EFFECTS OF MATERNAL SAFETY EDUCATION ON KNOWLEDGE AND PRACTICE OF MATERNAL HEALTH CARE AMONG TRADITIONAL BIRTH ATTENDANTS IN RIVERINE AREAS OF LAGOS STATE, NIGERIA

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CERTIFICATION

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DEDICATION

This Thesis is dedicated to all sufficient God, the Alpha and Omega, who has proved over and over again that He is more than able in my life.

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ABSTRACT

Traditional birth attendants (TBA) are pseudo midwives with limited skill, saddled with the responsibility to take deliveries within a particular locality. There are evidences that the

patronage of TBA is on the increase, their performances are replete with high incidence of infection transmission and complications, leading to high maternal morbidity and mortality. Previous studies focused largely on TBA's patronage, effectiveness and challenges with less emphasis on educational interventions in riverine area of Epe and Ikorodu to improve on their functionality. This study was carried out to determine the effect of maternal safety education (MSE) on traditional birth attendants functionality (knowledge and practice of maternal healthcare) in Lagos State, Nigeria. The moderating effects of educational status and years of practice were also examined.

Bandura's Social Cognitive Theory was used as the framework, while the pretest-posttest control group quasi experimental design of 2x2x2 factorial matrix was adopted. Two local government areas (Epe and Ikorodu) were randomly selected, while four riverine communities that were not easily accessible were purposively selected from each LGA's. Fifteen TBAs who are unregistered with the TBAs association in riverine communities were purposively selected. The LGA's were randomly assigned to MSE (60) and control (60) groups while treatment lasted nine weeks. Instruments used were instructional guides, knowledge of maternal health (r=0.77), maternal health practice (r=0.95) scales. Data were analysed using descriptive statistics and Analysis of Covariance at 0.05 level of significance.

Participants were females (71.7%) with mean age of 41.4 ± 3.1. There were significant main effects of treatment on knowledge ($F_{(1,107)}$ = 1189.16, partial η^2 = .42) and practice ($F_{(1,107)}$ = 1059.62, partial η^2 = .41). Safety education enhanced participants' knowledge (48.75) and practice (48.75) of maternal healthcare posttest mean scores than those in the control group (knowledge- 22.52; practice- 21.34). There was a significant main effect of years of practice on practice ($F_{(1,107)}$ =7.19, partial η^2 = .06). Participants with longer years of practice were better in knowledge and practice of maternal healthcare (39.17) than those with short years of service (32.78). There was significant interaction effect of treatment and years of working experience on knowledge ($F_{(1,107)}$ = 19.61, partial η^2 = 16). Participants with tertiary education were better in knowledge and practice of maternal health care (44.50) than those with primary education (35.96). There were no significant main effects of educational status as well as interaction effect of treatment and educational status on knowledge and practice of maternal healthcare. The three-way interaction effect of treatment, educational status and years of working experience was also not significant.

Safety education improved knowledge and practice of maternal healthcare among TBAs in the riverine area of Lagos state. Government should ensure that there is continuous retraining on safety for TBAs so as to improve their services.

Keywords: Safety education, Knowledge and practice of maternal health, Traditional Birth Attendant, Riverine areas in Lagos State.

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CHAPTER ONE
INTRODUCTION

Background to the Study

Maternal and child health constitutes vital index of the overall health status of any society. Poor maternal and child health has persistently plagued Nigeria's health ranking and this in turn has serious implications for the Nigerian health care delivery system. The health care framework is all around not confined to a solitary mode or framework. In a few places, the health care framework is absolutely universal while in others it includes the combination of orthodox and traditional ways. In Nigeria, the latter is prevalent and as a matter of fact, this approachis common in Africa. The public sub-system is made up of essentially what is referred to as orthodox medical services provided in government health facilities while the private sub-system refers to orthodox medical services provided in private (including missionary) hospitals, clinics, maternity homes, chemists shops who are all profit oriented. The traditional sub-system refers to medical services provided by herbalists, traditional healers, Traditional Birth Attendants (TBAs), bone-setters, spiritual healers and many others (Imogie, 2014).

Maternal mortality is defined as the death of women during pregnancy or during delivery as a result of any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes(WHO, 2005). According to Maternal Mortality Estimation Inter-Agency Group (MMEIG) (2014), with a maternal mortality of 560 death per 100,000 live births, Nigeria is among the top 10 countries that contribute about 60% of the maternal mortality burden of the world. Although there is a slight improvement from the 630 deaths per 100,000 lives recorded in 2010, a lot needs to be done for Nigeria to drastically reduce maternal mortality. As reported by Marchie and Anyanwu (2009), most reported causes of maternal mortality in developing countries include haemorrhage, infection, prolong labour and eclampsia.

Nigeria is among the nations with the highest maternal and child death rates in the world. According to Inyang, and Anuch, (2015), the nation loses around 2,300 under-five years' old children and 145 women of child bearing age eveyday. As clarified by Idowu, (2013), woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 13. According to Adewemimo, Musa, Olaiyan and

Adegoke (2014) greater part of these deaths are preventable andunfortunately the coverage and quality of healthcare services in Nigeria continues to fail women. Presently less than 20% of health facilities offer emergency obstetric care and only 35% deliveries are attended to by skilled birth attendants.Presently less than 20% of health facilities offer emergency obstetric care and only 35% deliveries are attended to by skilled birth attendants.

Maternal mortality occurs when there are complications during pregnancy or during or after childbirth. Most maternal deaths occur on the day of delivery, which is why having a skilled birth attendant present at the birth is very important. Approximately 80 per cent of all maternal deaths are from the following major complications: Severe bleeding or hemorrhage (during or after childbirth), Infections such as sepsis (mostly after childbirth), High blood pressure or hypertension (during pregnancy) and unsafe abortion.

The leading cause of death and disability among women of reproductive age (ages 15–49) in the developing world continues to be from complications during pregnancy and childbirth. Nearly 300,000 women die of complications during pregnancy or childbirth every year, and 99 percent of these deaths occur in the developing world. Maternal and infant mortality rates in numerous developing countries are persistently high. Addressing these became a global priority with the introduction of the Millennium Development Goals (WHO, 2005). The problem is multi-faceted and solutions lie in various domains, including the provision of better nutrition, improved health services, improved training for TBA, innovative technologies for infant care, among others (WHO, 2010).

To improve maternal health, the Millennium Development Goals 4 and 5 (MDG 4 and 5) set out the objective of decreasing maternal mortality by 75% and accomplishing all-inclusive access to maternal health by 2015. Be that as it may, advances in decreasing mortality in developing nations and giving appropriate administrations havenot been able to meet the objective. A noteworthy test is pregnant ladies' absence of access to quality care before, amid and after childbirth. In developing countries like Nigeria, pregnancy and child birth complications are major causes of maternal and child death and these deaths are attributed to the fact that most pregnant mothers do not get the appropriate care they need as a result of certain barriers to the health care facilities.

The programme of activity of the International Conference on Population and Development (ICPD), the Millennium Development Goals (MDGs) and Maputo Declaration and Action plan call for purposeful activity to lessen maternal mortality, advance maternal

health and enable ladies with knowledge so they are more valuable to themselves, their families and networks (World Health Organisation, United Nations Fund for Population Activities, United Nations International Children's Emergency Fund, 2004). To move towards this objective, satisfactory knowledge of maternal health is an essential. It is outstanding that advanced education has emphatically corresponded with enhanced maternal health knowledge (MDGs, 2000).

Accessible information by the World Health Organization (2005) demonstrated that an expected 289,000 worldwide maternal passing were recorded in 2013. The report additionally demonstrated that Nigeria is among top five nations with most elevated rates of maternal mortality with around 40,000 pregnant women death in the nation in 2013. Notwithstanding the efforts of the State Governments to give quality health programs the foundation of Mother and Child Hospitals, safe parenthood, free medicinal administrations for pregnant women and other excellent frameworks, some pregnant ladies still disparage traditional birth attendants in Nigeria.

Since the adoption of the primary health care approach in Nigeria in 1979, the three tiers of government (Federal, State and Local Government levels) have accepted the idea of the need to integrate TBAs into PHC system and have consequently initiated TBAs training programmes (OfiliandOkojie, 2005). The authors went further that TBAs presently take delivery of the majority of women in Nigeria as in other developing countries. It is estimated that between 60 and 80% of all deliveries in the developing countries occur outside modern health care facilities, with a significant proportion of this attended to by TBAs. Reportsreveal that a considerable number of pregnantwomen in the least income countries (LICs) dieunattended to by skilled service givers and the deaths normallyoccur in many forms due to various causes. Some of the death occur while the mothers concernedare on their way toward seeking skilled pregnant care atformal health care facilities or while delivering at homein the absence of skilled attendants (Armstrong, Schellenberg, Mushi, Obrist, Mshinda,Tanner, and Schellenberg, 2007; Smith, 2008).

