

UTILIZATION OF TRAINED
TRADITIONAL BIRTH ATTENDANTS
IN THREE FARMERS' ASSOCIATIONS IN
HAYKOCH AND BUTAJIRA AWERAJA



BY

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A Thesis
submitted in partial fulfillment
of the requirement for the degree of
Master Of Public Health
in the Addis Ababa University

October 1986

ADDIS ABABA UNIVERSITY
School of Graduate Studies

Utilization of Trained Traditional Birth Attendants in Three Farmers
Associations in Haykech and Butajira Awraja

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ACKNOWLEDGEMENT

The author wishes to express her deepest gratitude and appreciation to her research advisor Dr. Tadesse Alemu, Assistant Professor, Department of Community Health, Medical Faculty, AAU, for the guidance and encouragement given throughout the study.

I would like to thank Dr. Adanetch Kidane Mariam, Assistant Professor, Department of Community Health, for her valuable suggestions and unreserved help during the process of writing this thesis.

Likewise, I wish to thank Dr. Hagos Beyene, Assistant Professor, Department of Paediatrics for the valuable criticism received at the final stage of the project.

I would also like to express my indebtedness to Dr. Audrie Hathaway, Assistant Professor, Department of Medical Microbiology and Parasitology, Medical Faculty, for editing this thesis.

My thanks also go to my husband who encouraged and helped me when I was preparing this thesis and to Wizero Enanu Negatu and Wt. Telaya Desta for typing the manuscript.

Finally the financial support from the Addis Ababa University and through it, from the Swedish Agency for Research Cooperation with Developing Countries (S.A.R.E.C.) is acknowledged.

This thesis has been submitted for examination with my approval
as University Advisor.

Dr. Tadesse Alemu _____

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ABBREVIATIONS

The following abbreviations are used in this paper.

1. TBA Untrained traditional birth attendant.
2. TTBA Trained traditional birth attendant.
3. All types of TBA Untrained traditional birth attendant,
family members, neighbours and others
who manage deliveries.
4. CHA Community Health Agent
5. ANC Antenatal Care
6. MOH Ministry of Health of Ethiopia
7. AAU Addis Ababa University

ABSTRACT

The utilization of the trained traditional birth attendants in three Farmers' Associations was studied. These Farmers' Associations include Weyu Gebriel, Geraba Fila and Aedo Kontela. The method of the study was by questionnaire interview survey.

All mothers with children less than three years of age in Aedo Kontela and with children less than six months of age in the other two Farmers' Associations were interviewed. Five trained traditional birth attendants, one community health agent, the chairpersons of Women's Associations, and the health personnel who are involved in the training and /or supervision of the trained traditional birth attendants were also interviewed.

The findings revealed the low utilization of trained traditional birth attendants. Antenatal service was rendered to only three of the mothers. Nineteen women (15.1%) were attended by trained traditional birth attendants during delivery. Of all mothers, 48(38.1%) had knowledge on child spacing and out of these, one mother acquired her knowledge from trained traditional birth attendant and the rest from clinic staff. Supervision of trained traditional birth attendants is not done in these three Farmers' Associations.

1. INTRODUCTION

1.1. Overview

The traditional birth attendants (TBAs) have been rendering services to the majority of mothers and children throughout the developing world. It is estimated that 60-80% of babies in the developing countries are delivered by TBAs (1,2,3). Ethiopia, as one of these countries, has been served by TBAs. Because they speak the same language and share the same culture with the public they serve, these practitioners can be trusted by the community more than some of the highly skilled practitioners such as nurse-midwives. This trustworthiness has helped them enjoy lasting prestige in their communities. As a result of this unique position, they can be highly influential figures in local maternal and child health services decisions.

While the contribution of TBAs in the maternal and child health care efforts is unequivocal, some aspects of their delivery practices may be harmful. In order to enable them to be safe practitioners tailored training and systematic supervision must be instituted. To this end efforts have been intensified since late 1970's. In September 1978, the World Health Organization and UNICEF jointly sponsored the first International Conference on Primary Health Care which was held in Alma-Ata in the Soviet Union. Its declaration included "...maternal and child health care and family planning, immunization against major infections.."

as one of the programmes by which the nations can reach the goal of health for all by the year 2000 (1,4,5).

In order to achieve this social and global goal the training of TBAs to improve their knowledge, skill and practice, as well as their attitude in managing deliveries is recognized to be important. As such their central role in primary health care strategy has been accepted and utilized throughout the developing countries. Ethiopia, as member nation of the Alma-Ata Declaration, has been officially training TBAs since 1980. The training aims at eliminating harmful practices, reinforcing beneficial customs, as well as enabling the practitioners to manage broader health problem of mothers and children in collaboration with other levels of health care providers.

In Ethiopia the practice and utilization of TBAs have not been adequately documented. The only two available data are, by Widad Kidane Mamiam collected from the mothers who came to the former Princess Tsehai Memorial Hospital (6), and by Gebreselassie was on a very small sample of TBAs from eight road-side towns in Gondar Region.

1.2 The Status Of Traditional Birth Attendants In Developing Countries.

In most of the developing countries, the majority of TBAs are usually elderly post menopausal females who are illiterate and practice midwifery as a part -time occupation (8). Most

of them are farmers, some are housewives and engage in various trades. They generally are married and have their own children. Some may live with their husbands, some may be widows or separated. On the average, according to studies done in Ghana, Sierra Leon, and some other countries, they have been practicing midwifery for at least 10-25 years (3,9).

The services of TBAs are rendered on humanitarian principles (2,8,10). They are reassuring family figures who are unhurried and available when needed. In most countries they start giving service a long time before birth and continue for some time after birth (4,11). They assist the women during pregnancy, at labour and post delivery. They take care of the newborn and treat certain ailments.

Generally TBAs are paid either in cash or in kind as in Honduras they are paid between U.S. 1.50 - 10 (equivalent to Eth. birr 3.10 - 20.50) depending on the time spent with the mother and the type of additional service they render (3). In Ecuador, they are paid according to the difficulty of labour, sex of the child, relationship of the practitioner with the mother or according to the wish of the client. They also work free of charge if the client cannot afford to pay.

TBAs are also herbalists in most of the developing countries (7,13,14,24). They also claim to treat mothers who are thought to be possessed by evil spirits through witch-craft (15,16).

The TBAs acquired their knowledge and skill from mothers, grandmothers or older TBAs (15,16). There are criteria for the taking of a distant relative as her student by the elder TBA. These include: sense of religion, bravery, and tolerance of 'dirt'. The student should also be married and should have experienced the delivering of her own child. In some parts of Malaysia, if the family member dreams of performing certain activities involved in midwifery practice, she then becomes a candidate for training (16).

In Ethiopia, according to the available source (7), all the TBAs were females, illiterate, married and had their own children at the time of the first midwifery practice. Mean age of these TBAs when they began practicing 'Midwifery' was 21.1 years and the mean parity was 4.8 at the time of the study conducted by Gebreselassie in Gondar Region (7). The TBAs had been practicing 'midwifery' for the preceding 15 years.

1.3 Culturally fostered functions of traditional birth attendants

TBAs practice 'midwifery' according to the norms and values of the society in which they live. The most important programme areas of the TBAs which are relevant for this study are the following.

1.3.1 Antenatal care

Antenatal care is one of the main ways of improving maternal and child health. In most developing countries the service

is rendered by TBAs only when there is a request from the expectant mother. The TBAs are notified between the fifth and the seventh month of pregnancy in most Latin American countries (17), during the seventh month by some tribes in the Philippines (17), and between the second and eight month or not at all by some tribes in Guatemala (18). The following are some of the activities during the antenatal period.

a) Recognitions of the signs of pregnancy

The cessation of menstruation is used as the reliable sign of pregnancy by many TBAs in many parts of the developing world (7,15, 16). In Sierra Leon , Nigeria, Guatemala and Ethiopia, the TBAs believe that they can recognize pregnancy by the following signs: freshness of the skin and hair; weight gain; pale face, palms, nail beds, eyes and skin; engorged breasts and dark nipples (3, 7, 18, 19). These are signs also used by health personnel. The TBAs of Yoruba tribe of Nigeria claim to 'Diagnose' pregnancy with the use of medicinal herbs. This medicine is applied on the abdomen of the woman. If there is change in color, they say that the woman is pregnant (19).

b) Abdominal examination and massage

In Latin America, prenatal examination begins with an informal visit to the pregnant woman by the TBA. The TBA then collects all the necessary information on the health of the mother and the whole family (20). She then palpates the abdomen to locate the position of the Fetus and estimates its age.

She also predicts the sex of the child. If the child's shoulder lies on the mother's right side the fetus is thought to be a boy, and if it is on the left side, a girl (18).

During the abdominal examination, usually after the sixth month of pregnancy, the TBA massages the mother with a variety of warmed-up oils or fats (20,21). The expectant mothers put great importance on the massage. The TBAs and the pregnant woman believe that massaging loosens and softens the body. This is believed to prepare the mother for an easy delivery. Massaging is also believed to help put the fetus in the right position and to replace the heat lost during pregnancy (2,18,20,22).

c) Instruction during pregnancy

The TBAs are expected to give advice and instructions on antenatal taboos and the behaviour which should be observed by pregnant women. The pregnant women are also expected to respect the instructions to ensure a safe delivery and normal infant. The following are some of the areas on which the TBAs give instructions. Some of the practices could be harmful to the mother and /or child and thus the TBAs should avoid giving such kind of advise to the expectant woman.

