deliver at the health facility before passing in their homes for consultation of where*
This also shows some kind of hindrance of mother’s access to the health facility. However, some women claimed to deliver at home in order to avoid the common tradition of referring mothers in labour on a bicycle inside the special big basket normally called “Tenga” they strongly argue that is a shame on their part. This was raised because one big barrier in referring mothers to the hospital is transport as most people leave very far from a health facility. In case of emergency most people use bicycles or go by foot. The minimum walk for most villagers were 20 to 40 kms.

During home visiting we found 2 TBAs who had admissions of mostly under age girls and one claimed that is due to their expertise in delivery thus why most of the families bring at risk cases to her. They even claimed that they have asked even village leaders to give them a house as an office or delivery facility in the community to officiate their expertise. They also asked for uniforms.

All delivery books reviewed didn’t show any referral cases, although the content in the curriculum show much emphasis on referrals.

3.11. REPORTING

Reporting also is among the major topics emphasized during training in order to improve documentation of deliveries and to improve the information given to health facilities.

Most (83%) informed that they know they are supposed to submit their reports monthly at the health facility. However some (42%) reported not to submit it every month because they have
to walk from home, very far to the health facility and yet, they are not paid for any costs incurred for transport and time waste.

There were no reports for maternal and neonatal deaths in the delivery books and even in the village council office, neither in the health facilities. For the TBAs who were asked what they usually do incase of maternal mortality, they were seem not interested in that topic and most of them claimed that it had never happened to them. After going deeper with the discussion, some commented that if it does occur is “a will of God” and nothing happens except they bury the body. Again said “Normally people do not relate much of the causes of death to the delivery process”.

There is also no report of the problems that might occur during delivery at the delivery books and even at the health facility.

3.12. RECORDING

Almost all (92%) of TBAs interviewed had records in the exercise book. Although others were very old and not very easy to read but the reports were recorded well although most of them were recorded by another person, being either grand child or a child or sometimes neighbour. The most records kept in the exercise book are:

- Name of the mother
- Name of the husband
- Date of delivery
- Sex of the baby
- Condition of the baby at birth whether alive or dead.
There was no section for reporting any abnormality or any problem which might have been occurred. Few (4%) reported that the exercise books got lost and they do not have money to buy another one. They were just recording in some pieces of paper which were very easy to get lost.

During interview, one commented

“I don’t know how to write but after delivery if I get some one ready to assist me to write, I usually give him/her the information and they write for me.”

reliability hear is very questionable because if she got someone unreliable then can write anything for her without her awareness.

3.13. SUPERVISION

Almost all (96%) of TBAs interviewed informed to have no supervision or anybody to monitor their services from health facilities. There was no system planned from all levels for supervising TBAs. Even the monthly DHMT supervision from the district level does not take into consideration supervising TBAs; although is well known that TBAs contribution in deliveries are much.

3.14. BASIS EQUIPMENT AND SUPPLIES

(53%) of all TBAs had no delivery kit. Those who were trained especially by missionaries and UNICEF; they were given a delivery kit with very few equipment e.g. one forceps, cord ligature, pair of unsterile gloves, a pair of scissor. However, the finding revealed that most of them did not know how to use the forceps. Most of the equipment was not functioning, as they were broken. Unsterile gloves were used to protect TBA from becoming dirty and not for infection control.
3.15. When TBAs service were linked with HSR, Poverty Alleviation, Gender HIV/AIDS, Local Government the following were noted;

**Health Sector reform**

As far as health sector reform is concerned TBAs are recognized as CORPS and in the essential health package of service they have a role to play in promoting SMI. Furthermore the Ministry of Health has developed guidelines for implementation of TBA program. Adherence to the roles and responsibilities stipulated will lead to a better function program.

**Poverty Alleviation**

Most TBAs interviewed were individual farmers and performing deliveries was also felt main responsibility. None of them were able to form economic groups due to lack of guidance and assistance from village authorities. The community based health care guidelines understands the need for the CORPS to maintain a decent livelihood within their localities by encouraging them to have time to participate in community initiatives e.g. farming, etc. Its also encourages TBAs to form economic groups whereby measures to alleviate poverty can be provided e.g. using credit schemes etc.

**Gender**

As far as TBAs and delivery is concerned, the issue of gender disparity is of great concern. For example, in most areas of Lindi, the community cannot allow a woman to be delivered by a man, therefore since the health facility has no MCHA or Midwife and facility incharge was a male then they would rather go to a TBA even if they are close to the facility.

**HIV/AIDS**

Minimizing the risk of infection to the provider is very crucial. With reference to HIV/AIDS the TBAs have seen the need for gloves during the time of delivery. In some areas in Lindi, the
TBAs buy gloves to use for delivery but at the same time it is used as a mechanism to be paid, for a service. However, it is important to note that the TBA kits supplied originally had no gloves. The revised TBA training guides (1998) has incorporated the use of gloves as a pre-requisite in practice of TBAs.

**Local Government**

The local government particularly the village council recognizes the contribution made by TBAs as far as health is concerned. However, the TBAs, feel, due to the changing local government administration, they are not given their due respect as expected. Particularly on the issue of incentives, the TBAs wished the village executives could be more aggressive in enforcing the community to pay their due and also clarifying the role of the TBA in the community and counteracting the misconception that the TBAs are not employees of the government.
CHAPTER FOUR

4.0. EVALUATION OF THE EXISTING MATERNITY WAITING HOMES IN LINDI REGION

In order to achieve the above mentioned tasks, the following questions were posed by the researcher;

- How many maternity waiting homes in Lindi region?
- What are the conditions of these maternity waiting homes as according to MOH (1998) Guidelines?
- How is the infrastructure in general?
- How much are they needed by the people of Lindi region?
- What are the recommendations of different people concerning maternity waiting homes?