World Health Organisation (2010), traditional birth orderly is characterized as a man who helps the mother amid labour and at first procured her aptitudes by conveying babies herself or through apprenticeship to other conventional birth chaperons. However, in the challenge of this paper and what is possible in Nigeria, a traditional birth attendants is a (man or woman) who helps the mother or fills in as an understudy to different TBAs, amid conveyance, and more likely than not procured his or her knowledge and experience in

conveyance and is fit for conveying babies without help.They live in the community in which they practice and they are respected in that community. They operate mainly in a relatively restricted zones always limited to their own community and sometimes those close to them. Their roles include everything connected with the conduct of childbirth and this is where they hold most power and authority. Many of their beliefs and practices pertaining to the reproductive cycle are dependent upon religion or mystic sanctions. They are reinforced by rituals that are performed with traditional ceremonies which are intended to maintain the balance between the absence of ill health and state of ill health.

Traditional Birth Attendants give the bigger piece of basic maternity care in many developing countries, and may work inside specific systems in developed countries. They give basic health care supportand guide in the midst of and after prenatal period and giving birth, develop basically regarding experience and learning got casually through the customs and practices of the systems where they began (World Health Organisation, 2010). TBAs may not get formal education and getting ready in health care plan, and there are no specific professional prerequisites, for instance, affirmation or licensure. They often learn their trade through apprenticeship or self-prepared.

In most cases, women in labour are constrained to be dealt with by different people, for instance, their in-laws, neighbours, other elderly women or by Traditional Birth Attendants (TBAs), aside the people who fail miserably at health office in the wake of fail to get brisk thought from talented authorities (Smith, 2008, Izugbara, Eze and Fotso, 2009). TBAs have been described by the World Health Organization (WHO) (2010) Expert Committee as individuals who help mothers in the midst of childbirth, and these women have at first picked up a couple of aptitudes by taking an intrigue themselves in helping mothers to pass on babies or through apprenticeship to various TBAs (Smith, 2008). Protectors have fought that if TBAs had the best possible capacities required, they could pass on fitting care to save presences of various women livings in hard to accomplish settings. Such proponents or advocates maintain that sometimes pregnant women attend Antenatal Care (ANC) clinics late sometimes because of their negligence, but sometimes due to such factors as unaffordable travel costs.

As indicated by Kruske and Barclay (2004), roughly 50% of all births in developing nations are done by Traditional Birth Attendants (TBAs) and upwards of 95% of ladies are attended to by TBAs. Universally, TBAs aid 60– 80% all things considered

and considerably more in the provincial territories of creating nations. Tendency towards home births directed by TBAs is related with social norms and religious convictions and also cost and availability of the administrations. Numerous nations, including Nigeria, often have a lack of prepared restorative professionals and maternal health care is in this way generally given by TBAs (WHO, 1999; Bij de Vaate, Coleman, Manneh, and Walraven, 2002, Goldman and Glei, 2003).

Maternal Health Care alludes to care given to ladies amid pregnancy, labour and baby blues periods to guarantee great health results of the lady and child (World Health Organization, 2009); they contain Antenatal Care (ANC), work and conveyance (maternity) care and postnatal care. The universal rules for usage of maternal health care stipulate that; use of antenatal care ought to be at least four (4) visits and the primary visit ought to be finished amid initial three months of pregnancy, maternity care ought to be given by a talented chaperon and postnatal care ought to be done to both the lady and child quickly after conveyance and inside about fourteen days after birth and, all through 42 days after conveyance (WHO, 2009).

Deficient access to and under-use of value maternal health care administrations could be real explanations behind weakness of the ladies in the creating nations (Carroli, Rooney and Villar, 2001; de Sharrat and Abouzahr, 2003; Campbell and Graham, 2006; Bryce, Daelmans, Dwivedi, Faureau, Lawn and Masonet, 2008). Along these lines, the danger of maternal demise might be extraordinarily decreased if the ladies use talented participation for maternal health care administrations. The primary goals of bet natal care are to convey viable and fitting screening, preventive and treatment mediations. Viable utilization of antenatal care adds to better maternal health results, more secure birth; since the individuals who go to antenatal care ideally will probably look for talented care at birth; antenatal care is an open door for helping the ladies to make birth and crisis readiness plan.

Safety education is an inherent part of preventive and community health. It has the potential to cause behavioural change that will ultimately maintain and promote good health among individual and families in the community. Mothers can as well be encouraged through safety education to discourage their attitudes and behaviours that may expose them to diseases and death. Moronkola and Okanlawon (2003) stated that maternal and child mortality can be prevented and reduced through effective health and safety education. They stated further that the significant role of health and safety education in the

implementation of health interventions aimed at reducing mortality among members of the community especially women cannot be over-emphasized. Health education is the forerunner of all interventional programme designed to improve the health and wellbeing of mothers thereby reducing mortality among them. Safety education is the sum total of all experiences that helps in developing consciousness, forming attitude and understanding individual responsibility in taking precautions against engaging in acts that could cause infection or harm to a woman during pregnancy and child delivery.

Safety education is the process of helping an individual to acquire the relevant information, right attitude and practice of safety consciousness in the course of performing one's duty or profession. It is an important aspect of human life that cuts across all phases of life. It involves education about the development of individual responsibility in personal, community and professional programmes for safety, accident prevention and reduction of infections. Safety education is a well-designed educational programme to promote knowledge, attitude, behaviour and skills of people about safety in school, workplace, home and different settings in the community. Safety education, if well designed and implemented will prevent or drastically reduce prevalence of accident at different setting. Udoh and Haastrup (2006) also noted that safety education is overt and covert application of health knowledge, attitudes and skills for safe and effective living. Safety education consists of expecting accidents, reducing their probability and providing means to reduce their consequences.

Safety benchmarks which manage the occupation are either missing or not clung to in many creating nations including Nigeria. General blood and body liquid precautionary measures envelops an extensive variety of steps taken amid standard work day by health care labourers and must be clung to entirely in other to ensure self, patient and colleagues from contamination. All health care labourers ought to routinely take after these safeguards whenever there is the likelihood of contacting or being sprinkled with any individual's blood or body liquids on their skin. Routine instructional courses are vital in all health offices to enhance the health labourers knowledge of the diverse parts of all-inclusive insurances keeping in mind the end goal to guarantee safe practice and adherence to widespread safeguard rules. Health care professionals should be refreshed on the standards of widespread fundamental precautionary measures as it has been demonstrated that there are lacks in the knowledge and uses of the practice of the all-inclusive insurances (Nduka, Aguwa and Nduka, 2012).

In sub-Saharan African nations numerous child bearing ladies are as yet being taken care of by TBAs and relatives at conveyances (Jamison, Shahid-Salles, Jamison, Lawn, and Zupan, 2006; Crowe, Utley, Costello, and Pagel, 2012). Surviving writing demonstrate that births without gifted work force and without access to life-sparing medications are the commonest practice for many moms in the poorest nations where death rates and horribleness of the moms are the most elevated (Crowe, et al., 2012, WHO, 2012). Ongoing measurements demonstrate that over the world 287,000 ladies bite the dust in pregnancy and childbirth consistently (WHO, 2012). This is interpreted as one mother biting the dust like clockwork and 800 ladies passing on every day.

The utilization of incompetent staff (counting TBAs) is contended to be among the explanations behind the high maternal and baby death rate in sub-Saharan Africa. This has been impacted by a worldwide approach move from TBA-centered mediation to gifted participation and institutional birthing. For over three decades, the WHO and different organizations of the United Nations advanced preparing of TBAs as a worldwide general health technique to decrease maternal mortality. In any case, absence of confirmation to exhibit that prepared TBAs can decrease maternal mortality prompted debate over their preparation in connection to safe parenthood, and an approach move to talented birth participation was proposed (WHO, 2004). In spite of the extension of mediations, including development of more health offices near the network, expanded utilization of antenatal center, and expanded inclusion of vaccination (Choguya, 2014), the issue of TBA administered births has endured. It has been recommended that as opposed to regarding them as hellish cursedness in maternal health care, grasping the parts of TBAs and working with them could deliver positive maternal health results.