Diet

In many cultures the pregnant woman is instructed to avoid foods such as banana because it is believed to cause strangulation of the fetus by the cord. Eggs are believed to cause asphyxia (3).

Fish are associated with worms in the newborn babies and pregnant women. In Bodinga, a province in Uganda, and Nigeria, pregnant women are advised to avoid sugar and honey since they are culturally associated with prolonged and painful labour (23).

In Ethiopia, the expectant women are advised to refrain from eating a number of fruits and vegetables and milk products because they are believed to increase vernix on the fetus and make the baby very sticky at birth (6). They are also advised to take more food because they are supposed to eat for themselves and for the fetus (6,7). On the other hand in Nigeria (23), the pregnant women are advised to eat little and limited items of food in order to avoid a big fetus. In Latin America, Asia and some African countries, foods are classified as "hot" and "cold". Eggs, milk, beans, vegetables are considered as cold food and they are not eaten as they are believed to cause abdominal colics (3,12,24). In some areas, acid fruits such as oranges are believed to inhibit the production of milk and cause hemorrhage and abortion while milk and pork make the baby slippery and dirty at birth (18).

Practices to be avoided during pregnancy.

The TBAs advise the expectant women to avoid the following behaviour.

- Standing in the door way or crossing the arm over the breast are believed to cause obstructed labour in some African countries.

- Exposure to lunar eclipses as it results in the birth of deformed child (3).
- Being mistreated by the husband. This is believed to cause twisted cord or other complications at labour (3).

The prescription of medicinal herbs.

TBAs give medicinal herbs during pregnancy, labour and post delivery. The medicines are made of roots, barks of leaves of locally available flowering plants (12,18,20,21,25,26). During pregnancy, medicinal herbs are given to make the baby grow well, to make the expectant mother strong and to treat various ailments such as nausea, abdominal cramps and constipation. The herbal medications are also given to prevent premature labour .

During labour, the medicinal herbs are mainly used to increase uterine contractions and to make labour easy. Postnatally they are administered either to stop postnatal bleeding (19) or in some cases to encourage the flow of blood from the uterus(3).

Some studies were carried out to determine the pharmaceutical actions of the herbal medicines used by the TBAs. According to one of these studies (14), herbs used to improve the uterine contraction have oxytocic effects. The author thus recommended that the use of any medicine with known oxytocic properties by the TBAs be discouraged.

In studies conducted in Ethiopia, it was found that during the last month of pregnancy, the expectant mother drinks "Kosso" (medicines made out of flowers of Hagenia Abyssinica used in the treatment of taeniasis) every week till the end of the pregnancy for the purpose of having a clean baby at delivery (6). They also drink boiled flax seed (6,7), to make labour and delivery easy. The medicine made out of flowers of Hagenia Abyssinica is toxic and could endanger the life of the fetus; thus should be avoided as treatment during pregnancy.

1.3.2. Labour and delivery

In many of the developing countries, the majority of births take place at home with the assistance of TBAs. In Buganda, a province in Uganda and in some other places, delivery takes place in a banana- grove or in the house if at night (12, 27). The kneeling position is preferred (12, 18, 27) , and the pregnant women supports herself by holding the stem of a banana tree or a post in the house (27). The cord is cut after the expulsion of the placenta (3,15) but in some other studies, it is found that the cord is cut when there is delay in the expulsion of the placenta (27). When it is cut, the TBA of Buganda uses a reed taken from the door-post of the house for a boy, or from any other place near the stove for a girl (27). In the Sudan on the other hand, the TBAs use freshly cut reeds (4). In general, reeds, broken glasses, scissors (unsterile), razor blades, machetes, bone, sickles, knives or bamboo are used to cut the cord (9,18,24,28). The cord may or may not

be ligated depending on the local culture. If ligated, the cord is tied with a thread, cord, grass or string (20). In some places the cord is cauterized with a candle flame or a hot blade (20). The cord stump may be covered using one of the following: juice squeezed from a banana leaf, chewed tobacco leaves, petroleum jelly, ash, chicken manure, cow dung etc (3,20,29,30). (These obviously, are harmful practices of TBAs).

In a difficult labour an experienced and expert old woman is called in to assist in the delivery (27). The expectant mother is then forced to make confession of any immorality and even sometimes beaten if she fails to accept the order as it is believed that difficult labour is caused by marital infidelity or by broken taboos (30). In some places the TBA says prayers asking forgiveness of God or the spirit (20). Among the Hausa tribe in Nigeria on the other hand, obstructed labour is handled by partial cutting of labia minora which results in a vesico vaginal fistula (27), another harmful practice of TBAs.

In Brazil and in some other Latin American countries, difficult labour is managed by massaging the abdomen using warm oil, camphor, vaseline or any other greasy substance so as to warm the fetus and make delivery easy (20). Besides, a feather may be put in the pharynx of an expectant mother, or she may be asked to blow into a bottle or use anything to make her sneeze. This is believed to increase the intra-abdominal pressure and help the expulsion of the baby. Sometimes they

shake the expectant woman or may turn her almost upside down(3).
In case of malpresentation as in foot or hand presentation,
the TBA manipulates the baby externally to normal position
(3).

In West Guinea and South Africa, the woman squats for
delivery (1,4,28). Usually a relative squats behind the
pregnant woman to support her and to add pressure on the loins
and abdomen during labour pain (25).

In Kenya (14), a special hut is prepared for delivery
and when labour pains start, the TBA is called. When there
is bearing-down pain, the expectant woman kneels on a sack
while another woman supports her at the back and shoulders.
The TBA then sits on a low chair in front of the pregnant woman
and waits for the baby.

On the other hand, in Sierra Leon (31), the TBA or the
pregnant woman prepares the necessary facilities and equipment
such as a woven mat for the mother to lie on, pots for water
and for mixing medicine in, a razor blade, knife or machete
to cut the cord and a clean cloth or a rag for the baby.

A primigravida does not get any information in childbirth
before labour as it is believed that prior knowledge may frighten
the pregnant woman who then may seek an abortion. At the time
of delivery, the primigravida is instructed on how to control
her reaction to pain. If she does not follow the instructions,
she will be taken somewhere outside the village so that her

reaction to pain or her voice is not heard by the villagers or especially by her husband. If the husband hears his wife crying loud or screaming because of labour pain, he will accuse the TBA of malpractice,

In the case of a multipara, the TBA often gives laxative herbs to the expectant mother. She palpates the abdomen to determine the presentation and degree of engagement. She may also put her head on the abdomen to feel the movement of the fetus (3). When labour pain starts, most TBAs instruct mothers to bear-down before full dilation. This may cause exhaustion, fetal distress and perinatal asphyxia (3).

In the Philippines, to deliver the placenta, the TBAs in some tribes massage or press the abdomen with a cold flat-iron (1, 3). If the expulsion of the placenta is delayed, the cord will be cut and an axe will be tied to the end of the cord so that the placenta does not go up and suffocate the mother (3). The TBA then will try to remove it manually or else, she takes the new mother to another well experienced TBA. Once the umbilical cord is cut, the placenta is either buried or burnt depending on the beliefs of the community (16, 20).

In Ethiopia, the woman is kept in a kneeling or squatting position when labour starts. The abdomen is massaged to speed labour. Once the baby is born, the majority of TBAs in Gendar Region cut the umbilical cord with an unsterile blade. The mother is then shaken so as promote the delivery of the placenta

She is then instructed to sit until the placenta is expelled because it is believed that laying down will result in the death of the mother due to the pressure of the placenta on the brain (30).

If labour is difficult some TBAs in Ethiopia (6) massage the abdomen using "fresh butter" as a lubricant. If they are unsuccessful with this technique, the TBAs start certain rituals in order to expel the evil spirit and evil eye which are believed to be the causes of an obstructed or difficult labour (6). There are various rituals for different purposes. They are used either to assist the delivery of the baby or the placenta or to stop postpartum bleeding. Some of these rituals include (6):

- Beating drums to scare away the evil spirit.
- Moving a live chicken around the abdomen of the expectant mothers while muttering some prayer words.
- Shaking the woman up and down (This could be harmful practice)
- Irritating the nose and throat with straw or feather so that the woman sneezes or vomits.

1.3.3. Postpartum care

During the postpartum period it is believed that the infant and the mother are susceptible to physical and supernatural harm. Although there is slight variation among different cultures, usually the mother is secluded and her activities restricted from seven to forty days as in Latin America, The Sudan and

Ethiopia (20, 21, 30). In China the mother is allowed to rest for just a month (2). During this period, the mother avoids exposing herself to anything cold in the form of food, bathing etc.

In some cultures, the TBA does a lot of duties for some time after delivery. She washes the blood-stained cloths of the mother and helps with household tasks. She massages the mother and ties a cloth as a binder around her abdomen (17). The massage is believed to encourage the flow of blood out of the uterus and the flow of milk from the breast. It is also believed to relieve postpartum pain (20). In some places postpartum hemorrhage is seen as a way of cleaning the mother from collected menstrual blood (3).

During this period, the mother is expected to follow all the instruction given to her by the TBA. These include:

a) Postpartum dietary practices

Cold food such as eggs, milk, vegetables and citrus fruits are forbidden in Guatemala (18), China (31) and in the Philippines (20). Protein-rich foods such as chicken and fish are not allowed to be eaten by the new mothers in some tribes of the Philippines. Chicken soup and hot chocolate are considered to be highly nourishing and recommended during the immediate postnatal period in some countries in Latin America (20).

b.) Specific postpartum taboos

As cold is associated with disease, sitz baths, hot herbal baths or steam baths are prescribed by the TBAs in many parts of the world (18,20,32). Sleeping soon after delivery is encouraged by most tribes but in some tribes in the Philippines, the new mother is forbidden to sleep immediately after delivery because they are afraid of bleeding, insanity, eclampsia, stomach-ache or coma (20).