4.1. MATERNITY WAITING HOMES IN LINDI REGION

All five surveyed districts had no maternity waiting home, although most women live very far from health facilities.

Normally people in Lindi region are migrants because of looking for better farms. As they migrate, they go more further from health facilities. Others live more than 30-40kms from health facility.

Even the distance from one facility to another is very long e.g. in Liwale district, the distance from Barikiwa dispensary to Liwale hospital is 38kms passing through forests with wild animals from the nearby Selous game reserve. Most areas do not have public transport and usually private transport is very expensive to afford. Roads are impassable and during rainy seasons;
most of the areas are land locked with floods. Therefore, most people do not access health facilities because of poor communication and transport.

During survey, we were informed that, we may find maternity waiting home at St. Walburg’s hospital Nyangao. But when we surveyed the area, the hospital administrator reported that they don’t have a maternity waiting home. She said,

“What we have cannot be called maternity waiting home because it does not meet the standards. We only offer a resting place for those women who have been either discharge from the Antenatal ward or those who come with false labour. Normally after 38 weeks of pregnancy as we cannot admit them in the wards to avoid overcrowding. It is like a waiting camp.”

4.2. OBSERVATIONS MADE WHEN SURVEYED THE PLACE.

- The place was very near to the hospital, just a walking distance of about 500 meters.
- Was an old house with three rooms – each room can accommodate up to 20 women. But during our survey they were 22 in total, mostly coming from far about 40 to 60kms.
- There were no beds, only mats were spread down and very few having some pillows.
- There was no electricity for lightening.
- There were toilets and water facilities near the house.
- They use firewood for cooking their own food and everyone should have come with enough food to eat for the stay.
- They allow relatives to stay with them for assistance e.g. cooking, give escort to the labour ward incase there is a woman who might have been in true labour.
• There were no health providers allocated to give services in this place but every morning these women attend MCH clinic, where they can report of any problem. But anytime if there is any problem, they are allowed to freely go for consultation.

4.3. FOCUS GROUP DISCUSSION

Two focus group discussions (FGDs) were held. The participants were randomly selected after being asked for their willingness to participate in the discussion.

The first group was composed of 10 pregnant women and the researcher wanted to have their views on the quality of care given and their satisfaction. The second group composed of 10 women caretakers. The researcher wanted to compare their views on the care given.

The discussions were conducted outside under a big tree using guided interview and they were free to debate to reach the consensus on their general views.

The group discussion seemed to be very frank and cordial as respondents spoke out their minds freely. Whenever, someone gave false or inaccurate information, others gave their disapproval and volunteered more correct details and this debates went on until they reached consensus. The informants were asked for permission to record every interview and to take notes. Thereafter the tapes were transcribed to be reported.

4.4. CLIENTS SATISFACTION

Mothers and caretakers were very satisfied with staying near the hospital. They expressed that they feel they are in safe hands as anything which may happen would be taken care easily in the hospital rather than staying at home.
Although they complained of backache because of sleeping on mats on the floor but they felt that is only temporary. They also expressed the issue of good interpersonal relationship with care providers in the health centre, which they felt as most important before time of birth.

4.5. SUGGESTIONS

All key informants from districts to the community levels suggested that there is a need for having maternity waiting homes near the hospitals, at least one in each district. Most of them said that they would be more sustainable if caretakers will be allowed to assist the mothers and also come with own foods. They said most mothers do not access health facilities because of poor communication and transport systems in Lindi, that, some areas are off the major roads with poor or almost non-existence roads. Some of the districts in Lindi region e.g. Liwale had already put the idea of building maternity waiting home in their strategic plans of activities for development.

All the district officials interviewed said there is a very big need for having maternity waiting homes, if we aspire to reduce maternal mortality rates in future. The community leaders as well supported strongly the idea. But they suggested the maternity waiting homes to be located within communities in order to avoid costs for transport and foods for these women. They said that health workers should now move from hospitals to the communities to strengthen their relationships within the communities and this will allow provision of cultural sensitive care.
5.0. CONCLUSION

It is evident from the findings of this study that TBAs remain to play a unique role as a primary care given to women for child birth in rural communities. This was also argued by maternal health specialists in various studies worldwide that, until health professionals become more widely available, TBAs will continue to perform a significant percentage of deliveries and that safe motherhood interventions must include a component to train and integrate TBAs into the health system (Safe motherhood, 1998).

It was observed in Lindi that TBAs conduct (78%) of all home deliveries and the rest were assisted by relatives or mothers deliver alone. Only (2%) were reported to be assisted by health workers. Mostly were old people age ranging from 40-60 years and many of them not able to read and write because they had no formal education.

It was also noted that about one third (31%) of women who deliver at home are under 18 years of age and most of them also had no formal education.

The findings also revealed that this high risk group of underage do not know the risks of home delivery as during antenatal visits nothing was talked about the risks of home deliveries.

Some MCHAs encourage mothers to deliver at home by telling them first to consult TBA before going to the health facility because they would like to reduce workload.

It was observed from the study that the major role of TBAs was mainly to conduct home deliveries in all the surveyed five districts of Lindi. Other roles found were also counselors for immunization to the community, health promoters as they sensitize the communities on matters
affecting health because of their high value and respect from the people in the communities. They were also acting as Education for different groups in the communities including “Youth” on reproductive health issues where they are called “Nyakanga” or “Walombe”. Some few were found to be traditional healers and advisers of the people in the communities and were also coordinators for different activities in the communities.