According to Ayede (2012) TBAs are usually local women with little formal education. Their little formal education is additionally delineated as not very many of them had more than grade school (8%) education and a huge extent (20%) did not have any formal education. This pattern is comparable crosswise over nations where the utilization of TBA is normal. This is for the most part thought to be identified with the level of the general educational status of the natives and the level of destitution (Piper, 1997; Umar, Olumide and Bawa, 2003; Sibley, Sipe, Brown, Diallo, McNatt and Habarta, 2007). The way that this ability is generally passed from an experienced TBA to another is reflected in the wellsprings of their preparation before beginning to practice as TBAs. As of now in Nigeria, TBAs are viewed as untalented and are not perceived as a component of the formal health division.

The issue of inadequacy in logical knowledge and abilities of maternity care has thrown uncertainty over the need and nonstop presence of TBAs even in country zones where they are more unmistakable because of the reality these zones are underserved in conventional health offices. Inyang and Anucha (2015) noted that TBAs may not get formal education and preparing in health care arrangement, and there are no particular professional imperatives, for example, accreditation or authorizing. In like manner, because of absence of education with some TBAs, the manner in which they take care of conveyance is hazardous for ladies and their infants, prompting weakness results and even passing. Obsolete and unseemly obstetrical practices among TBAs were additionally announced by Bucher et al., (2016) in a study of self-detailed obstetrical practices among TBAs. These negative practices, notwithstanding, past specialists anyway reasoned that since TBAs have had incredible effect in the country networks, their parts cannot be abrogated or neglected accordingly powerful measures to prepare and enhance their abilities and characterize their parts is vital (Balogun and Odeyemi, 2010; Inyang and Anucha, 2015; Bucher,Konana, Liechty, Garces, Gisore, Marete, Tenge, Shipala, Wright and Esamai, 2016). A synopsis of proposals on TBAs parts in maternal health care is that there ought to be mix and joint effort with the health division to manage and screen their exercises. This joining and checking would help in upgrading their exercises with the general point of decreasing unsafe practices and advancing maternal and child health care.

Another basic issue in regards to knowledge and practice of TBAs that have genuine ramifications for maternal and youngster care is mother-child transmission of HIV. Accessible proof demonstrates that the weight of MTCT transmission of HIV is most elevated in sub-Saharan Africa where larger part of the assessed 350,000 newborn children who gained HIV disease from their moms' abide (Ogbolu, Iwu, Zhu and Johnson, 2013). Nigeria represents around 30% of the general worldwide weight of MTCT (Mother to child transmission) with in excess of 210,000 children living with HIV and an expected 56,681 yearly HIV positive births (UNAIDS in Abiodun,Sotunsa, Olu-Abiodun, Ani, Taiwo and Taiwo, 2015). The Nigerian health framework depends on essential health care (PHC) show. Be that as it may, PMTCT (Prevention of mother to child transmission) benefits in Nigeria are still generally aggregated at tertiary health offices, with not as much as alluring coordinated effort with PHC focuses or network bolster administrations. Traditional birth attendants participate in the utilization of unhygienic surfaces, unclean kitchen gear for rope cutting, prompting higher danger of disease for both mother and child (Balogun and Odeyemi, 2010; Prata,

Ejembi, Fraser, Shittu, and Minkler, 2012). Balogun et al., (2015) along these lines noted that it is consequently basic for TBAs and comparable unit of health care suppliers in asset constrained settings to be knowledgeable and can send prove based care practices in PMTCT if the UNAIDS objective of an AIDS free age will be accomplished.

Due to the lack of education in some TBAs, the way many attended the delivery is risky for women and their babies, leading to poor health outcomes and even death.. In their investigation, Mfrekemfon and Okere, (2015) found that traditional birth attendants have awesome effect in the rustic network, they are near the general population and the provincial ladies accept and have trust on them so much that they cannot be effectively nullified in the network. They inferred that, apportions ought to be brought to enhance their abilities through health teaching them and sorting out courses. Balogun and Odeyemi, (2010) additionally found that the educational status of TBAs is one of the most grounded factors influencing the conveyance of their administration. They inferred that if TBAs could get fundamental education, it will enhance their support of an incredible measure. Inyang and Anucha, (2015) found that TBAs with higher years of experience perform better in conveyance of their administration than those with bring down years of experience. They accordingly presumed that there is a huge distinction in conveyance of administration among TBAs in view of years of experience.

Itisagainstthisbackground thattrainingoftraditionalbirth attendants has been promoted on the basis that they are available, alreadyengagedinmaternitycare andappeartopresentalowercostalternative.This investigation is to be completed in Lagos State which lies in the South-western piece of Nigeria. The rate of populace development is around 600,000 for every annum with a populace thickness of around 4,193 people for each sq. km. With quick populace development, open and private assets including healthcare offices have been extended. In the developed territories of Metropolitan Lagos, the normal thickness is more than 20,000 people for every square km (Lagos populace, 2010). Lagos State has twenty (20) Local government Areas and thirty-seven (37) Area Development Councils conveying the aggregate to fifty-seven (57).

Statement of the Problem

Safe Delivery practice is a vital pointer of birth results for both mother and additionally child in conceptive health. However, there is insufficient distributed writing concerning the impacts of safety education on knowledge and conveyance practices in

Nigeria. Study carried out in the Northern part of Nigeria uncovered that absence of knowledge with respect to TBAs, low financial status; maternal lack of education all have unfavourable impact on birth outcomes (Idowu, 2013). Passing by the mid-point appraisal of the thousand year's improvement objectives in Nigeria introduced by Nigerian Institute of Social and Economic Research (2008), it could be seen that as opposed to moving towards the accomplishment of the Millennium Development Goal of decreasing maternal mortality by 75% by 2015, the pattern shows that the circumstance is deteriorating. Constantly 2007, passing by the objective of 2015, Nigeria ought to have lessened maternal mortality to 440 for every 100,000 live births. However, this is yet to be accomplished even as at 2016. The issues of accomplishing health for all in Lagos are basic highlights of all urbanizing social orders in Nigeria. Health care offices and administrations are moved in Lagos, yet this has not interpreted on the prosperity of the occupants particularly in the zone of maternal health, as maternal death rate in Lagos State was put at 650 for every 100,000 live births (Idowu, 2013). Poor use of standard health focus has been bounteously announced in creating nations including Nigeria. The utilization of the administrations given by Traditional Birth Attendants have been refered to as option in contrast to the utilization of accessible health administrations for maternal purposes (Kruske and Barclay, 2004).

Preliminary investigation and experience of the researcher while working as mid-wife in the area of study revealed that a number of pregnant women died during delivery with TBAs and all attempt to discourage pregnant women from patronizing TBA proved abortive. Also, the concentration of primary, secondary and tertiary healthcare facilities in the urban areas of the state, leaving these riverine area no other choice than to patronize TBAs who are not very knowledgeable about some cogent procedures involved in child delivery necessitate this study.

The knowledge and practice of traditional birth attendants should be tended to by approach creators and organizers. There is the need to try through research in view of a firm comprehension of what TBAs can and cannot do. It is additionally vital to know the qualities and restrictions in TBAs practice particularly as they influence maternal death rate. The knowledge and practice of Traditional Birth Attendants (TBAs) wind up pertinent particularly in territories where general health offices are either non-existent or inadequate; this is the thing that acquires in Lagos State. A pre-think about study

completed demonstrated poor maternal health knowledge and hurtful practices among TBAs in Lagos.

Delivery includes presentation to blood and body liquids thus traditional birth attendants ought to have the capacity to secure moms, children and themselves. Knowing and seeing all issues encompassing HIV/AIDS, methods of transmission, signs and side effects and contamination control can help health specialists and all traditional birth attendants to ensure themselves as well as other people. It wound up important that Traditional Birth Attendants are furnished with the applicable knowledge of safety insurances in maternal health through formal preparing in light of the high rate of support they appreciate from customers.

One intercession that has been received in numerous parts of the world is the preparation of traditional birth Attendants (TBAs) particularly where talented professional attendants are rare. It has been accounted for that seventy five percent of maternal passings in creating nations are owing to coordinate obstetric causes. In any case, essential health care benefits in Lagos are as yet aggregated at tertiary level, with little coordinated effort with PHC focuses or network bolster administrations. Upwards of 60% of children conceived in Nigeria are conveyed by TBAs who talk the nearby dialects, permit traditional birthing practices, and often have the trust and regard of the network (Balogun and Odeyemi, 2010). Both provincial and urban ladies may look for care with TBAs on the grounds that they share the same social codes and have comparative financial qualities (Ejikeme, Umeora and Obuna, 2007). In the light of the above, it is essential that examination on impact of safety education on knowledge and practice of maternal health care among Traditional Birth Attendants in Lagos is directed as a stage to diminishing maternal grimness and mortality in the State.