In Ethiopia, the mother is confined in a dark room to avoid bright light (6). The mother is also instructed to put metallic items under her pillow and under the pillow of the infant in order to avert the intrusion of the evil spirit (6).

1.3.4. Care of the newborn

Immediately after delivery, the infant is put in a banana leaf (12) or in piece of cloth in Uganda and Sierra Leon respectively. The TBA washes its mouth out with water and blows up its nose to make it sneeze and start breathing (12, 18). She may blow on its face, splash water, rub its back or slap its bottom (20,32). In Sierra Leon , the TBA or her assistant will suck mucus from the nose and mouth of the baby. In the Sudan, the TBA cleans the mouth and the eyes of the newborn with her tongue (4). The baby is then washed with warm water sometimes containing herbs (3,25) or cleaned with oil (20). The baby

will be massaged all over to strengthen and warm him and to mould his head to a good shape (12). In Ethiopia, it is a custom for a mother to feed the newborn with 'fresh butter' for the first few days of life (6).

1.3.5. Methods of child spacing

In developing countries where modern contraceptive measures are not readily available and accessible, women use different methods to avoid or terminate pregnancy. Some of these are:

- Herbs as contraceptives and for the termination of pregnancy (20,25).
- Abstinence often combined with certain taboos, such as forbidding sexual relations during lactation or until the child can crawl or walk (20).
- Rhythm method although there is error in recognizing the time of high fertility (20,25).
- Coitus interruptus (20,25).

1.4. The Status Of Trained Traditional Birth Attendants In The Developing Countries

Eighty - two percent of the developing world now have training programmes (33,34) for the TBAs. It was believed that if the TBAs were taught to follow clean procedures during the process of delivery and if they take proper care of the umbilical cord, death from neonatal tetanus will be reduced (20). It is also believed that the ability of TBAs to recognize

abnormalities early in pregnancy and labour and referral such cases to the nearest health institution, will reduce perinatal mortality, maternal mortality and stillbirth (20). However from the experiences of other countries such as Sierra Leon, Niger, Thailand and the Philippines, it was found that without good relationships between the health personnel and the TBAs, without systematic and proper supervision and follow up, and without support from the health personnel and the Community, it is less likely that the objective of the training programme will be fulfilled.

In Ethiopia, the TBA training takes 20 working days or 160 hours (35). The Ministry of Health had trained 3000 TBAs upto 1983 and had planned to train 30,000 more to have a total of 33,000 TBAs at the end of the 10 year plan (36). According to an unpublished document by Gebreessie in Gondar Region, where the TBAs were supervised following training, the number of deliveries attended by these practitioners was found to be more than that of the pre-training period. Other documents in other Regions of the Country recommend arrangements for good supervision in order to successfully utilize the TBAs (38).

In Zambia, training had a negative effect on the functions of the TBAs. The community expected free service as they assumed that the TBAs were employees of the government (20).

In India, the auxiliary nurse midwives, who are supposed to supervise the TTBA's, were less experienced and less knowledgeable than the average TTBA's. As a result they lost the respect of TTBA's without which their activities could not be fruitful. In Malaysia on the other hand, the TTBA's had a poor relationship with the trained midwives until a complementary role was established for the TTBA's. The TTBA's were allowed to carry out the rituals and supportive duties during the process of labour, delivery and post delivery while the government employed midwife assisted the mother during the actual delivery including the cutting of the cord (15).

The effect of supervision has not been widely studied. However, according to some of the few studies done the supervised TTBA's were found to have twice as many family planning acceptors than those who had received training only (20).

⊗ In the Philippines, it is during the last session of the training course that plans for the supervision of the TTBA's are discussed. The midwife or public health nurse conducts monthly meetings with the TTBA's under her jurisdiction, during which deliveries attended are discussed and delivery kits are checked and restocked with the necessary supplies (3). During these meetings, the TTBA's are also expected to bring their record books with them. The supervisor compiles the monthly report and sends it to the next higher level of health

administration. The midwife or public health nurse is also supposed to observe deliveries actually managed by the TBAs (3). In Thailand on the other hand, the auxiliary midwife closely supervised the TBAs for the first month after training followed by quarterly supervision. Group meetings of TBAs with the supervisor is supposed to be held at regular intervals (3). The TBAs are also supposed to renew their supplies by going to the health stations monthly. In Niger, a mobile health team renews supplies for TBAs, discuss problems and collects the necessary data for statistical analysis (20).

At present there are four different supervisory groups by different countries (20).

- a) Supervision by the community
- b) Supervision by more experienced TBAs as in the Philippines
- c) Supervision by other health workers. This is the most common one used in the Philippines, Thailand, Niger, Ghana and some other countries. In Ethiopia, in places where there are no CHAs, the health personnel in the nearby Health Institutions are supposed to supervise the activities of TBAs.
- d) Supervision through state licensure. Some countries like Costa Rica (20) license the TBAs to practice (34). The TBAs are licensed to practice either by the Midwives' Association or by the Ministry of Health (20).

Most of the countries emphasize that supervision is inadequate; this is usually due to poor planning, lack of material resources and shortage of health personnel (2, 39). In most instances, the only contact of the supervisor with the TBAs is when she comes to the clinic to renew the supplies of the midwifery kit, or accompanying her client (2).

1.5. Significance Of The Study

In Ethiopia as in many other developing countries, women between the ages of 15 to 45 years and children below 5 years of age constitute 20% and 18% of the population respectively (40, appendix 1). These groups of the population are also vulnerable to disease, disability and death. According to the 1984 national census, the infant mortality rate is 144 per thousand live births and the maternal mortality rate in Addis Ababa, according to Kwast et al; (42) is 5.66 per thousand live births. The high maternal and infant mortality can be reduced. One way to do this would be to increase the availability and accessibility of conventional health services. One of the short comings of the conventional health services is acute scarcity of community-based trained health personnel. To overcome this problem in line with the concept of Primary Health Care, the Ethiopian Ministry of Health has been training traditional birth attendants since 1980.

While the training itself is one of the efforts of the

Government to improve the health status of the mothers and children, the importance of parallel utilization of the trained practitioners by the community cannot be overemphasized. Along the same line of reasoning the evaluation of the level of the expected utilization of the TTBA's by the specific members of the community, the mothers, is of utmost importance. The results of this small scale study are, therefore, hoped to provide baseline data on the utilization level of TTBA's by the mothers in the three Farmers' Associations in order to stimulate more refined as well as broad scale studies in the subject area.

1.6. Objectives Of The Study

1.6.1. General objective

To generate baseline information on the utilization of trained traditional birth attendants by the women in the three Farmers' Associations.

1.6.2. Specific objectives

- a) To determine the level of utilization of the trained traditional birth attendants by the mothers.
- b) To record the prevailing knowledge and attitude of the mothers regarding services of trained traditional birth attendants.
- c) To identify the kind of support the community gives to the trained traditional birth attendants.
- d) To assess the degree of supervision by the health institutions.

2. METHODS AND MATERIALS

This study is conducted using a questionnaire interview survey method. The survey included three Farmers' Associations in Haykoch and Butajira' Aweraja' in Adami Tulu and Dugda 'Woreda'. The three associations are:-

1. Aedo Kontela
2. Weyu Gebriel
3. Geraba Fila

2.1 Instruments

Five different kinds of questionnaires were Constructed to interview the following:

- a) All mothers with children born after the training of the TTBA's in each of the three Farmers' Associations.
- b) All the five TTBA's in the three Farmers' Associations.
- c) The CHA in one of the Farmers' Associations (The CHA is directly or indirectly involved in the activities of the TTBA).
- d) The Chairpersons of Women's Associations (they are involved in the activities of TTBA's).
- e) Health Personnel in Zeway Health Center and Meki Clinic. (Zeway Health Center is responsible for the training of the TBAs for the three Farmers' Associations and directly responsible for the supervision of the TTBA's in AedoKontela and Weyu Gebriel Farmers' Associations while Meki Clinic is responsible for the supervision of the TTBA's in Geraba Fila Farmers' Association).

The TTBA's, the CHA, the Chairpersons of the Women's Associations in the three Farmers' Associations and the Health Personnel were interviewed in order to verify the response of the mothers and to obtain additional information on the pattern of utilizations of the TTBA's.

2.2. Description Of The Study Location

- a) Aedo Kontela Farmers' Association is about three kilometers north-west of Zeway and about 500 meters off the main-road leading to the south-east of the country (appendixes 2,3) Aedo Kontela has a population of 635. It has three TTBA's. Two of these were trained 3 years prior to the time of the interview. One of these became the Chairperson of the Women's Association. The third TBA was trained some six months before this investigation.
- b) Weyu Gabriel Farmers' Association is about 15 kilometers north-west of Zeway and about 400 meters off the same main-road leading to the south-east of the country. Weyu Gabriel has a population of 1246. It is served by one TTBA who was trained some six months prior to the study period.
- c) Geraba Fila Farmers' Association is located 35 kilometers north-east of Zeway and about 300 meters off the main road stated above. It has a population of 638 and one TTBA. The TTBA was trained some six months prior to the time of the study.