Most of their roles during pregnancy and postnatal care, being with low or high risk factors were insignificant as they were found not giving care during these periods. For any care during pregnancy and postnatal period they were found only advisors for women to attend at the health facilities.

The TBAs major focus was on attending deliveries being normal deliveries as well as abnormal one. They were found to feel prestigious when succeeded to deliver abnormal deliveries and most people in the communities perceive those who conduct abnormal labour as “experts” in the communities they were also found to delay some referrals because they usually try local management first then observe for success or failure before referrals to the health facilities.

The study also observed gap between knowledge and practice for TBAs as they were found to have a good knowledge on danger signs that needs referral during births but in contrary they were found most of them to attend even the most difficult deliveries. Again, also they were found to manage danger signs during delivery locally. It was also noted that they even prohibit those who were referred from first levels of health facility from compliance in order for them to show their expertise in the communities by assisting their deliveries. It was also observed that referrals were perceived as a sign of lack of “expertise” of “failure” on the side of attendant during delivery. Also mothers revealed this is sign of being “a coward” as a mother.
After delivery TBAs encouraged most mothers to rest and not to go for medical check-ups.

Practices on infection control were found to be low as shown by some TBAs who were conducting deliveries with bare-hands which gloves were not available. Others informed that they were performing up to three “per vaginal examinations” before delivery. There were some who said because of lack of enough gloves; they were putting on gloves for several deliveries by just washing them with soap and dry them for use to other deliveries until when they show signs of warning out. HIV infection was related to the outsiders – people who are coming from towns and not the people within the communities, although TBAs knowledge on risks of infection when performing their roles was found to be high.

Clients satisfaction on TBAS care provided was highly ranked and mothers revealed to perceive no difference between the care provided by TBAs and that care provided by health providers in the health facilities.

Among the major factors that contribute for the mothers to deliver at home as perceived by both TBAs and mothers were, costs, sudden labour, bad attitude of midwives at the health facilities, good care at home, accessibility and affordability of TBAs and long distance to the health facilities.

Some facilities were found to have good relationships with TBAs while others showed to have bad relations on personal clashes.

The reporting system was found to be inadequate because of costs and lack of proper supervision from all levels. There were no reports for maternal deaths. Proper records from TBAs were observed. It was also found that, TBAs after training were left without any proper
planned supervision from all levels. Most TBAs were also observed to have no delivery kits and not getting enough supplies of gloves from the health facilities.

It was also found from the study that there are no maternity waiting homes in all districts of Lindi region. It was found that St. Walburg’s hospital Nyangao had felt a need to assist those women who are coming from very far at least some place for rest but they disagreed to call it maternity waiting home because it doesn’t meet the standards needed for maternity waiting homes. However most of key informants from districts to community levels felt a need for having at least one maternity waiting home in each district, to access more mothers to the health facilities.

5.1. RECOMMENDATIONS

On the basis of the research findings, analysis and discussions made, two types of recommendations are put forward, namely: recommendation for action and recommendation for further research.

GENEAL RECOMMENDATIONS FOR POLICY MAKER AND CURRICULUM DEVELOPERS

a. It is evident in this study that TBAs conduct most of all home deliveries being normal an abnormal deliveries. It is therefore recommended that the TBAs training guidelines should strongly emphasize on the expected roles in reality including pregnancy postnatal care and the limitations of TBAs. The health facilities also should appear more clients-friendly.

b. It is also evident in this study that risks for home deliveries are not addressed during antenatal visits and some health providers encourage mothers to consult TBAs before going to health facilities as means of reducing their workload. Hence it is recommended that enough manpower according to the standards set by MOH should be assured at the first level facilities for quality assurance from the primary levels.
Furthermore, it is evident from the findings that TBAs contributions in the communities are more than just attending deliveries. They are counselors, educators and many more. They could be used as catalysts for development in the communities given the potentials. It is therefore recommended that specific incentives for them be spelled out and also their training guideline should focus their multiple roles and frequent training be conducted with proper supervision using proper local methods applicable to their daily performance in the real communities. This might assist knowledge-practice gap. Training should be on-job training in their communities and not in the hospitals to avoid contaminating their practices with the hospital practices.

It is also evident from the findings that TBAs lack equipments and knowledge of using them when performing their roles. It is then, recommended that a proper system be developed from the community itself and other resources available to assure proper and enough supply of equipments for TBAs proper functioning. Prior trainings of proper use and maintenance of the equipment should be considered.

It is also evident from the findings of this study that communication, transport, distance and attitude of health providers are among the major factors that prohibit women access to the health facilities. It is recommended that policy makers within the communities to mobilize enough resources to improve communication and transport system incase of emergency. Service providers should be trained for behaviour modification, communication, cultural sensitive and quality of care to improve, services for more client-friendly. Maternity waiting homes should be among the priorities in the district strategic plans.

It is also evident from the findings that the working relations between TBAs and health facilities are poor because of improper interpersonal relations and supportive supervision. It is
recommended that proper supportive supervision plan be put in the strategic plans from regional, district and other level to assure quality control in all levels.

**RECOMMENDATIONS FOR FURTHER RESEARCH**

From the above discussions, it is evident that there are gray areas for researchers to investigate, for instance,

- Since the present study was conducted in Lindi region, a similar study could be carried out in other regions for comparison.