Objectives of the study

The main objective of this study was to determine the effect of safety education on knowledge and practices of maternal health care among TBAs in Lagos State, Nigeria.

Specific Objectives of the Study

The study achieved the following specific objectives:

1. established the main effect of safety education on knowledge and practices of maternal health care among TBAs in Lagos State

2. examined the main effect of educational background on knowledge and practice of maternal health care among TBAs in Lagos State
3. investigated the main effect of years of working experience on knowledge and practice of maternal health care among TBAs in Lagos State
4. determined the interaction effect of treatment and educational background on knowledge and practice of maternal health care among TBAs in Lagos State
5. established the interaction effect of treatment and years of working experience on knowledge and practice of maternal health care among TBAs in Lagos State
6. investigated the interaction effect of treatment and years of working experience on knowledge and practice of maternal health care among TBAs in Lagos State
7. investigated the interaction effect of treatment, educational background and years of working experience on knowledge and practice of maternal health care among TBAs in Lagos State

Research Questions

The following research questions were answered:

1. What is the level of knowledge of safety education on maternal healthcare?
2. Is the practice of maternal care by TBA in line with maternal safety procedure?
3. Does the educational background of TBA influence the maternal healthcare practice?
4. Will years of working experience interfere with the knowledge and practice of maternal healthcare?

Hypotheses

The following hypotheses were tested at 0.05 level of significance:

1. There will be no significant main effect of treatment on:
   a. Knowledge
   b. Practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria
2. There will be no significant main effect of educational background on:
   a. Knowledge
   b. Practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria
3. There will be no significant main effect of years of working experience on:

a. Knowledge
b. Practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria

4. There will be no significant interaction effect of treatment and educational background on:
   a. Knowledge
   b. Practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria
5. There will be no significant interaction effect of treatment and years of working experience on:
   a. Knowledge
   b. Practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria
6. There will be no significant interaction effect of educational background and years of working experience on:
   a. Knowledge
   b. Practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria
7. There will be no significant interaction effect of treatment, educational background and years of working experience on:
   a. Knowledge
   b. Practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria

Delimitation of the Study

This study was delimited to the following:

1. Pretest- posttest control group quasi experimental design
2. All TBAs in Lagos State, Nigeria as population
3. One hundred and twenty (120) Traditional Birth Attendants as participants
4. Independent variable of Maternal Safety Education
5. Dependent variables of knowledge and practice of maternal health care

6. Self-developed structured questionnaire, Safety Education Training Package and Disease education (Lassa fever; causes, prevalence, mode of transmission, prevention and control) Package as placebo
7. Nine weeks of training programme
8. Descriptive statistics of frequency counts, percentages, pie charts and bar charts will be used to analyse the demographic data and research questions while inferential statistics of Analysis of Covariance (ANCOVA) was used to test hypotheses at 0.05 level of significance
9. Ten (10) trained research assistants

Limitations of the Study

Inability of some of the participants to complete the programme was the major limitation of this study due to work demand. Another limitation of this study was that the study lack evidence for continuation of behaviour learnt by the participants. Also, since the participants were not camped, the researcher was not able to control some extraneous variables such as watching films and internet use (for information on maternal care) which may have effect on the result. Also, the inclusion of formal health workers as research assistants in data collection could not guarantee a complete avoidance of bias. The responses are based on self-report, any of the participants might be tempted to alter their responses in an effort to please their interviewee or overstate the impact of the intervention to reflect positively on the programme. However, the researcher encouraged and educated the participants on the importance of being sincere by providing objective information that will assist in designing effective maternal health programme that may enhance community-based healthcare delivery.

Significance of the study

The study provided empirical data on effect of safety education on maternal health care. It also provided empirical data on the effect of years of working experience on knowledge and practice on maternal health. The findings of this study might be of help in reducing maternal mortality and morbidity. This is achievable because since the Traditional Birth Attendants are closer to the people at the community level, they are better poised to render maternal health care. Therefore, if they are equipped with requisite

safety knowledge and skills, it may help in the reduction of maternal mortality and morbidity that is presently alarming in Nigeria.

The findings of this study might reinforce the need to foster interaction between TBAs and orthodox maternal health workers/government agencies especially Ministry of Health through broader education programmes. The findings of this study may also serve as a resource material that may be utilized to train other health care professionals involved in maternal health care apart from Traditional Birth Attendants. This study may add to existing body of knowledge and other researches on care and management of maternal health for reducing maternal mortality and morbidity.

Moreover, governmental agencies and international developmental partners could also find the programme useful in their quest to reducing maternal mortality and morbidity in sub-Saharan Africa. The findings of the study might also strengthen scholarship and deepen research knowledge as well as serve as an important step to bridging research and practice in Health Education. The study and its outcome might trigger future research interests and thereby contribute immensely to sustained developmental efforts using research as a tool.

Operational Definition of Terms

Knowledge: ability of Traditional Birth Attendants to respond to emergency through proper management of client's condition while observing the rules of hygiene and putting on safety kits

Maternal Health Care: care giving to women during pregnancy, child birth and postpartum periods to ensure the good health outcome of the women and their babies

Maternal Mortality: the destruction of a woman while pregnant or inside 42 days of the period of ending of pregnancy, free of the range and site of the pregnancy, from any reason related to or chafed by the pregnancy or its organization yet not from spontaneous and inadvertent causes.

Risk factors: these are variables that are unfair and inimical to maternal health

Safety Education: the act of developing consciousness, forming attitude and understanding individual responsibility in taking precautions against engaging in acts that could cause infection or harm to a woman during child delivery.

Traditional Birth Attendant (TBAs): a person who assists mothers during child birth and initially acquired his/her skills by delivering babies or through apprenticeship to other TBAs.

CHAPTER TWO

REVIEW OF LITERATURE

Literature relevant to the study shall be discussed under the following sub-headings:

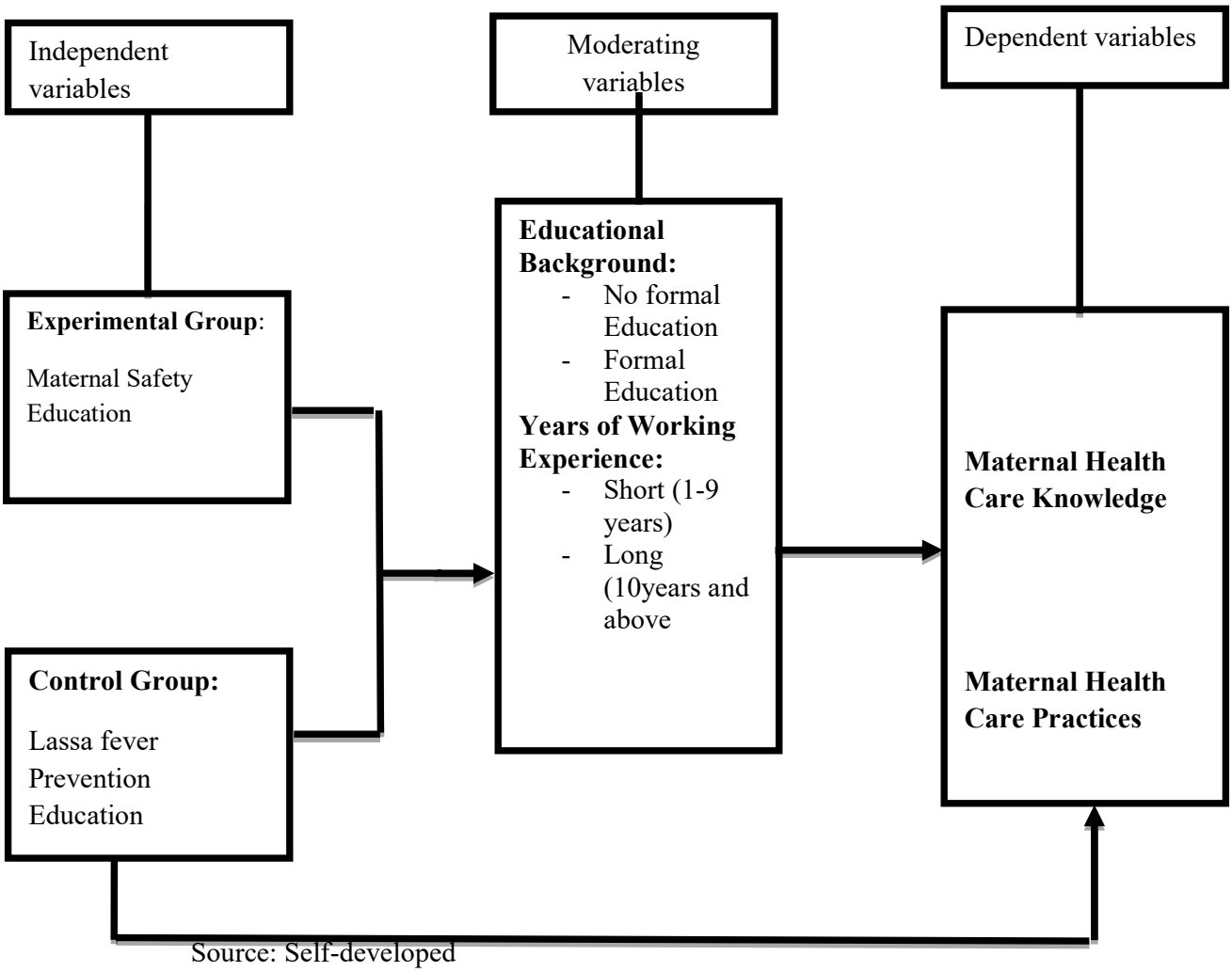
1. Conceptual framework for the study
2. Theoretical framework for the study (Socio-Cognitive Theory)
3. Theoretical Review
   - (a) Concept of safety education
   - (b) Global Overview of maternal health care
   - (c) Maternal health care in Nigeria
   - (d) The Millennium Development Goals (MDGs) and maternal health
   - (e) Traditional Birth Attendants and the Millennium Development Goals
   - (f) Maternal health care and traditional birth attendants' training
   - (i) Rationale for training traditional birth attendants
   - (ii) Theoretical considerations in measuring outcomes of training TBAs
   - (iii) Evidence of maternal mortality reduction from programmes of TBA training
   - (iv) Additional benefits from TBA training
   - (g) Management of bleeding in pregnancy
   - (h) Observing aseptic techniques during delivery
   - (i) Personal and environmental hygiene among TBAs
   - (j) Management of delivery environment and use of delivery kits among TBAs
   - (k) Traditional Birth Attendants Practice in Nigeria and Lagos State
   - (l) Factors contributing to utilization of TBAs services globally, Africa and Nigeria

4. Empirical Review

   a. Knowledge and practice maternal health practice of TBAs
   b. Awareness and Knowledge of TBAs on HIV/AIDS prevention in pregnancy
   c. Safety education and knowledge of maternal health care among TBAs
   d. Safety education and practice of maternal health care among TBAs
   e. Effect of years of experience on knowledge and practice of maternal health care of TBAs
   f. Effect of educational background on knowledge and practice of maternal health care of TBAs

5. Appraisal of reviewed literature

Conceptual framework for the study



Source: Self-developed

The model above represents the pathway of the variables under investigation in this study. The aim of this study is to examine the effect of the treatment on the problem variables which are maternal health care knowledge and maternal health practices of TBAs in Lagos State. The extent to which this effect will be mediated or moderated by the educational background and years of experience of the TBAs will also be studied. It is expected that the effect of the treatment might be affected by the educational background of the TBAs just as years of experience might also moderate the effect of the treatment on the problem variables.

Theoretical framework (Social Cognitive Theory)

A few health advancement models created by researchers from various fields present factors influencing health direct and give a structure to understanding health penchants and kept up lead change. Social cognitive theory sets that human direct is dynamic and affected by the cooperation of internal and outside forces and individuals' relationship with their condition. It particularly emphasizes the overall effect of clear self-efficacy, which impacts health inclinations direct by influencing target setting, wants concerning results, and impression of socio-structural support and obstacles to health propelling practices (Bandura, 2004).

Social cognitive theory grasps a genetic perspective to human change alteration and change. The theory perceives among three techniques for office, singular office practiced autonomously, go-between office in which people secure needed outcomes by influencing others to catch up for their purpose, and total association in which people act perfectly healthy their future. In near and dear office practiced only, people assist their effect to hold up under direct themselves and their condition in managing their customary everyday presences. In various circles of life people don't have facilitate order over the social conditions and instructional practices that impact their normal every day presences. Under these conditions they search for their thriving and regarded results through the action of mediator association. It is socially interceded strategy for association, people attempt to get the people who approach resources, fitness or who utilize effect and ability to act at their order to stay the outcomes they need.

Social Cognitive Theory (SCT) is a psychological framework/model of direct change made by Albert Bandura in 1977. It is a theory that highlights that erudition happens in a communal setting and that a considerable measure of what is gotten is from side to side discernment. SCT places on a twosome of fundamental doubts about erudition and lead, one of which is triadic correspondence or the view that individual, social and common parts impacts each other in a bi-directional, integral way. This relies upon the manner in which that a man' on-going working is a consequence of a nonstop association amongst thought, lead and sensible factors. In a general sense, SCT set that learning is formed by factors inside nature, for instance, strongholds experienced by individuals and others and furthermore understudies' own specific thought, self-conviction and their comprehension of what is learnt.

A second doubt of SCT as demonstrated by University of Twente (2013) refering to Bandura, is that people have ability to affect their own specific direct and the earth in a think and goal facilitated ways. This relies upon the dispute that people can through reasoning ahead, self-

reflection and self-managerial process, apply huge effect over their own specific outcomes and the earth simply more thoroughly.

A third assumption inside the SCT is that learning can occur without a fast change in direct or that learning and presentation of what is learnt are specific methodology. This relies upon the acknowledgment that learning incorporates not just the anchoring of new lead yet also of knowledge, cognitive aptitudes, thoughts, exceptional benchmarks, values and other cognitive forms and that understudies can learn anyway not demonstrate that learning until stirred to do all things considered.

Denler, Wolters and Benzon (2009) included five of the middle thoughts inside SCT. These are; observational getting the hang of/illustrating, result want, saw self-feasibility, target setting and discretion. Regarding observational learning, it is put in SCT that people learn by review the lead of others in the earth and the result of such direct process is in like manner depicted as vicarious learning or showing. Inside the SCT, showing can consolidate live presentation of aptitudes or lead by an instructor or distinctive understudies or verbal or created depictions or diverse less quick kind of execution. According to SCT, observational learning of direct or inclination is liable to four between related methods including thought, upkeep, creation and motivation.

Concerning result wants, it is put in SCT that individual' feeling about results of lead often shapes the decision such individual make about the direct. Exactly when the outcomes expected are regarded, the repeat of the lead is extended while direct related with loathsome or insignificant outcomes are avoided. Seen self-practicality is another thought inside SCT. Denler et al (2009) described self-sufficiency as individuals' feeling about whether they can achieve a given level of advancement at a particular endeavor. According to SCT, understudies with more noteworthy self-ampleness are increasingly sure about their abilities to be powerful when stood out from their mates with low self-feasibility. Self-ampleness is seen in SCT as individual's own one of a kind outcome past execution, the recognition and verbal impact of others in the earth and also individual's on-going physiological state.

Target setting is a thought inside SCT which reflect cognitive depictions of anticipated, needed or supported outcomes. Refering to Bandura, Denley et'al (2009) stated that destinations speak to the office see inside SCT that people not simply learn anyway use thinking ahead to envision the future, perceive needed outcomes and make designs of movement. Targets are set in light of the outcome the understudy foresee from partaking in a particular direct and the sureness he or she has in completing the lead successfully. Goals

give goals that understudies are endeavoring to achieve and benchmarks against which to condemn progress consequently, they are essential pre-basic for restraint.

Restraint, as shown by Denler et'al (2009), is another prominent thought inside SCT that encapsulates the shrouded assumption as for association and the effect of individual factors on direct and condition. Discretion is liable to various strategies inside SCT, including target setting and self-feasibility. It is set in SCT that with the exception of if understudies have destinations and feel sufficient about reaching them, they may not start the methodology required for self-course.