2.3 The Study Population

The study population constitutes 126 mothers of babies born after the TBAs were trained in each of the associations. This comprises all the mothers in Aedo Kontela with children less than three years of age and all the mothers in Weyu Gebrial and Geraba Fila Farmers' Associations with infants of less than six months of age.

2.4 Pre-testing Of The Questionnaires

The questionnaires were pre-tested in Abosa Village which is located some 10 kilometers north of Zeway. As a result some of the questions which were not clearly understood were modified before the actual utilization with the study population.

2.5 Training Of The Interviewers

Zeway Health Center was approached for help. Four farmers who were under training at the Health Center to become CHAs were assigned to work with the investigator. They were trained on how to conduct interviews and fill in the questionnaires. The training took place both in Zeway Health Center and in the Farmers' Associations where the study was conducted.

2.6. Data Collection

On the first day of the survey, the three CHAs were assigned to conduct a house-to-house listing of all mothers with children under three years of age in Aedo Kontela Farmers' Association

and with less than 6 months of age in Geraba Fila and Weyu Gabriel Farmers' Associations. The Fourth CHA interpreted from ('Oremenga' to Amharic) for the investigator throughout the data collection period, as 'oremenga' is the local language of the community.

On the following days, one of the CHAs was assigned to guide the other members of the team to each house where the interview was conducted while the other two were left to interview mothers with close supervision and spot checking by the investigator. About 70% of the interview was conducted by the investigator and the rest 30% by the CHAs. The filled-in questionnaire forms were collected each day and checked by the investigator for proper completion.

2.7. Limitations

- a) The study which is based on a convenience sample may not yield data applicable to the Regional population.
- b) The conclusion derived from it cannot be generalized to other Regions, ie, it would be limited to the three Farmers' Associations.
- c) Time and finance limited more detailed data collections on the reasons for the level of utilizations that could be observed.

3. RESULTS

All the TTBA's in the three Farmers' Associations are married and three of them are farmers and two are housewives. The mean age of the TTBA's at the time of the study is 44.6 years with age range of 39 to 55 years.

A few mothers received antenatal care from TTBA's. Table I indicates that three of the pregnant women in the three Farmers' Associations obtained antenatal care from the TTBA's. Two of the pregnant women had antenatal services by TBAs. Sixty-one (48%) of the expectant mothers had antenatal services by the clinic staff and 60 (47.6%) had no antenatal care at all.

TABLE I Distribution of Mothers by Antenatal Care Provider

Location of Study	TTBA		TBA		Clinic Staff		No ANC*		Total No.
	No.	%	No.	%	No.	%	No.	%	
Aedo Kontela	3	3.2	2	2.2	54	58.1	34	36.6	93
Weyu Gabriel	-	-	-	-	2	9.5	19	90.5	21
Geraba Fila	-	-	-	-	5	41.7	7	58.3	12
Total	3	2.4	2	1.6	61	48.4	60	47.6	126

* Antenatal Care

When the TTBA's were asked whether they had rendered antenatal service to pregnant women, three of them (one from Wayu Gebriel the second one from Geraba Fila and the third one from Aedo Kontela Farmers' Associations) said that they have never rendered antenatal service to any of the expectant women. Two of the TTBA's from Aedo Kontela Farmers' Association on the other hand, reported rendering antenatal service to three pregnant women in their own community.

Table II shows that 19 (15.1%) of the mothers were delivered by TTBA's, 63(50%) by TBAs, 14 (11.1%) by family members, 17(13.5%) by neighbours, 5(4%) self-help and 8 (6.3%) by clinic staff.

TABLE II Distribution of Deliveries
by Type of Attendants

Location of Study	TTBA		TBA		Family member		neighbour		Self		Clinic Staff		Total No.
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Aedo Kontela	14	15	45	48.4	9	9.7	13	14	4	4.3	8	8.6	93
Weyu Gebriel	2	9.5	17	18	2	9.5	-	-	-	-	-	-	21
Geraba Fila	3	25	1	8.3	3	25	4	33.3	1	8.3	-	-	12
Total	19	15.1	63	50	14	11.1	17	13.5	5	4	8	6.3	126

The number of deliveries attended by TBAs, family members, neighbours, and self-help can be lumped together in order to have a general view of the overall utilization pattern of the attendants in the community. It is observed that 99(78.6%) of deliveries were attended by untrained persons, 19(15.1%) by TTBA's and 8(6.3%) by Health Center Staff.

All of the five TTBA's reported that they attended two to four normal deliveries since their training but have not referred patients to the Health Institutions. If labour is long, all the TTBA's reported that they will wait for some time and then refer the pregnant woman to the nearby Health Institution. They, however, have never encountered such cases. The practitioners also said that their call to attend deliveries after training have been the same as before the training. That is, they were utilized similarly regardless of their training. It is, however, observed that the TTBA's seem to perform according to the instruction they had during training. They tie the cord and cut it with sterile scissors. If the placenta is delayed they apply slight pressure on the abdomen and wait till it is expelled by itself.

Table III. indicates the reasons given by the mothers for not calling the TBAs during labour and delivery. Of the 126 mothers, 78 (78.8%) did not know of the existence of the TBAs in their community, 11(11.1%) said that labour was not difficult, 5(5.1%) reported that the TBAs were not found easily and 5(5.1%) stated that they delivered unexpectedly.

Table III Distribution of Deliveries Attended by Untrained People by Reason for not Calling the Trained Traditional Birth Attendants.

Location of Study	Labour was Not Difficult		Difficult to find TTBA		Delivered Unexpectedly		Do not know the existence of TBAs		Total No.
	No.	%	No.	%	No.	%	No.	%	
	Aedo Kontela	7	9.9	3	4.2	2	-	59	
Weyu Gebriel	-	-	1	-	1	-	17	89.5	19
Geraba Fila	4	44.4	1	-	2	-	2	-	9
Total	11	11.1	5	5.1	5	5.1	78	78.8	99

Regarding postpartum visits, three of the five TTBA's reported that they visited mothers during the first days after attending deliveries but the number of visits usually depended on the proximity of the house where they lived. The other two did not pay any postpartum visits.

Table IV shows distribution of mothers by knowledge of child spacing. Of all mothers, 78 (61.9%) had no knowledge and 48 (38.1%) had knowledge on how to space pregnancies. When the mothers were asked from whom they learned about child spacing, 47 (97.9%) of those who knew how to space pregnancies said that they learned it from the staff of the Health Center. One of the 48 mothers stated that she acquired the knowledge from a TTBA.

TABLE IV Knowledge on Child Spacing

Location of Study	Have Knowledge		Have no Knowledge		Total
Aedo Kontela	44	47.3	49	52.7	93
Weyu Gebriel	-	-	21	100	21
Geraba Fila	4	33.3	8	66.7	12
Total	48	38.8	78	61.9	126

* For the purpose of this study, knowledge is defined as general orientation to the means of child spacing

With regard to supervision, the chairpersons of the Women's Associations and the CHA (there is only one CHA in one of the Associations while the other two do not have CHA) reported that none of the TTBA's are supervised by the health personnel from the conventional health care institutions or by the Farmers' Associations. The health personnel at Zeway Health Center and Meki Clinic who were responsible for the training and /or supervision of the TTBA's said that reports from the TTBA's were not regular. This is partly due to lack of supervision. Supervision is absent because of a reported lack of transportation facilities, the shortage of health personnel and inadequate budget for per-diem

Lack of community support in the form of recognition of their existence and compensation for the time the TTBA's spent with the mothers was also observed. All the TTBA's except one, reported that they do not receive any kind of payment for the service they render to the mothers. One TTBA who had attended three deliveries within the six months period following training reported having received 4 Eth. Birr from one mother.

Additional information was gathered in the involvement of the community in the selection of TBAs for training through the process of the interview. The selection of the TBAs for the training did not follow all the criteria set by the Ministry of Health of Ethiopia. One of the five TTBA's complained of



having been recruited by the community for training against her wish. In addition, another TBA was found to be the chairperson of one of the Women's Association.

To sum up the results, 78.8% of mothers interviewed in the three Farmers' Associations do not know of the existence of TBAs in their communities. Three out of 126 mothers had antenatal care by the TBAs. 15.1 percent of deliveries were attended by the TBAs. There is no supervision of the TBAs by the staff of the nearby Health Institutions or the community. TBAs are not paid for the service they render to the mothers in the three Farmers' Associations.

4. DISCUSSION

According to the 1975 report of the WHO expert Committee on maternal and Child Health, mothers and children are affected by the beliefs and customs of the society more during pregnancy, childbirth and childhood than at any other times of their lives (42). The concept of Primary Health Care fosters the mobilization and utilization of community resources to enhance self-reliance and provision of acceptable and accessible health care to individuals and families in the community. In light of these facts, training TBAs would be expected to correct the harmful practices relating to pregnancy and delivery and reinforce the beneficial ones. In Ethiopia, a training programme was started in 1980. Follow-up of the utilization pattern of the trained birth attendants, however, has not been sufficiently studied. The findings in the present study indicate low utilization of the TBAs by the mothers in the three Farmers' Associations.

About 47.6% of the mothers did not have antenatal care at all while 2.4% of the mothers obtained antenatal care from TBAs and 1.6% from TBAs. This is contrary to the findings in Sierra Leon and the Philippines where the majority of expectant mothers consult the TBAs for antenatal services regularly.