TERMS OF REFERENCE (TOR) FOR SITUATIONAL ANALYSIS OF THE ROLE OF TRADITIONAL BIRTH ATTENDANTS AND FUNCTIONALITY OF MATERNITY WAITING HOMES IN LINDI REGION

Rationale
The main objective of this assignment is to assess the role and practice of active TBAs in selected communities as well as to evaluate the conditions of existing maternity waiting homes in Lind Region as stipulated in the Lindi project plans of Operations developed March 1999.

The assignment will be carried out in Lindi Region between Mid June end of July 2001

Specific Tasks
♦ Conduct baseline survey in the selected communities to assess the role of active TBAs and the conditions of existing functional maternity homes.
♦ Examine the functions of TBAs and maternity waiting homes including strength, weakness/challenges for effectiveness and sustainability.
♦ Assess the working relations with the nearby health facilities of the referral system.
♦ Review TBAs service in the community and linkage with the health sector reform, local government, poverty reduction and HIV/AIDS.
♦ Examine infrastructure, quality of services, basic equipment and supplies in the maternity waiting homes.
♦ Determine user satisfaction for both TBAs services and maternity waiting homes based on perceived quality of care.
♦ Examine the current reporting, recording and monitoring system for both TBAs and maternity waiting homes.
♦ Make recommendations for future support that is sustainable and efficient.

OUTPUT:
Consultant is expected to give preliminary report to the regional and district authorities and submit a written report (3 binded copies and electronic copy)
## Appendix 2

### TIME TABLE FOR THE CONSULTANT SITUATIONAL ANALYSIS OF THE ROLE OF THE TBAs AND MATERNITY WAITING HOMES IN LINDI REGION

<table>
<thead>
<tr>
<th>DATE</th>
<th>PLACE/DISTRICT</th>
<th>VILLAGE VISITED</th>
<th>RESPONSIBLE OFFICER</th>
</tr>
</thead>
<tbody>
<tr>
<td>17th – 18th June 2001</td>
<td>Arrival Lindi</td>
<td>Meet with regional and district authorities</td>
<td>Consultant RMO, DMO and RRCH Coordinator</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19th – 22th June</td>
<td>Lindi rural</td>
<td>Nyangao</td>
<td>Consultant RRCH Coordinator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kilimahewa</td>
<td>Asst. RRCH Coordinator</td>
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<tr>
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<td>Consultant RRCH Coordinator</td>
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<tr>
<td>• Obtain Socio-demographic characteristics of TBAs and mothers delivered by TBAs</td>
<td>• Marital status</td>
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<tr>
<td></td>
<td>• Age</td>
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<td>• Education</td>
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<td>• No. of deliveries</td>
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<td>• Client accepted</td>
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<td>• Place of delivery</td>
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<td>• Initial learning to deliver</td>
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<td>• Identifying functions of TBAs</td>
<td>• Daily activities</td>
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<td>• Roles–Normal/Abnormal pregnancy</td>
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<td>• Roles – Normal/Abnormal Labour</td>
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<td>• Roles – Normal/Abnormal pueperium</td>
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<td>• Examine quality of care provided -strength -weakness -challenges</td>
<td>• Identification of risk case</td>
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<td>• Assess the working relations with nearby health facilities</td>
<td>• Advice for referral and compliance</td>
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<td>• Management during pregnancy, labour and pueperium – Normal and Abnormal</td>
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<td>• Infection control</td>
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<td>• Clients satisfaction</td>
<td>X</td>
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<td>• Interpersonal relations</td>
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<td>• Supervision</td>
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<td>• Infrastructure</td>
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<td>• Equipment</td>
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QUESTIONNAIRE FOR TRADITIONAL BIRTH ATTENDANTS (TBAS)

1. Name of District ____________________________________________
2. Name of Ward ______________________________________________
3. Name of Village _____________________________________________
4. Date of Interview ___________________________________________

Instructions:

We are Midwives working on a project concerned with Maternal and Child Health Services. We would like to ask you few questions if you have time to spare because you are among the service providers in this area and your answers to this questions are crucial in improving the quality care of TBAs in future. Your participation in this study is entirely voluntary and you can withdraw from the interview at any time you feel like. Your responses to these questions are confidential and they will not be shown to anyone else except the investigators. Thank you for taking time off to answer our questions.

SECTION A: SOCIAL AND DEMOGRAPHIC DATA

5. Sex ____________________________
6. Religion
   (i) Muslim [ ]
   (ii) Christian [ ]
   (iii) Others (specify) ______________________________
8. Age ____________________________________________
9. Educational level
   (i) No education [ ]
(ii) Madrassa [ ]
(iii) Primary education [ ]
(iv) Secondary education [ ]
(v) Post-secondary education [ ]
(vi) Others (specify) _________________________________

10 Can you read and write
(i) Yes [ ]
(ii) No [ ]
(iii) With difficult [ ]

11. Have you participated in any midwifery training?
(i) Yes [ ]
(ii) No [ ]

12. How many deliveries have you conducted last year (2000) _________
1. Less than 10 [ ]
2. 10 – 15 [ ]
3. More than 15 [ ]

13. What type of women do you assist during delivery?
1. Every woman who need assistance [ ]
2. Only relatives and friends [ ]
3. Any one who can pay [ ]
4. Other (specify) -----------------------------------------------

14. Where do you usually conduct deliveries?
1. In your home [ ]
2. Mother’s home [ ]
3. Both [ ]
4. Other (specify) -----------------------------------------------
15. Where did you initially learn to attend deliveries?
   1. A health worker
   2. An older relative TBA or a friend
   3. On my own
   4. Other (specify) _________________________________