This study carried out the effect of safety education on knowledge and practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria with the aim of reducing maternal and infant morbidity and mortality. Based on the SCT that individual learn through modeling, the researcher together with his assistants served as models to teach the participants ways of ensuring adequate and proper delivery process using safety education. During the intervention, the importance of following proper delivery process to healthy growth and development of both mother and child as well as the detrimental effect of not following these proper processes were emphasized. This was expected to create in the participants, the knowledge of the perceived cost, thus, producing in the participants attitude that favours following proper delivery process. Thus during this study, participants were taught the extent of damages in term of health (perceived severity) that not following proper delivery process could cause.

With regards to goal setting, the models helped the participants to develop an action plan towards following rules of safety when taking deliveries. This was expected to result in self-regulation. Also during the course of the intervention, the participants assessed themselves based on the written goals to see the extent of progress.

Comprehensive Health Education Model

The focus of this study is to impart on traditional birth attendants the skills required for ensuring safety and taking necessary precautions in attending maternal care in order to reduce maternal mortality and morbidity. Furthermore, this study aimed at equipping TBAs with knowledge and safety skills that will bring about change attitude and practice of maternal care in Lagos. The conceptual framework for this study is the Comprehensive Health Education Model developed by Sullivan (1973). An important aspect of health education and health teaching is knowledge of what makes and keeps people healthy and

why they react the way they do to health issues. People stay healthy or become ill as a result of their action or behaviour. Considerable research has been directed towards factors influencing individual's adoption of preventive health practices and compliance with safety measures. Manual of Primary Health Care (1988) identified four factors influencing people's behaviour; thoughts and feelings, knowledge, beliefs and attitudes. These factors are guided by theories and models for justification. For this study two theoretical models are inter-married.

The model consists of six steps, namely:

Step1. Determining the roles of those involved and establishing necessary relationships: The TBAs are the individuals affected, nurse clinicians, nurse educators and other medical personnel that would serve as instructors and research assistants are the individuals who possess necessary skills to help deal with the problem. The roles are that of impacting safety education knowledge that will assist the TBAs in adopting universal safety precautions for maternal care.

Step 2. Setting appropriate goals for the programme: At the end of the training, the participants will be able to:

Have in-depth knowledge of safety education and universal safety precautions (Awareness and Knowledge of HIV/AIDS transmission and prevention including other infections, health education for pregnant women, perceiving risk signs and alluding ladies with inconveniences to offices where care is accessible, management of bleeding occurring during pregnancy, observing aseptic techniques, discouraging harmful practices, maintaining personal and environmental hygiene and use of delivery kits.

Step 3. Defining the problem: Inadequate knowledge about strategies for attending maternal care Attitude towards pregnant women Practice of universal safety precautionary measures TBAs practices towards attending maternal care

Step 4.Identifying the most appropriate plan for the programme: The pretest-posttest experimental research design will be adopted for this study. There will be two groups, experimental group will be given health education intervention on safety education knowledge and practice of maternal care, the control group will be given a health seminar on disease prevention education (Lassa fever).

Step 5. Obtaining necessary resources to implement the programme: The resources for training will include securing training venues, writing materials, pamphlets on health education, questionnaire, charts and posters, projectors, computer sets and loud speakers

Step 6. Evaluating the programme: test and questionnaire

The KAP Theoretical Model

This theoretical model has been used in health education research and behaviour change for a long time. This model postulates that health education is conducted to increase the knowledge base of the target population. It is believed that increased knowledge will lead to a change in attitudes while attitude change in turn leads to change in behaviour. Behaviour change (in the direction advocated) is expected to lead to reduction in risk of infection/diseases and death.

Though, within the KAP model the correlation between attitudes and behaviour is assumed to be substantial and focuses uni-directionally on how attitudes are supposed to influence behaviour. However, the objective of this study is to look at the effect of safety education on knowledge and practice of maternal health of traditional birth attendants and the change the intervention can bring on the behaviour and practice of safety precautions towards the reduction of maternal mortality in Lagos state.

Figure I: The KAP Model

Health Education
Knowledge
Attitudes
Practices
Health/diseases

The Force Field Theory

This theory was formulated by Lewin (1953), the proponent postulated that the actual process of changing to a new behaviour (goal) would involve series of steps and that the forces for and against moving from one step to the next must be analysed in order to initiate the process of change in the individual. This theory concerns itself with the fact that behaviour is a product of both driving and restraining forces. Lewin offers a model representing actual decision-making process in which an individual 'unfreezes' old behaviour patterns and after trying to adopt new ones 'refreezes'. Unfreezing represents an attempt to give up habitual or stereotyped behaviour and/or considering new or alternative behaviours.

Unfreezing and Refreezing

Steps	Activity
Unfreezing	A conscious recognition that an existing behaviour may no longer be functional or that a new behaviour is needed
Evaluation	An effort to understand and consider the implications of the change
Goal setting	A decision on trying to change the nature of the behaviour involved and the circumstances under which the behaviour will be performed
Trial/Action	An effort is made to enact the new behaviour/refrain from the old behaviour and at the same time, the person is taking cognisance of the problems and benefits encountered.
Refreezing	The new learning has become a habit or a routine part of an individual's on-going behaviour as to be taken for granted, self-sustaining

The process of 'moving to new levels' now follows, wherein an individual may need new skills, knowledge and social support to make necessary changes. The interim steps include efforts to evaluate and understand the new behaviour, set goals for change and actually try out the new behaviour. Goal setting occurs when the person considers behavioural alternatives. It is then that the individual will experiment with new behaviour. Refreezing occurs when the new learning has become a habit or routine that the individual finds it difficult to ignore.

Applying this theory to this work, unfreezing occurs when the traditional birth attendant realises that the present state of knowledge and safety practices may not be adequate and constitutes a risk to both the people patronising them and they that are attending to their care. The TBA now makes attempt to give up the unsafe habitual practices or stereotyped behaviour. Evaluation on the part of an individual (participant) is making effort to comprehend and consider why there must be attitudinal change in attending maternal care and reducing the risk of maternal death and infections.

The individual proceeds to the third level-Goal setting in which safety strategies for the reduction of infections and management of delivery will be adopted. The next step is Trial/Action whereby the individual tries to adopt universal safety precautionary measures correctly and rendering maternal care to mother and child. Refreezing as the last step comes in when the new knowledge becomes a habit or routine forming part of an individual's life and behaviour. The participant at this stage conducts the action without

being prompted; it becomes a regular course of action. Thus, the knowledge becomes stabilised and internalised and self-sustaining.

The driving forces identified in this study include; imparting knowledge on identifying risk signs and alluding ladies with confusions to qualified personnel and facilities, discouraging harmful practices, awareness and knowledge on HIV/AIDS transmission and prevention, management of bleeding occurring during pregnancy, health education for pregnant women, adopting universal safety precautions, attending delivery in clean environment and use of safety kits and personal and environmental hygiene. Restraining forces on the other hand are incorrect practices of universal safety precautions, engaging in harmful practices, poor personal and environmental hygiene and not observing aseptic techniques.

In the area of moving to new levels, this will integrate resource persons (Nurses, Midwives, Specialists in HIV/AIDS, Clinicians and Nurse Educators) as resource persons to teach the TBAs new skills and knowledge required for maternal in the present age. The research will address social support at the end by reaching out to Hospitals Manage Board and Lagos State Traditional Medicine Board to provide the requirements for the practice of universal safety precautionary measures.

Concept of safety education

Safety education is a well-designed educational pogramme to promote knowledge, attitude, behaviour and skills of people about safety in school, workplace, home and different settings in the community. Safety education, if well designed and implemented will prevent or drastically reduce prevalence of accident at different setting. Udoh and Haastrup (2006) also noted that safety education is overt and covert application of health knowledge, attitudes and skills for safe and effective living. Safety education consists of expecting accidents, reducing their probability and providing means to reduce their consequences. The purpose of safety education is lean about safety measures desirable, put safety education into practice, avoid needless risks and hazards and to safe-guard life and property against accidents. Safety education is an inherent part of preventive and community health. It has the potential to cause behavioural change that will ultimately maintain and promote good health among individual and families in the community. Mothers can as well be encouraged through safety education to discourage their attitudes and behaviours that may expose their children to injuries and death.

Moronkola and Okanlawon (2003) stated that child morbidity and mortality can be prevented and reduced through effective health and safety education. They stated further that the significant role of safety education in the implementation of health interventions aimed at reducing mortality among members of the community cannot be over-emphasized. Health education is the forerunner of all interventional programme designed to improve the health and wellbeing thereby reducing morbidity and mortality. Safety education is the sum total of all experiences that helps in developing consciousness, forming attitude and understanding individual responsibility in taking precautions against engaging in acts that could lead to unintentional injuries among under five children. Safety education is the process of helping an individual to acquire the relevant information, right attitude and practice of safety consciousness in the course of performing one's duty or profession. It is an important aspect of human life that cuts across all phases of our life. It involves education about the development of individual responsibility in personal, community and professional programmes for safety, accident prevention and reduction of infections.