In this study 78.6% of the deliveries were attended by untrained persons, and 15.1% by TBAs. The untrained persons

comprise the TBAs, family members, neighbours and the mothers themselves who managed their own deliveries. The TTBA's reported that the number of deliveries they attended after training was the same as before the training. This is contrary to the unpublished study by Gebreselassie in Gondar Region where it was reported the majority of deliveries were attended by TTBA's and that the number of deliveries performed by the TTBA's increased after training (37). The result of the study by Gebreselassie cannot be directly compared with the findings of this study because of differences in the study methods. In his study supervision of the TTBA's during the time of the investigation was an important variable which was not done in this study. Supervision may have increased the utilization of the TTBA's by the community because of an increase in creditability of the practitioners resulting from the supervision.

It was reported that the number of postnatal visits by the TTBA's in the three Farmers' Associations usually depend on the proximity of the houses. Three of the TTBA's reported to have visited postnatal mothers during the first five days and two of the TTBA's do not pay postpartum visit at all. Of the 126 mothers, 38% know of the existence of family planning services. One of the mothers claimed to have acquired this knowledge from a TTBA while the rest said that they learned it from clinic staff. This is not in line with the training objectives set by the Ministry of Health of Ethiopia (35). It is during this period that the TTBA's are expected to teach

the mothers about breast feeding, immunization, child care and spacing of births.

This small scale survey reveals that the TTBA's in the three Farmers' Associations are underutilized. This may be attributed to many factors. Some of the possible factors are the following.

Lack of supervision and refresher course.

The TTBA's in the three Farmers' Associations have never been supervised by health personnel from the nearby Health Institutions or by the community. They have never had any refresher course after their training. Activities are recorded by three out of the five TTBA's and reported by two of the TTBA's.

As reported in various studies (1,3,20,38), it is during supervision that supervisors can determine the degree to which the trained personnel are utilized, whether knowledge has been retained, and new skills put into practice (20). The supervisor can identify reasons for underutilization, can guide the TTBA by helping her to correct her weaknesses, and motivate her to improve practices in ways which utilize what she has learned during the training period.

It is only through regular supervision that the actual practice reported by the TTBA's as cutting the umbilical cord

with sterile scissors, avoidance of herbal medications for pregnant women and children etc, could be evaluated. Through supervision the technical skills of the TTBA could be improved. Supervision increase the credibility of the TTBA as a health service provider. This in turn would increase utilization by the community. It is through supervision that the supervisor can collect useful information which would help in the evaluation of the utilization patterns of the TTBA by the mothers in the community (34). Thus, without supervision and support from the health personnel and the community the optimal utilization of the TTBA by the mothers in the three Farmers' Associations can hardly be achieved.

Lack of Support by the Community

For the effective utilization of the TTBA, the communities are expected to give full support to the trained practitioners. The community should participate in the proper selection of the TTBA for training. It should compensate for the time spent by the TTBA in the care of mothers and children either in cash or in kind. The community should recognize and accept the services of the TTBA.

In this study it was found that the selection of the TTBA did not strictly follow the prescribed guideline set by the Ministry of Health of Ethiopia (MOH). As a result one of the TTBA stated her discontent with the selection and with the midwifery practice in general.

In the three Farmers' Associations none of the TTBA's are paid for the service they render to the Community. The same is true in the findings of Gebreselassie in Gondar Region (37) and the Committee for the Review of Primary Health Care (40).

According to the present policy of the MOR, TTBA's are not government employees and therefore the communities in the three Farmers' Association have to mobilize their resources and provide them with remuneration (35) of some type. In the absence of remuneration, full utilization of TTBA's cannot be expected.

5. CONCLUSION AND RECOMMENDATIONS

5.1. Conclusion

Because of the low number in the study population and the TTBA's taken due to administrative and logistic limitations, this study does not by any means claim to have assessed the level of utilization of the services of the TTBA's in the whole of the Region. Therefore while this study is complete in itself, conclusions to be drawn from it cannot be generalized. The results, however, reveal very low utilization of the TTBA's in the three Farmers' Associations. This may mainly be attributed to:

- a) Lack of supervision by health personnel and community.

As a result the reported safe delivery practices of the TTBA's could not be verified. Also, one of the effective TTBA's has become chairperson of the Women's Association and no longer functions as a TTBA. This is a 20% attrition rate and it was not noticed by the health personnel who were supposed to supervise the TTBA's.

- b) Failure of the community to support the TTBA's by way of recognition of the service they provide and remuneration for the time they spend in rendering the services.
- c) Lack of knowledge of mothers about the availability and accessibility of the TTBA's in the community.
- d) Failure to strictly follow the guideline for the recruitment of TTBA's for training.

On the other hand the investigator believes that, the nationally reported total number of TTBA's of about 3000 at the end of 1983 (36) to serve 8.5 million women of child bearing age seems out of reality. Considering also the eminent role the TTBA's are expected to play in Primary Health Care, particularly in maternal and child health, this investigation would serve as an indication of the need for further and broader studies in the subject area. The results of such studies may help improve the underutilization of the TTBA's as observed in the three Farmers' Associations.

5.2. Recommendations

Based on the experiences of different countries and the findings in this study, the following generalized recommendations are emphasized in order to increase the utilization of the TTBA's.

- a) Community support for TTBA's deserves serious attention. The importance of TTBA's services for the health care of the mothers and children should be made known to the community in general and mothers in particular through available media so that the TTBA's are recognized and utilized as planned.
- b) Supervision of TTBA's by the health personnel must be considered as a routine part of their regular

health activities; the established regular reporting system with the built - in feed back mechanism should be followed.

- c) Selection of the trainees should be accomplished strictly following the guideline of the Ministry of Health.

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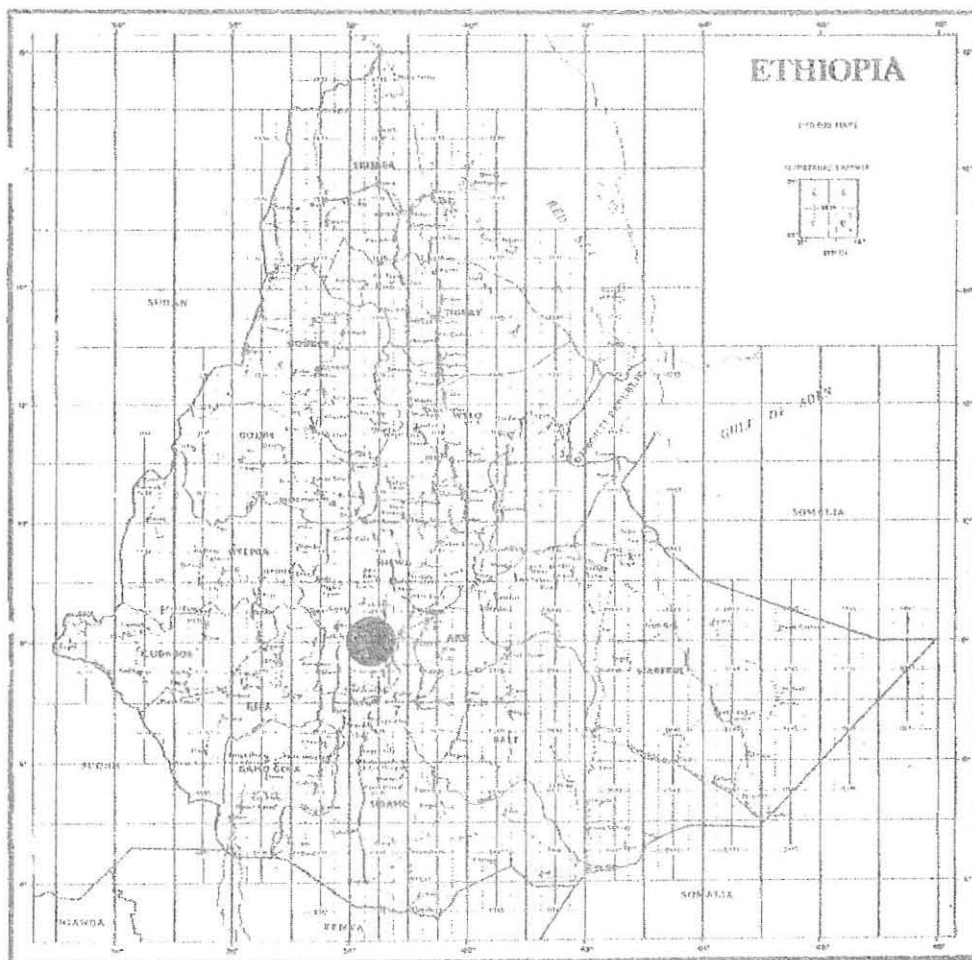
Appendix I

Estimates of Key-Socio-Demographic Indices (40)