16. Is there any payment that you get for attending deliveries?
   1. No payment
   2. Cash (specify amount) ____________________________
   3. In kind (specify) _________________________________

17. What did you learn?

________________________________________________________________________

   _____

18. How do you perceive the quality of the training given to you?
   (i) Excellent
   (ii) Good
   (iii) Satisfactory (need improvement)
   (iv) Poor (need to teach different things)

19. What tools were provided after training?
   (i) ___________________________________________________
   (ii) ___________________________________________________
   (iii) ___________________________________________________
   (iv) ___________________________________________________

SECTION B: THE ROLES OF TBAS

20. What specifically do you do? _________________________________

21. Do you perform any other work? _________________________________
SECTION C: KNOWLEDGE AND SKILLS OF TBA ON PREGNANCY, BIRTH AND AFTER BIRTH

22. How many deliveries have you conducted last year?

1. None [ ]
2. 1 – 5 [ ]
3. 6 – 10 [ ]
4. More than 10 [ ]
5. Don’t know [ ]

23. What type of women do you assist in delivery?

1. Any women who need assistance. [ ]
2. Women from this village. [ ]
3. Relatives and friends only. [ ]
4. Any women who is able to pay. [ ]
5. Others (specify) _________________________________

24. Where do you conduct deliveries?

1. In your home [ ]
2. Mother’s home [ ]
3. Other places (Specify) _________________________________

25. How did you learn to conduct deliveries?

1. By a health provider [ ]
2. Mothers/Grand mothers [ ]
3. Relative [ ]
4. Another TBA [ ]
5. On my own [ ]
6. Others (Specify) ___________________________________________
26. Is there any payment that you get for conducting deliveries?
   1. No payment [ ]
   2. Cash (specify amount) ________________________________
   3. In kind (specify) ________________________________

27. Explain the danger signs that may occur to a woman during pregnancy?

__________________________________________________________________

28. What are the danger signs that would require you to advise the mother to deliver in a health facility?

__________________________________________________________________

29. Have you ever attended a woman who got problems during pregnancy?
   1. Yes [ ]
   2. No [ ]

30. If yes, what was the problem? ________________________________

__________________________________________________________________

32. What did you do? ________________________________

33. What are the danger signs after delivery that would require you to advise the mother to deliver in a health facility?

__________________________________________________________________

33. Have you ever attended a woman who got problems after delivery?
   1. Yes [ ]
   2. No [ ]

34. If yes, what was the problem?

__________________________________________________________________
35. What did you do? ______________________________________________

36. What do you usually do before starting the procedure of conducting delivery?
   1. Wash hands [ ]
   2. Wash hands then put on gloves [ ]
   3. Put on gloves without washing hands [ ]
   4. Boil equipments [ ]
   5. Nothing [ ]
   6. Others (specify) ______________________________

37. What do you see to cut the baby’s cord? ____________________________

38. How are the instruments used for delivery and cutting the cord prepared before using them? ________________________________

39. How are the instruments for delivery and cutting the cord prepared after using them? ________________________________

40. Do You think you are at risk of infections like HIV when attending deliveries?
   1. Yes [ ]
   2. No [ ]
   3. Don’t know [ ]

41. If yes, explain some measure which you can use to control infections when attending deliveries. ________________________________

42. Do you think that gloves are necessary for infection control during delivery?
   1. Yes [ ]
   2. No [ ]
   3. Don’t know [ ]

43. If yes, how many times do you put on the same gloves before discarding them?
44. What do you do if you don’t have gloves and a mother is in labour?

45. How do you rank your clients satisfaction with the care you provide to them?
   1. Highly satisfied [   ]
   2. Fairly satisfied [   ]
   3. Poorly satisfied [   ]

46. What are the factors which make women deliver at home?

47. What are your relationship with the nearby health facility?

48. What makes you to assist deliveries which need referral?

49. How do you submit your reports in the health facility?

50. How do you make records of the work done?

51. Who writes the records for you?
   1. Yourself [   ]
   2. Someone else [   ]

52. Have you ever been supervised by a health worker?
   1. Yes [   ]
   2. No [   ]
   3. I don’t recall [   ]

53. If yes, give more details.
1. From where ______________________________________________________

2. How often? ______________________________________________________

54. How do you feel being a TBA in this community? ____________________________

55. How best would you like to be assisted to strengthen your performance?
___________________________________________________________________
QUESTIONNAIRE FOR MOTHERS WHO DELIVERED AT HOME

1. Name of District _________________________________

2. Name of Ward ________________________________

3. Name of Village ________________________________

4. Date of Interview ______________________________

Instructions:
We are Midwives working on a project concerned with Maternal and Child Health Services. We would like to ask you few questions if you have time to spare because you are among the mothers who have delivered at home and most probably by a TBA. Your answers to this questions are crucial in improving the quality care of TBAs in future. Your participation in this study is entirely voluntary and you can withdraw from the interview at any time you feel like. Your responses to these questions are confidential and they will not be shown to anyone else except the investigators. Thank you for taking time off to answer our questions.