Overview on Maternal Health Care (World view)

The 1994 International Conference on Population and Development (ICPD) concentrated on populace, advancement and individual prosperity. At the ICPD, 179 nations received a movement concentrating on 20-year Program of Action (POA) that based on the accomplishment of the populace, maternal health and family arranging projects of the earlier decades while tending to, with another viewpoint, the need of the early piece of the twenty-first century.

The gathering thought of a more extensive command on improvement issues than past populace meetings, mirroring the developing mindfulness that populace, destitution, examples of generation and utilization and the earth are so firmly interconnected that none of them can be considered in segregation (Idowu, 2012). The meeting accomplished agreement on two fundamental targets on maternal health; these incorporate advancement of ladies' health and safe parenthood; to enhance the health and nourishing status of ladies (particularly pregnant and nursing ladies), to accomplish a quick and considerable decrease in maternal dreariness and mortality and lessen the distinctions saw among creating and created nations and inside nations. Nations are commanded to progress in the direction of critical decreases

in maternal grimness and mortality to levels where they no longer establish a general health issue continuously in 2015.

The World Health Organization (WHO) has perceived a critical prerequisite for programs that address the health and safety of pregnant women in the regenerative age, the United States Agency for International Development (USAID) has in like manner recognized fundamental factors for upgrading maternal health by encouraging women to use pre-birth care to recognize and treat intestinal ailment, feebleness, and other health issues; giving obstetric care to ensure safe transport for energetic mothers and their infant youngsters; and postnatal care to perceive postnatal depression health issues among others (Graczyk, 2007). Giving quality maternal health organizations enables women to alter safe childbearing with various parts of life and fills in as a right course towards achieving diminish in maternal mortality.

In 2000, there was a measure of 529,000 maternal passings around the globe, the report revealed that Asia and Africa spoke to around 95% (502,550) passings, with each landmass contributing part of this figure, and around 4% (22,000) occurring in Latin America and the Caribbean and under 1% (2,500) in made countries. In spite of the way that, the peril of maternal end is to an incredible degree high in making countries, generally expected that maternal mortality isn't a test in wealthier countries. In any case, the United Nations checks (2010) revealed that the United States situated 50th in the World for maternal mortality, with its maternal mortality extent higher than all other European nations consolidating a couple of countries in Asia and the Middle-East. Notwithstanding the way that, in some industrialized nations, this isn't the circumstance.

For example, China has recorded superb headway in maternal health comprehensively, their general maternal mortality has diminished from 64 for each 100,000 out of 1996 to 38 for each 100,000 out of 2008, and total movements in the specialist's office rose to 94.7% in like manner in 2008. On a general note, the normal number of women that fail horrendously is some place in the scope of 10 and 15 for each 100,000 live births in made countries. As demonstrated by United Nations Children's Fund (2008) report, in excess of 500,000 women fail horrendously consistently as a result of complexities from pregnancy and work, and appallingly, 99% of these passings occur in making countries. To be specific, around 56% of these passings occur in sub-Saharan Africa, with another 29% in south Asia, appropriately, these two regions are responsible for 85% of maternal mortality around the (World Bank data, 2012).

A ground-breaking Primary Health Care (PHC) advantage is starting at now settled all through Nigeria. Since October 1988, PHC providers are seen as including TBAs, ponder town head workers, junior and senior system health enlargement experts and Community Health Officers (CHOs), (Ahmed et al, 2004). Regardless, PHC benefits in Nigeria are up 'til now collected at tertiary level, with minimal joint exertion with PHC centers or system support organizations. Upwards of 60% of children considered in Nigeria are passed on by TBAs who talk the close-by tongues, allow traditional birthing practices, and often have the trust and respect of the system. Both commonplace and urban women may search for care with TBAs in light of the way that they share a similar social codes and have tantamount socio-economic traits. (Burtlery's et al. 2002; Ejikeme, Umeora and Obuna, 2007). World Health Organization (2004) checks exhibit that 60% of births in low wage countries occur outside a health office where 47% were helped by simply traditional birth attendants and relatives.

The goal of diminishing maternal mortality by 75% by 2015 has been gotten as an International Development Target (IDT) (OECD2000). The test being looked by enormous quantities of the making nations fusing Nigeria is in the locale of recognizing and completing convincing and sensible mediations all together headway towards the achievement of target. One intervention got in different countries is that of getting ready traditional birth attendants (TBAs) in Regions and Communities where capable professional attendants are uncommon. 2008 report of the World Health Organization (WHO) revealed that 358,000 women passed on of complexities in the midst of pregnancy or childbirth, the lion's share of which could be avoided in light of the fact that the essential helpful interventions exist and are depended upon to be gotten to. A noteworthy test is pregnant women's nonappearance of access to quality care beforehand, in the midst of and after childbirth.

To improve maternal health, the Millennium Development Goals 4 and 5 (MDGs 4 and 5) set the target of diminishing maternal mortality by 75% and achieving far reaching access to conceptive health by 2015. In any case, progress in diminishing mortality in making countries and giving proper organizations has been excessively move back, making it impossible to meet the target. WHO is supporting countries by passing on composed, demonstrate based and monetarily canny care for mothers in the midst of pregnancy, childbirth and postnatal anxiety period (WHO, 2008). Experiences released by the WHO (2010) on maternal mortality revealed that in 20 years the amount of maternal passings has decreased from more than 540,000 passings in 1990 to under 290,000 out of 2010. This is a

rot of 47% and 33% of these maternal passings occur in just two countries: India with 20% of the overall total and Nigeria with 14%. WHO (2010) place assets into the health system especially in the readiness of maternity masters and in making emergency obstetric care available round-the-clock. This is important to diminishing maternal mortality, and it was represented by WHO that one million youths worldwide are left motherless reliably, basically in light of the fact that their mothers had no passageway to or couldn't deal with the cost of significant worth health care. These youths are moreover more inclined to kick the can inside two years of their mothers' end.

Maternal Health Statistics in Nigeria

To the extent the genuine number of maternal passings, Nigeria is situated second on the planet behind India and Nigeria is a bit of a social affair of six countries in 2008 that inside and out spoke to the greater part of each and every maternal end universally. To the extent the maternal mortality extent, Nigeria is situated eighth in Sub-Saharan Africa behind, Angola, Chad, Liberia, Niger, Rwanda, Sierra Leone and Somalia (Bankole et al. 2009). One noteworthy hindrance is that there are no immediately open across the country estimations for nature of care, for example, horrendousness and passings caused by substandard care. Emotional affirmation and individual mending focus experiences proposes these are noteworthy issues. In government specialist's offices in a solitary territory in North-central Nigeria, poor work methodologies, including for example substandard cesarean section procedures, speaks to 40% of all fistula wounds persevered by women.

The data support the necessity for an extended response in maternal health care and course of action thought on the issue of maternal health in Nigeria, particularly given that Nigeria's masses (158.2 million out of 2010) is 18% of the total people of Sub-Saharan Africa (863.3 million of each 2010), (World Population Prospects, 2008). The report revealed that 62% of all births in 2008 happened in the home in Nigeria, undeniably proposing a strong purpose behind Nigeria's high maternal mortality extent. The data moreover demonstrates place of movement and help in the midst of transport. Assistance from a skilled health professional (support, maternity expert, authority) is undeniably fundamental in choosing the likelihood of issues in the midst of work: the data evidently exhibits that about all gifted health professionals are incorporated with work at a health office, while not a lot of births in various territories are gone to by capable health professionals, and most births don't happen in a health office.

The information proposes a nonappearance of genuine health offices inside reach of families (along these lines families who can pay go to private health providers) or possibly a nonattendance of satisfactorily particularly arranged open plan (e.g. in many making countries open government run mending focuses and offices require supplies of major drugs and distinctive consumables which patients and patients' families are then constrained to pay for themselves). Nigeria's poverty setting was represented by the World Bank in 2010 as 64.4% of the masses living in incredible desperation, and 83.9% living in immediate and uncommon dejection, consequently given the conceivable nonattendance of general health care and the need to go private, evidently access to health care by the people is simply proficient when family pay increases, as showed up by the data. Given the abnormal state of dejection in the country and the need to pay for health care in one casing or other (private course of action or to fill lacks of arrangements at government centers particularly by the patient), there will obviously be a broad number of women with unquestionably diminished access to essential antenatal, transport and post-movement care. In the proposed northern focus program region of the city of Kano, in Kano state, arranged in the Northwest Zone, skilled movement is particularly low, at 6.6% for sustain/birthing pro, with 25.9% passed on by TBAs and 18.5% by relative, and irritatingly, 43.8% passed on by "no one" making a difference.