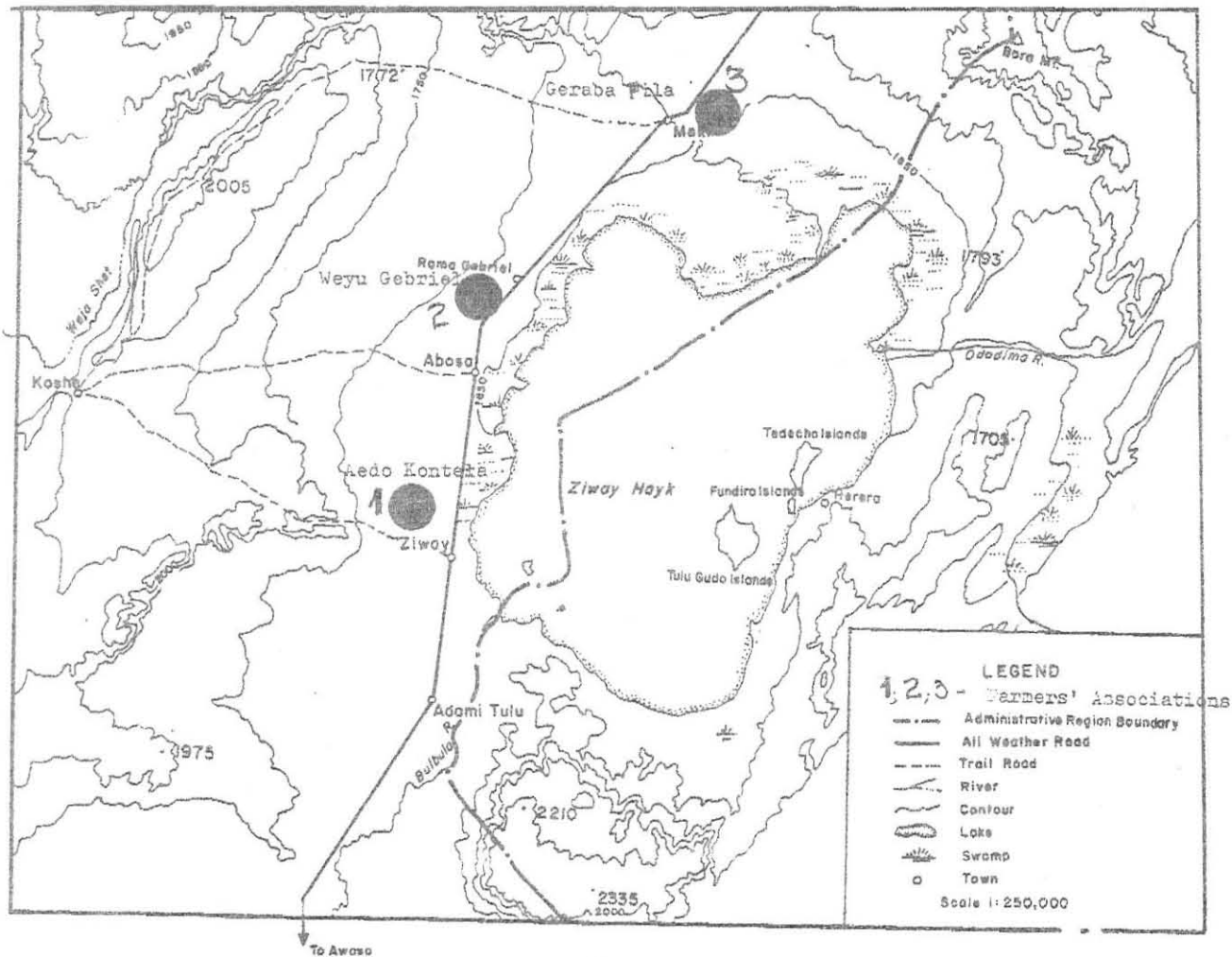
1984 Census

1.	Total Population in Millions	42
2.	% Population below 5 years of age	18
3.	% Population women 15-45 years of age	20
4.	Crude birth rate per 1000 pop.	47
5.	Crude death rate per 1000 pop.	18
6.	% natural population increase per yr.	2.9
7.	Infant mortality rate/1000 births	144

Appendix 2



Haykoch and Butajira Aaraja



LEGEND

1, 2, 3 - Farmers' Associations

--- Administrative Region Boundary

— All Weather Road

- - - Trail Road

— River

~ Contour

○ Lake

▨ Swamp

○ Town

Scale 1: 250,000

Appendix 4

Guideline for the training of TBAs.

1. Recruitment

Recruitment of the TBAs for training are made by either the URBAN DWELLERS ASSOCIATION or FARMERS' ASSOCIATION and should fulfill the following criteria.

- 1.1. The recruitee must have attended several deliveries before training and must be recognized by the community. She should have some or suitable experience in 'Midwifery' practices.
- 1.2. The recruitee should be healthy so that she will be able to travel and give services to the community.
- 1.3. She must have the interest and good will in rendering service to the community .
- 1.4. She must have developed no addiction to toxic drugs, or alcohol. Instead she should have won the respect for her exemplary behaviour.
- 1.5. Those who read and write should have the priority, however, if they do not, it is essential that they first be taught how to read and write.

2. Payment for service

- 2.1. During training, the expenses should be borne by the association that has sent them for training.

Questionnaire for trained traditional birth attendant (TTBA)
in the Farmers' Associations.

1. Name of TTBA _____
2. Name of the Farmers' Association _____
3. Age of the TTBA _____
4. Marital Status
 single married
5. Other than Midwifery practice, what other task do you perform for your self and your family?
 farming
 trading
 other- specify _____
6. When did you have your training in midwifery
 3 months before
 6 months before
 two years before
7. How many deliveries were you attending before training in a year?
 1- 2
 3 - 5
 more than 5
9. Were all the deliveries normal?
 Yes No

Validated by 199A
201 N 2000
Dept. of Community Health
Faculty of Medicine

10. If no, what complication did you face?

- prolonged labour
- delayed expulsion of placenta
- bleeding
- abnormal presentation .
- other/ specify

11. For how many pregnant women have you given antenatal care since training?

- 1 - 2
- 3 - 5
- over 5

12. If yes, what care do you give to the mothers?

- Advise on diet
- " " child care
- other/ specify _____

13. Have you referred patients to health institutions?

- Yes
- No

14. What do you do to enhance labour?

- administer herbs
- ask the mother to walk
- other - specify _____

15. What position does the pregnant women assume for deliver?

- dorsal
- squatting
- semi-sitting
- side lying
- other, specify _____

16. Do you tie the cord?

Yes No

17. With what do you cut the cord?

reeds

knife

razor

scissors

other, specify _____

18. Do you dress the stump of the umbilical cord?

Yes No

19. If yes, with what do you dress the stump of the cord?

clean ash

cow dung

soil

butter

other, specify _____

20. If there is delayed placenta, what action do you take?

massaging the abdomen

supporting the abdomen and asking a mother
to jump up and down

Lifting the mother and shaking her

other, specify _____

21. When do you give postpartum care?

a week after delivery

a month after delivery

after 45 days

other, specify _____

22. Who supervises your activities?

- CHA
- Health personnel from clinic
- Farmers' Association
- Women's Association

23. How often do the supervisors visit you?

- every week
- every month
- " 3 months
- not at all
- other , specify _____

24. To whom do you submit performance report ?

- CHA
- Health Center
- Farmers' Association
- None

25. How often do you submit your report ?

- every week
- every month
- every three months

26. Do you record your daily activities?

- Yes No

27. If yes, where do you record it? _____

28. How often do you fill your delivery kit?

- as often as necessary
- every month
- not at all
- other, specify _____

29. Where do you fill your delivery kit?

at the clinic

at the office of the Farmers' Association

other, specify _____

30. Are you paid for the service you render?

Yes No

31. If yes who pays you?

the client

Women's Association

Farmer's Association

other

32. Have you had refresher course?

Yes No.

33. How often do you have refresher course?

every three months

every six months

every year

other, specify _____

Questionnaire for mothers with children
under 3 years of age in Aedo Kontela and under
6 months of age in Geraba Fila and Weyu Gebriel

Farmers' Associations

1. Name of the mother _____
2. Age of the mother _____
3. Name of Farmers' Association _____
4. When did you have the last delivery? _____
5. Where did you delivery the last child?
 home
 clinic
6. Who assisted you in this delivery?
 TTBA
 TBA
 family member
 Clinic staff
 other, specify _____
7. Did you have antenatal care?
 Yes
 No
8. Who was taking care of you during pregnancy?
 TTBA
 TBA
 clinic staff
 other, specify _____

9. Why did you choose TTBA/ or TBA? _____
- she is accessible
 - she is knowledgeable
 - she is sympathetic
 - she is a respected person
 - other, specify _____
10. What kind of care did you get from these people during pregnancy?
- abdominal massage
 - advise on balanced diet
 - other, specify _____
11. Do you know anything about child spacing?
- Yes
 - No
12. If yes, from whom did you get this information?
- TTBA
 - TBA
 - Health personnel
 - others, specify _____
13. Have you practiced the child spacing knowledge on your self?
- Yes
 - No

Questionnaire for the chairpersons'
of Women's Association in the three Farmers'

Associations

1. Name _____
2. Responsibility in the association _____
3. Name of the Farmers' Association _____
4. How many TTBA's are there in this Farmers' Association? _____
5. What is the responsibility of the Women's Association during the training of the TTBA's?
 Pocket money for the TTBA's
 Helping the family of the TTBA's
 other, specify _____
 no responsibility
6. Are the TTBA's paid for the service they render?
 Yes no
7. If yes, who is paying the TTBA's
 Women's Association
 Farmers' Association
 The client of the TTBA
 other, specify _____
8. How are the TTBA's paid?
 in cash
 in kind, specify _____
9. Is there any attrition of the TTBA's?
 Yes no
10. If yes, what is the reason for the attrition?
 no payment for service they render
 low pay for service they renders
 not accepted by mothers
 other, specify _____

Questionnaire: for the Supervisors of the TBAs in the
three Farmers' Associations