SECTION A: SOCIAL AND DEMOGRAPHIC DATA

5. Religion
   (i) Muslim [ ]
   (ii) Christian [ ]
   (iii) Others (specify) ________________________________

6. Age ________________________________

7. Educational level
   (i) No education [ ]
(ii) Primary education [ ]
(iii) Secondary education [ ]
(iv) Others (specify) ______________________________

8. Did you attend antenatal clinic during pregnancy?
   1. Yes [ ]
   2. No [ ]

9. Who gave you advice to go for ANC?
   1. A health worker [ ]
   2. Yourself [ ]
   3. TBA [ ]
   4. Other (specify) ______________________________

10. How many pregnancies have you ever had?
    1. 1-5 [ ]
    2. 6-10 [ ]
    3. >10 [ ]

11. How many children (live/dead) have you delivered?
    1. 1-5 [ ]
    2. 6-10 [ ]
    3. >10 [ ]

12. Who assisted you during delivery?
    1. TBA [ ]
    2. Health worker [ ]
    3. Alone [ ]
    4. Others ______________________________

13. Where do you usually conduct deliveries?
    1. In your home [ ]
2. Mother’s home
3. Both
4. Others (specify) ________________________

14. What was the outcome of the last delivery?
   1. Still birth
   2. Live birth
   3. Neonatal death
   4. Twins
   5. Others ___________________________________

15. Where were your deliveries conducted?
   1. A health worker
   2. An older relative TBA or a friend [ ]
   3. On my own [ ]
   4. Other (specify) ________________________________

SECTION B: THE ROLES OF TBAS


17. Do they perform any other work? ________________________________
18 What type of women do they assist in deliver?
   1. Any women who need assistance [ ]
   2. Women from this village. [ ]
   3. Relatives and friends only. [ ]
   4. Any women who is able to pay. [ ]
   5. Others (specify). __________________________ [ ]

19. Where do they conduct deliveries?
   1. In her home [ ]
   2. Mother’s home. [ ]
   3. Other places (Specify). _____________________ [ ]

20. Explain the danger signs that may occur to a woman during pregnancy?
____________________________________________________________

21. What are the danger signs that would require a mother to deliver in a health facility?
_______________________________________________________________

22. Have you ever had problems during pregnancy?
   1. Yes. [ ]
   2. No. [ ]
23. If yes, what was the problem?__________________________________________________________

24. What did they do?__________________________________________

25. What are the danger signs after delivery that would require a mother to go in a health facility?
_______________________________________________________________

26. Have you ever had problems after deliver?
   1. Yes [ ]
   2. No [ ]
27. If yes, what was the problem?
______________________________________________________________

28. What did they do?
______________________________________________________________

29. Do you think TBAS are at risk of infections like HIV when attending deliveries?
   1. Yes [ ]
   2. No [ ]
   3. Don’t know [ ]
30. If yes, explain some measures which TBAS can use to control infections when attending deliveries.

31. How do you rank your satisfaction to the care provided to you by a TBA?
   1. Highly satisfied [   ]
   2. Fairly satisfied   [   ]
   3. Poorly satisfied  [   ]

32. What factors made you or which you think make some women to deliver at home?

33. How best would you suggest TBAS to be assisted to strengthen their performance.
## APPENDIX 6

### CHECKLIST TO ASSESS TBA DELIVERY KIT BOOK AND ENVIRONMENT

**District:** ……………………………………..  **Ward:** …………………

**Village:** ……………………………………..  **Age:** ………………….

**Date:** ……………………………………….

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<th>S/No</th>
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<th>NO</th>
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<tr>
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<td>Delivery kit</td>
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<td>2.</td>
<td>Clean kit</td>
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<td>3.</td>
<td>With Soap</td>
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<td>4.</td>
<td>With Gloves</td>
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<td>5.</td>
<td>With Gauze swabs</td>
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<td>6.</td>
<td>With Cotton Balls</td>
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<td>7.</td>
<td>With Cord ties</td>
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<td>8.</td>
<td>With Scissor or new blade</td>
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<td>9.</td>
<td>With towel or clean cloth</td>
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<td>10.</td>
<td>With cord clamps</td>
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<td>11.</td>
<td>A lamp or torch</td>
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<td>12.</td>
<td>A bicycle</td>
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<td>13.</td>
<td>Delivery book</td>
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<td>14.</td>
<td>Delivery book filled by herself</td>
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<td>15.</td>
<td>Delivery book filled by a helper</td>
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<td>16.</td>
<td>Delivery book complete filled</td>
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<td>With name of the mother</td>
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<td>18.</td>
<td>With name of the father</td>
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<td>With date of birth</td>
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<td>20.</td>
<td>With condition of mother at birth</td>
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<td>21.</td>
<td>With condition of the child at birth</td>
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<td>22.</td>
<td>With sex of the child</td>
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<td>23.</td>
<td>Other observations</td>
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Appended 7

INTERVIEW GUIDE.

DED

1. **Basing on the fact that your district is predominantly rural, in which case TBA’s and Maternity waiting homes are an important resource as far as health promotion is concerned. How can the district assist in retaining their capacity within their localities.**

2. **What are the roles of TBA/maternity waiting homes existing in your area?**

3. **According to International Standards (WHO) the Traditional Birth Attendant is regarded as an unskilled personnel as far as maternal care is concerned. What are the future plans of the district in trying to rectify this.**

4. **One of the major intervention in reducing ill health, is the improvement of referral systems in terms of roads and transport. What mechanisms/plans are in place to improve the current situation.**

5. **Your comments regarding TBA’s/maternity waiting homes and how they can be assisted in your district**
Appendix 8

Indepth interview guide

DPLO

1. Administratively,
   How many divisions
   Wards
   Villages in your district
   Homlet (sub-village -Kitongoji).

2. With regards to the local government who are the employees of LG.

3. How many types of data collection systems are in use in the district.

4. How does the district make use of the data collected in its planning process.

7. Apart from GTZ what other NGO’s (International/Local) are providing support to the
   district as far as community based health care is concerned and which geographical
   areas are they supporting?

8. How far is your office co-ordinating their activities? Progress reports?, technical
   meetings? and Supervisory visits?

9. What strategies has the district put in place to ensure sustained effective performance
   by TBA’s/Maternity waiting home. How is the district involved in ensuring support by
   village council to the community based health workers.

10. As a Co-ordinator of the Health programmes in the district as far as Safe Motherhood
    Initiative is concerned what is the future role of TBA’s and Maternity waiting homes.

11. Give your views about the existing TBA’s/Maternity waiting home and on how they can
    best be improved.
Appendix 9

Interview Guide

DMO

1. With regards to district health plans what are the overall goals for improving maternal and child health in the district (Refer SMI strategies). What are the obstacles?

2. How many health facilities are there in the district? (Private/NGO/Government). How many are capable of handling obstetric complications? E.g. blood transfusion /theatre facilities/transport for referral to the next facility and how far is one facility to the next facility?

3. What is the current status of staff deployment in the district? (Adequate/Inadequate) How many midwives/ doctors?

4. What are the common causes of admissions in the district health facilities in the last one year? (for 2000)

5. What are the common causes of admissions in the district hospital in the last one year? (2000)

6. How many women were referred to the district hospital due to maternal complications in the last 6 months? (Jan - June 2001)

7. What are the roles of TBAs and maternity waiting homes in the district?

8. What is the contribution of the TBA’s and maternity waiting homes in the overall district health plans.

9. In your opinion, as far as health is concerned are the current TBA’s and maternity homes adequate or is there a need to increase their number.

10. Are TBAs functioning efficiently as planned?, please give your views on how to improve their quality.

11. Is Maternity Waiting Home functioning efficiently as planned? Give your views on how it can be best improved.

12. Give your views about the role of the existing TBA’s/Maternity waiting homes and how best they can be improved.

13. Are TBAs/maternity waiting home of any help in Maternity care (SMI)? Give comments!
Interview Guide

DNO/DRCH Coordinator

1. What are the major causes of maternal and child health morbidity in the district in health facility level.

2. How many women have died due to maternal causes in the district in the past 5 years - MTUHA only existed 3 years.

3. How many women are attending ante-natal care services in the district during their delivery.

4. How many women were attended by skilled attendants (excluding TBA) in the district.

5. In the past 6 months how many women have been referred to the district hospital due to maternal complications.

6. What is the level (%) of reporting of data from the lower level to the district level.

7. In the past 1 year what is the ratio of women delivered by TBA versus those delivered in health facilities.

8. With regards to MTUHA data collection at district level is there a feedback mechanism to the lower levels, can it be improved?

9. Give your opinion about the existing roles of TBA’s/Maternity waiting homes and how best they can be improved.
Appendix 11

DVHW COORDINATOR.

1. How many TBA’s are currently existing in the district?

2. What is the target of the district (no. of TBA’s needed)

3. How many TBA’s have been trained so far (list of villages/wards/trained (what tool are provided after training, and how are they being selected?

4. Who conducted the training?

5. Which training guidelines was used?

6. What are TBA/maternity waiting homes roles in the community?

7. Are there dropouts from TBA?, What could be the possible reason?

8. Who constitutes the TOT’s? How are they selected.

9. How long are they trained?

10. Who trains the TOT’s?

11. How are they distributed in the community? i.e. for each TOT what is the catchment

12. How often are TBA’s supervised in the field? (per month)

13. How many referrals to the facility are brought by TBA’s (any tool used?)

14. Do you have maternity waiting homes in your district?

15. Do you think TBA/maternity waiting homes are needed in your district?

16. Give your views concerning the existing TBA’s maternity waiting homes and how best they can be improved.
Appendix 12

VILLAGE EXECUTIVE.

1. What is the current population of the village
2. Does a village register exist? If yes (observe - registered births, deaths)
3. When did it start - do you find it useful
4. Any problems so far in recording data?
5. How many TBA’s do exist - functional - all trained, drop-outs, dead
6. What are the benefits of having TBA’s in the community? are they useful?
7. Do you think the current number of TBAs are enough?
8. Are there any problems which have been encountered through the existing TBA’s (e.g. are they acceptable - if no why?
9. How is the village supporting the TBA’s are there any existing mechanism e.g. if a women
    has complications and needs to be referred can the village assist with transport or - leave it to
    the family (husband and relatives)
10. Do you receive any report from TBAs/Maternity waiting homes and how are they been used?
11. What are your views concerning TBAs/Maternity waiting homes roles and how best can they be helped?
    - What should be done by the society?
    - What should be done by the health facilities?
    - What should be done by the government?
    - What should be done by NGOs?
Appendix 13

Interview Guide

INCHARGE OF MATERNITY WAITING HOME.

1. What is the distance between your maternity waiting home and health facility.

2. Who are your clients and how do you get them and how many clients do you admit per month/year? (average)

3. How many staff do you have?

4. How do you run this facility?

5. What kind of management do your clients get from this facility?

6. Explain about the referral/discharge system from the facility.

7. Do you have any linkage to the community levels and the health systems?

8. Do you get any support from the community and health facilities?

9. If yes, what kind of support do you get?

10. What current system exists to enable the maternity waiting home to function efficiently (incentives)

11. What are the major problems and how do you solve them?

12. How does your facility link up with other community owned resource persons e.g. CBD’s, TBA’s etc. Is there a co-ordination mechanism.