1. Name of the Supervisor _____

2. Professional status _____

3. Are you involved in the training of the TBA?

Yes

No

4. How many did you train for the three Farmers' Associations
and when did you train them?

No. of TBAs	Date of training
Aedo Kontela	
Weyu Gebriel	
Geraba File	

5. Are all the TBAs actively working at present ?

Yes

No

6. If no, how many have stopped giving service? _____

7. If there is attrition of TBAs, what is the reason for
it?

there is no payment for service they render

shortage of supply

lack of recognition by the Community

other, specify _____

8. Who is responsible for the supervision of the TTBA's?

The clinic Farmers' Association

CHA others, specify _____

9. If the clinic is responsible for the supervision, how often do you supervise the TTBA's ? _____

10. How often do you receive reports from the TTBA's?

weekly

monthly

every three months

other / specify _____

11. Who restocked the delivery kit after the supplies are used by the TTBA's?

Health Center

Women's Association

Farmers' Association

no one

other, specify _____

Questionnaire for Community Health Agent (CHA)

1. Name of CHA. _____
2. Age of CHA _____
3. Name of the Farmers' Association _____
4. For how long have you been working as CHA _____
 six months
 a year
 over 2 years
5. How many TTBA's are there in this Farmers' Association? _____
6. How many are still actively working? _____
7. If there is attrition of TTBA's, what is the reason for it?
 lack of money (Remuneration)
 shortage of supply
 lack of recognition by the community
 other, specify _____
8. Who is responsible for the supervision of TTBA's?
 Farmers' Association
 CHA
 Health personnel from the clinic
 none
9. How often are they being supervised?
 weekly
 monthly
 every 3 months
 other, specify _____
10. What problems do the TTBA's face ?
 shortage of supplies including drugs
 low pay for service

- no payment for service
- shortage of time to render service
- other, specify _____

11. Whom do the pregnant women prefer for assistance?

- TTBA
- TBA
- other, specify _____

12. To whom do they report their activities

- to the CHA
- to the clinic staff
- to the Farmers' Associations

= 64 =

1 ለሰለጠኑ የልምድ አጥላጆች የተዘጋጀ ቃለ መጠይቅ

- 1. የልምድ አጥላጅ ስም _____
- 2. የገበሬ ማህበረ ስም _____
- 3. የልምድ አጥላጅ ዕድሜ _____
- 4. የጋብቻ ሁኔታ

ያገቡ ያሳገቡ

5. ከልምድ አጥላጅነት ሌላ ምን ሥራ አለዎት ?

ገብርና ንግድ ሌላ/ይለይ/ _____

6. የሚቀለድ ትምህርት በዘመናዊ ዘዴ ያገኙት መቼ ነው?

ከሶስት ወር በፊት

ከ 6 ወር በፊት

ከሁለት ዓመት በፊት

7. በሰለጠና በፊት በቀን ስንት እርጉዞችን ያዋልቶ ነበር?

1-2 3-5 ከአምስት በላይ

8. ከሰለጠና በኋላ በቀን ስንት እርጉዞች ያዋልቶ ነበር?

1-2 3-5 ከአምስት በላይ

9. ሲያዋልቶ ችግር አጋጥመዎት ያውቃሉ?

አጋጥመኛል

አሳጋጠመኝም

= 65 =

10. ከጋጠመ ያት ምን ዓይነት ነበር

- ረዥም ምጥ
- የእንግዲህ ልጅ መዘገየት
- በብዛት ደም መፍሰስ
- ለየት ያለ የጸገሰ አቀጣጫ
- ሌላ/ይለይ/ _____

11. በአሁኑ ወቅት በሕክምና ሆኖ በምክር በቀን ስንት ነፍሰጥሩ ያቸን ይረዳሉ?

- 1-2 3-5 ከአምስት በላይ
- ምንም አሳይም

12. በእርግዘና ወቅት ምን ዓይነት እርዳታ ይሰጣሉ?

- ስለ ተመጣጣኝ ምግብ ምክር
- ስለ ልጅ አያያዝ
- ሌላ/ይለይ/ _____

13. ሴቶች በእርግዘና ሆኖ በወሊድ ጊዜ ወደ ሆስፒታል ወይም ሄልዝ ሴንተር ልከው ያውቃሉ።

- አውቃለሁ አላውቅም

14. ምጥ እንዲፋጠን ሲፈልጉ ምን ዓይነት እርዳታ ይሰጣሉ?

- የአበሻ መደጎነት መስጠት/ የባህል መደጎነት መስጠት/
- ነፍሰጦሯ ወዲህና ወዲያ አያለቸ እንትን ቀባ ቀስ ማድረግ/
- ሌላ /ይለይ/ _____

= 60 =

15. የመጠላጠፍ ሰዓት ሲደርስ እንዴት ሆኖ እንት ተኛ ይፈልጋሉ?

- በጀርባ ወ ተኛ ተኛ እግር ቷን አጥፋ ማለ ያየት
- ቁጢጥ ብሳ ወ ቁጥጥ
- ቀና ብሳ ወ ቁጥጥ
- በጉኔ ወ ተኛ ተኛ
- ሌላ/ይለይ/ _____

16. እትብ ተን ይ ቋጥራሉ?

- እ ቋጥራለሁ አል ቋጥርም

17. እትብ ተን በምን ይ ቀርጣሉ

- በሽንብ ቀ በቢሳ/ የፈሳ፣ ያልፈሳ/
- በምሳጭ / አዲስ፣ አርጌ፣ የፈሳ፣ ያልፈሳ/
- በመ ቀስ / የፈሳ፣ ያልፈሳ/
- ሌላ/ይለይ/ _____

18. እትብ ተ ከ ተ ቀረጠ በኋላ ከሀዳኑ በኩል የቀረውን እትብ ተ የተቀረጠ ውን ጫፍ ይሸፍ ኑታል?

- እሸፍ ነዋለሁ አልሸፍ ነውም

19. ከሸፈ ኑስ በምን ይሸፍ ኑታል?

- በአመድ እበት አፈር ቅቤ
- ሌላ /ይለይ/ _____

20. የእንገዳ ልጅ ቢዘገይ፣ በቶሎ እንዲወጣ ምን ዓይነት እርዳታ ያደርጋሉ?

- ሆድን ማሸት
- ሆኋን ደግፋ ወደ ሳይ ወደታቸ እ ያለቸ እንደተዘሰ ማድረግ
- ወሳድዋን ተሸክቆ ወ ነቀ ነቀ
- ሌላ/ይለይ/ _____

= 67 =

21. ከወለዱ በስን ተኛው ቀን ሌላና ቶቶ ምርመራ ያደርጋላቸዋል?

- ከሰዎች በኋላ
- ከወር በኋላ
- ከአርባ አምስት ቀን በኋላ
- ሌላ /ይለይ/ _____
- አይታዩም

22. የሚቀጠሉ ስራዎችን የሚቀጠሉ ማኑ?

- የቀበሌ ጤና ተጠሪ
- የጤና ጣቢያ ሠራተኛ
- የገበሬ ማህበር
- የሴቶች ማህበር
- ሌላ /ይለይ/ _____
- የለም

23. ተቀጣጣሪዎች በየስንት ጊዜ ለሥራ ወደ እርስዎ ይመጣሉ?

በየሰዎች ተ በየወሩ በየሶስት ወሩ

24. የሠራትን ስራ ስንት በጽሑፍ ለማን ነው የሚያስታውቁ?

- ለቀበሌ ጤና ተጠሪ
- ለጤና ጣቢያ ሠራተኛ
- ለክሊኒክ ሠራተኛ
- ለገበሬ ማህበር
- ለማንም አሳሳቢውም

25. በየስንት ጊዜ የሠራትን ስራ በጽሑፍ ያሳውቃሉ?

- በየሰዎች ተ
- በየወሩ
- በየሶስት ወር
- ሌላ /ይለይ/ _____

= ፎጆ =

26. በቀን የሚሰሩትን ሥራ ይመዘገባሉ?

እመዘገባሉ አልመዘገብም

27. ከመዘገቡ የት ሳይ ነው የሚመዘገቡት? _____

28. የማዋለጃ እቃዎን በየሰዓት ጊዜ ይተካለዎታል?

እንደአስፈላጊ ጊዜ ት

በየወሩ

አልተካም

ሌላ / ይለይ / _____

29. የማዋለጃ እቃ በአለቀ ቀጥር የሚተካልዎት ማነው?

የጤና ጣቢያ

የገበሬ ማህበር

የሴቶች ማህበር

አይተካም

ሌላ / ይለይ / _____

30. ለሚያበረክቱት አገልግሎት ይከፈለዎታል?

ይከፈለኛል

አይከፈለኝም

31. የሠሩበትን ዋጋ ..ሚከፍልዎ ማነው?

የሴቶች ማህበር

የገበሬ ማህበር

ሌላ/ይለይ/ _____

32. ትምህርት ተሃድሶ አገገተው ያውቃሉ?

አውቃለሁ አሳውቅም

33. በየሰዓት ጊዜ ትምህርት ተሃዳሪ ተሰጥቶታል?

በየሰዓት ወረ በየሰዓት ወረ

በየአንዳንድ ዓመት

ሌላ/ይላይ/_____

= 70 =

ከአንድ ዓመት በታች ህፃን ለሳቸው እና ቶቶ የተዘጋጀ ቃለ መጠይቅ

1. የእናት ስም _____
2. የእናት ዕድሜ _____
3. የገብራ ማህበረ ስም _____
4. የመጨረሻ ልጅዎን የወለዱት መቼ ነው _____
5. የመጨረሻ ልጅዎን የወለዱት የት ነው?

ክሊኒክ ቤት

6. ይህንን ልጅ ያዳለድዎት ማን ነው ?