13. What data collection system is in place with respect to maternity waiting home?

14. How often is the data collected (monthly, quarterly) and the system used.

15. How is the data collected from maternity waiting home made use at hospital and district level.

16. Are there guidelines for supervision at he maternity waiting home?

17. Who does the supervision and how often do they supervise? Any report/feedback given

18. Give your views on how best you can be assisted to improve your services and by whom

- What can the community do
- What can the health facilities do
Appendix 14

Interview Guide for mothers/Care takers – Maternity Waiting Homes.

1. How far is your home to the hospital?
2. What are your views concerning the care provided here?
3. Do you think maternity waiting homes are necessary in this community?
4. How best do you think this maternity waiting home can be improved?
Indepth interview guide

TBA TOT’s

1. Name

2. Location:
   - Facility
   - Ward
   - Division

3. Year of training?

4. How long was the training?

5. Any training or supervision guide provided after the training course?

6. How many TBA’s are you supervising?
   - Total number
   - How many are trained
   - Any performance records?

7. How many times have you conducted training for TBA’s?

8. How often do you conduct supervision?

9. How many and how often do you send reports to the hospital?

10. Have do you receive feedback on the reports sent to the district?

11. How often does the district VHW Co-ordinator supervise you (in the last 6 months)

12. What are the roles of TBAs in the community?

13. How are the TBAs performance in the community?

14. What major problems do you encounter while performing your duties?

15. What suggestions do you have to improve the current situation?
PROPOSED FRAMEWORK FOR THE IMPLEMENTATION OF COMMUNITY BASED HEALTH INITIATIVES (CBHI) IN THE DISTRICTS IN THE CONTEXT OF HEALTH AND LOCAL GOVERNMENT REFORMS

In April 2000, the MoH with support from UNICEF REVIEWED IMPLEMENTATION OF CBHI in Tanzania and came up with the following recommendations:

1. Community Based Participatory Situational Analysis, Planning and Management

   Participatory management of CBHI in Tanzania was the recommended approach to be adopted throughout the country.

   This approach will require capacity building at all levels for evidence based participatory integrated bottom up planning, implementation and management of CBHI. The coordination role of the DPLO was seen as crucial signs in enables the process to be implemented as a regular approach to planning incorporating the reform efforts across the sectors.

   The DED takes ultimate responsibility for the implementation process assisted by the DPLO, District Community Officer and the District Community Based Coordinator.

2. Community Based Health Information Systems
There is a need to streamline the information system and to build capacity for its management through a careful design, training, development of instruments and supervision.

The Community information system should be linked to the MTUHA data at village, ward and district levels. The village health days should be recognized as special days for sharing information based on service and assessment data. They should also lead to recognition of excellence in performance of adjustment of action plans. They should be days of celebration of progress.

3. **Community Based Resource Mobilization**

   The potential for revenue generation at the local level could be maximized if the councils strengthened their capacity for revenue collection at all levels. People’s confidence to pay taxes would improve if the plan/budgeting/controls processes were transparent and accountability to the tax payers is ensured. The percentage from development levy retained at village level could be used to support the work of VHWs and to establish First Aid kits. It would be up-to the local CHF Boards to decide on their contribution towards CBHI activities.

4. **Community Based Human Resource Management**

   In would be necessary to reform the human resource at the community level and let the community decide what they want to accomplish in health, who they suggest should do it and how such people should be supported by way of incentives, based on their own village priorities and resources. CBHWs should be appointed and deployed by village government (with contracts specifying tasks, workload, area of responsibility and support, based on village plan and budget), 2 per Hamlet
suggested, male and female. This would ensure that VHWs are internally recruited and accountable like other local officials.

5. **Community Based Service Delivery Package**

The service delivery package issues would best be resolved at the community level within the participatory planning process where problems are identified and how they can be solved within the resources available. The CBHC Coordinator can facilitate ad process to negotiate best interventions for each village situation during the planning process. Consideration should be made for provision of First Aids kits for villages that are far from a facility.

However, the content of such a kit should be decided by the DHMT in consultation with the villagers. In general, the service delivery package at the household and village levels should focus on preventive and simple curative/referral elements of:

- Reproductive and child health care including HIV/AIDS, Nutrition and IMCI
- Control of communicable diseases particularly malaria, vaccine preventable diseases, diarrhoeal diseases
- Health promotion, water and sanitation.

6. **Community Based Communication Strategy**

There was need for a coherent communication strategy. The strategy should be focused on behaviour change at the household level particularly in the wake of increasing HIV/AIDS transmission among the youth in the country. The VHW need to include HIV/AIDS education as a priority. The strategy should maximize the use
of traditional and multi-sectoral channels as opportunities for behaviour change. In addition, the strategy will need to build on the bottom-up process of clarifying communication content, audiences, channels, and material support needs.

7. **Coordination and Building of Linkages for CBHI**

Use of District Master Plan developed through participatory bottom up process, involving all stakeholders (including NGOs and Donors), as the main tool for coordination and linkage, based on the reformed local government framework. This could be reinforced by joint awareness workshops, common training, tools and guidelines used by all stakeholders. Such guidelines should clarify roles, responsibilities and mechanisms for joint supervisory support to the community base health initiatives in the new context. The mechanism would require focal point staff persons and district, ward and village levels from each of the sectors involved. These focal staff persons could form a task force at each level, to ensure adequate support to the community based workers, using a common supervisory tool. Additional by-laws may be enacted to ensure compliance.