- የሰለጠነ የልምድ አዋላጅ
- ያልሰለጠነ የልምድ አዋላጅ
- ከቤተሰብ አንድ
- የጤና ባለሙያ
- ሌላ /ይላይ/ _____

7. በእርግዝና ወቅት እርዳታ ተገቢ እንክብካቤ አግኝተዋል?

- አግኝቻለሁ
- አላገኝሁም

8. በእርግዝና ወቅት በጤና ያለውን ስራ ላይ ለመመዘን የሚያስፈልጉት ማን ነው?

- የሰለጠነ የልምድ አዋላጅ
- ያልሰለጠነ የልምድ አዋላጅ
- ክሊኒክ ውስጥ የሚሠሩ የጤና ባለሙያዎች
- ሌላ /ይላይ/ _____
- ማንም የለ

9. እንዲያየሰጠው የሚረገግ ለውጥ የሚያደርግ ለምንድን ነው::

- በቶሎ ስለሚተገኝ
- እውቀት ስለሚገኝ
- አዛዥ ስለሆነ
- በሕዝብ ዘንድ የተከበረ ስለሆነ
- ሌላ /ይላይ/ _____

10. በእርግዘና ወቅት ከሚረገግ ለውጥ ምን ዓይነት እንክብካቤ /እርዳታ/ ያገኙ ነበር::

- ሆስፒታል /መሀጠን/ ማሸት
- ስለ ተጠቅመው ምንም ዓይነት ምክር
- ሌላ /ይላይ/ _____

11. ስለወላጅ ቀጥሎ ትምህርት ተሰጥቶታል

- ተሰጥቶታል አልተሰጠም

12. ከተሰጠው እንዲያቀየሩት ማን ነው?

- የሰለጠነ የልምድ ለውጥ
- ያልተሰለጠነ የልምድ ለውጥ
- የክሊኒክ ሠራተኛ
- ሌላ /ይላይ/ _____

13. ስለወላጅ ቀጥሎ ያገኙትን እውቀት ስራ ላይ አውሎ ያውቃሉ?

- አውቃለሁ
- አላውቅም

ለሴቶች ማህበር አመራር ስሜት አባልነት የተዘጋጀ ቃለ መጠይቅ

1. የሴቶች ማህበር አመራር ስሜት አባል ስም _____
2. በማህበሩ ውስጥ ያሳቸው የሥራ ደረጃ _____
3. የገበሬ ማህበሩ ስም _____
4. በማህበሩ ውስጥ ስንት የሰለጠኑ የልምድ አዋጅዎች አሉ _____
5. የልምድ አዋጅዎች በሚሰለጥኑበት ወቅት የሴቶች ማህበር አሳፊ ነት ምን ድነው?

የኪስ ገንዘብ ለተማሪ የልምድ አዋጅ መስጠት

የልምድ አዋጅዎን ቤተሰብ መርዳት

ሌላ/ የለም

ምንም ዓይነት የለን

6. ለሰለጠኑ የልምድ አዋጅዎች የሚከፈላቸው አለ?

አለ

የለም

7. ለሥራቸው ከተከፈላቸው ከፋይ ማነው?

የሴቶች ማህበር

የገበሬ ማህበር

አያንዳንዱ ተገልጋይ

ሌላ /ይለይ/ _____

8. ከተከፈላቸው እንዳት ነው የሚከፈላቸው

በገንዘብ

አቃ/ ምን/ _____

ሌላ /ይለይ/ _____

9. ከሰለጠኑ የሰው ልጅ አዋጅ ጭነት ስራውን የተውሰደው ስራ?

ስራ የሰው

10. ከሰው የሰው ልጅ ስራ ስራ ስራ ነው?

የሰው ልጅ አዋጅ ስራ ስራ ስራ

ስራ ስራ ስራ ስራ

ስራ ስራ ስራ ስራ

ስራ ስራ ስራ ስራ

ስራ / ስራ / _____

III ለሰለጠኖች የልምድ አዋላጅ ተቀጣጣሪ የተዘጋጀ ቃለ መጠይቅ

1. የተቀጣጣሪው ስም _____

2. የተቀጣጣሪው የስራ ደረጃ _____

3. በልምድ አዋላጆች ስልጠና ላይ ይካሄዳሉ?

አካሄዱ አልካሄዱም

4. ለሚከተሉት የገበሬ መሀበር ስንት የልምድ አዋላጆች ሰልጥነዋል?

የሰለጠኑትን መጽ ነው?

የገበሬ መሀበር ስም	የሰለጠኑ አዋላጆች	የሰለጠኑት ጊዜ
ኤዶ ቀንጠላ		
ወዳ ገብርኤል		
ገረባ ፈላ		

5. የሰለጠኑት የልምድ አዋላጆች በአሁኑ ወቅት በሙሉ ስራ ላይ ይገኛሉ?

ይገኛሉ

አይገኙም

6. ከሰለጠኑት ስንት ናቸው ስራቸውን የለቀቀ? _____

7. ከሰለጠኑት የልምድ አዋላጆች ውስጥ ስራቸውን የለቀቀ ካሉ

የለቀቀበት ምክንያት ምንድነው?

ለስራቸው ስለማይከፈላቸው

ለስራቸው ዝቅተኛ ዋጋ ስለሚከፈላቸው

እና ቶች ስለማይቀበሏቸው

ሌላ /ይለይ/ _____

8. የሰለጠኑት የልምድ አዋላጆች ሥራ የሚቀጣጠር /supervise /

ማነው?

የጤና ጣቢያ ሠራተኛ

የቀበሌ የጤና ተጠሪ

የገበሬ ማሀበር

ሌላ /ይለይ/ _____

9. የልምድ አፋጋጆችን የሚቀጣጠር ጤና ጥበቃው ከሆነ በየሰንት ጊዜ ትቆጣጠራላችሁ?

በሰዎችን አንድ ጊዜ

በየወሩ አንድ ጊዜ

በየሶስት ወር አንድ ጊዜ

ሌላ /ይለይ/ _____

10. የልምድ አፋጋጆችን የሥራ ሪፖርት በየሰንት ጊዜ ታገኛላችሁ?

በየሰዎችን ተ

በየወሩ

በየሶስት ወር

ሌላ /ይለይ/ _____

11. ለማዋለድና ለመሰባሰብ የሚያስፈልገውን ቀን ቁጥ ለልምድ አፋጋጆች በየጊዜው የሚሰጣት ማነው?

ጤና ጥበቃ

የሴቶች ማህበር

የገበሬ ማህበር

አድሰጣት

ሌላ/ይለይ/ _____

= 76 =

ለ ቀበሌ ጤና ተጠሪ የተዘጋጀ ቃለ መጠይቅ

1. የቀበሌ ጤና ተጠሪ ስም _____

2. የቀበሌ ጤና ተጠሪ ዕድሜ _____

3. የገበሬ መሀበረ ስም _____

4. በቀበሌ ጤና ተጠሪ ነት ለሰንት ጊዜ አገልግሏል? _____

ስድስት ወር

አንድ ዓመት

ሁለት ዓመት በላይ

5. ከዚህ ገበሬ መሀበር ውስጥ ሰንት የሰለጠኑ የልምድ አዋሳጆች አሉ?

6. ከሰለጠኑ የልምድ አዋሳጆች ውስጥ ስራቸውን የለቀቀ አሉ?

አሉ የሉም

7. ከሌሎች የለቀቀበት ምክንያት ምንድነው?

ለስራቸው ስለማይከፈሉባቸው

የመገልገያ እቃ እጥረት ስላለ

በነፍሰጤር እና ቶች ዘንድ ተቀባይ ነት ስለሌላቸው

ሌላ /ይለይ/ _____

8. የሰለጠኑ የልምድ አዋሳጆችን ስራ የሚቀጣጠር ማነው?

የገበሬ መሀበር

የቀበሌ ጤና ተጠሪ

ክሊኒክ ውስጥ የሚሠሩ ጤና ባለሙያዎች

ማንም የለ

$$= \frac{73}{77} =$$

9. በ የሰንተ ጊዜ የሰራ ቀጥባር ይደረጋል?

- በ የሰንተ ተ
- በ የወረ
- በ የሰንተ ወር አንድ ጊዜ
- ሌላ /ይለይ/ _____

10. የሰለጠኑ የልምድ አዋላጆች ከሰራቸው ላይ ምን ትግር ያጋጥማቸዋል?

- የመገልገያ እቃና የውሳኔት አጥረት
- ለሰራቸው የሚከፈላቸው ዝቅተኛ ጠቃሚነት
- ለሰራቸው አለመከፈላቸው
- የጊዜ አጥረት
- የሚያገለግሉ ሰው ብዛት
- ሌላ /ይለይ/ _____

11. ከሰለጠኑ ካልሰለጠኑ የልምድ አዋላጆች በነፍሰጠሮች የሚመረጡት የትኞቹ ናቸው?

- የሰለጠኑ የልምድ አዋላጆች
- ያልሰለጠኑ የልምድ አዋላጆች

12. የሰለጠኑ የልምድ አዋላጆች የሰራቸውን ውጤት ሪፖርት የሚያደርጉት ለማንኛው?

- ለ ቀበሌ የጤና ተጠሪ
- ለጤና ጣቢያ ሠራተኞች / ለጤና ባለሙያዎች /
- ለገበሬ ማኅበረ ጽ/ቤት

DECLARATION

I, the undersigned declare that this thesis is my original work and has not been presented for a degree in any other University.

Name- Salelesh Abebe

Signature - 

Place and date of submission

Addis Ababa, Oct., 1986.