Epidemiology of Maternal Mortality

The Millennium Development Goals (MDGs) and Maternal Health

Enhancing maternal health has been one of the real concerns comprehensively, the Millennium Summit received maternal health as one of the eight Millennium Development Goals in the year 2000 (WHO, UNICEF, UNFPA and The World Bank, 2010). Objective five of the MDGs centers around maternal health and particularly focuses on a decrease in maternal death rate by seventy five percent by 2015 (WHO 2007). The WHO report demonstrates that the rate of decrease in Sub-Sahara Africa is low contrasted with different parts of the world. As per UNFPA (2004), the second focus of MDG-5 is antenatal care administrations to ladies with gives the chance to correspondence with health professionals. This is in accordance with suggestions of the Millennium Project Task Force on Maternal and Child health.

The administrations offer diagnosis and treatment of existing health issues, screening for iron deficiency and HIV/AIDS, health education identified with counteractive action of

mother-to-kid transmission of HIV and healthy parenthood. Another critical mediation for maternal health is to guarantee suitable care for ladies amid labour, to accomplish this it will require sufficient spotlight on conceptive health care for ladies. These health intercessions have significant relationship with set for maternal and child health and furthermore spares the lives of both. The provide details regarding maternal health benefit usage in Eritrea (NSEO and ORC-Macro, 2003) uncovered that at the national level, three of every ten ladies don't get antenatal care (ANC), while family arranging use is just at 8%.

Besides, it was accounted for that lion's share of conveyances occur at home with the help of TBAs (72%). this means that insufficient access to appropriate maternal health care. There is consequently a requirement for preparing TBAs on knowledge and practice of maternal health care since this arrangement of care providers have high support in Nigeria. This will help with conveying assist nearer with mothering; this can help in accomplishing this exceedingly critical objective in Nigeria.

Traditional Birth Attendants and MDGs

It has been accounted for that dominant part of the births in rustic Nigeria happen with the help of traditional birth attendants (Essien, Shehu, Ikeh, and Juna 1997; Ransom and Yinger, 2002). However, the WHO supported the preparation of these TBAs through the mid-1980s (WHO, 1986), a few researchers have censured their viability (Okafor and Rizzuto, 1994; Brouwere, Tonglet, and Lerberghe 1998; Yayla, 2003). In any case, ponders from Guatemala and Nigeria have demonstrated that the preparation of TBAs can for sure increment the quantity of referrals of ladies with obstetric difficulties to clinics, which underpins the expansion of such projects until the point that the nearness of gifted birth attendants is a reality in creating nations (RHS, 2003). Creators have additionally contended that throughout the years the preparation of TBAs in creating nations has had little effect on maternal mortality and that the best measures are those which make it conceivable to achieve an all around prepared clinic (Fauveau and Chakraborty, 1994; Turmen and AbouZahr, 1994).

An audit of the preparation of TBAs with the point of enhancing the health conduct of pregnant ladies found that such preparing did not enhance maternal results (Sibley, Sipe, and Koblinsky 2004). Davis (2004) states that any finding that the preparation of TBAs has little impact on diminishing maternal mortality are not upheld by great quality confirmation. He notes that either the on-going help or the coordination with existing health administrations

did not shape some portion of past preparing of traditional birth attendants. This suggests the preparation itself was not defective yet rather the inability to coordinate, screen and manage the TBAs in their practices. In perspective of this, Asghar (1999) notes that supervision of TBAs comprises the significant connection among them and the formal healthcare framework. Support for this is offered by Bergstrom and Goodburn (2001), who contend that TBAs have a place in obstetric care, the same number of nations do not have the administrations of gifted professional healthcare suppliers and TBAs might be ladies' solitary wellspring of care.

The creators communicated solid conviction that prepared TBAs would diminish maternal mortality, in spite of the fact that they can give socially fitting supporting in the network setting and offer a first-connect line with the formal healthcare framework. What's more, they recommend that the TBAs ought to be firmly connected with present day health administrations and provoked to allude their customers to doctor's facilities offering basic obstetric care administrations. They reasoned that the part of TBAs ought not be ignored, yet that their preparation ought to be given low need, while inclination ought to be given to the arrangement of talented attendants at the season of childbirth. The point of MGD 5 is to enhance maternal health, while the objective was converted into two segments:

a. To lessen maternal mortality by seventy five percent somewhere in the range of 1990 and 2015.

b. To accomplish general access to conceptive health by 2015 (Islam and Yoshida 2009).

Also, the two key pointers for checking the advancement towards the main part are the maternal mortality proportion and the level of births gone to by gifted birth attendants (Islam and Yoshida 2009). The practice of Traditional Birth Attendant in the country setting cannot be under-appraised; this is on account of the knowledge and practice of Traditional Birth Attendants in the change of maternal health is essential and imperative. Moreover, Traditional Birth Attendants stayed one of the health assets in provincial regions of Nigeria in light of the fact that there are still individuals who might not for social and ethnographic reasons go to the maternity wards in present day doctor's facilities to have their infants (Ugal, Ushie, Ushie and Ingwu, 2012). They would like to have them with the help of a Traditional Birth Attendant. In an examination did by Imogie, (2004), it was accounted for that Traditional Birth Attendants stay alluring and advantageous to the two clients and non – clients.

In Nigeria, lion's share of our kin live in country regions where health offices are often hard to find. Since ladies must be helped before pregnancy, amid pregnancy and after pregnancy, it is hence vital that some care must be given and, for this situation, it is the Traditional Birth Attendants (TBAs). On the off chance that the MDG must be acknowledged in Nigeria, it relies upon how all around coordinated this essential arrangement of health care providers are given the vital preparing that will help with achieving a more prominent level of the populace.

Maternal Health Care and Traditional Birth Attendants' Training

In the previous decades, WHO and other health offices (UNFPA, UNICEF) advanced preparing of TBAs keeping in mind the end goal to enhance access to safe conveyance and scale up inclusion of maternal and conceptive health administrations. This activity turned into a general health technique as upheld by UNICEF in the 1950s by support through arrangement of conveyance units to TBAs. Following the Alma Ata tradition in 1978, endeavours were engaged to fortify the connections between traditional birth attenders in the network and the general health framework. Confirmation of expanding maternal death rates and constrained effect of untrained TBA intercessions prompted a reconsider on more compelling techniques.

All the more as of late, endeavours to progress to gifted birth participation has brought about advancement of preparing and in-benefit coaching of TBAs so as to improve their abilities. Because of the change in both the substance, span and the nature of preparing gave in numerous nations by taxpayer supported organizations, NGOs, and private division centers, this has brought about absence of institutionalized methodologies and at times really practicing broadened parts of TBAs. As indicated by an examination by Bulterys, et al (2002) which advocates for TBAs to give quick HIV testing, they alert on issues identified with absence of education related with preparing results and privacy. They advocate for the utilization of TBAs inside networks to be examined all the more broadly while practicing worry about such broadened parts.

While in most created nations, it is accepted that most births happen in the doctor's facility, in creating nations, the greater part of births happen in the home. Freedman et al (2007) states that the field of maternal health has numerous cases of seeking after an intercession which has little impact on health results because of inability to address the

important health framework bolster. A few discoveries from a requirements evaluation that feature the deficiencies in crisis care are exhibited as take after;

Geographic dissemination of offices for crisis obstetric care is a test, particularly in country regions while nature of care is additionally a noteworthy worry in most health offices.

Addressed requirement for crisis obstetric care is low, National needs appraisals; addressed issue was just 28% crosswise over nine African nations, recommending that such a large number of ladies are not getting treatment for obstetric difficulties. Cesarean conveyance rates studied in African and Asian nations were under 3% where the UN suggested extend is 5%-15%.

The continuum for maternal, new conceived and child care is now the suggested demonstrate utilizing a health frameworks approach as supported by the PMNCH and the worldwide network. It has been contended this advances access by families and networks, by outpatient and effort administrations and by clinical administrations, going to the full life cycle approach. It advocates for high inclusion and nature of incorporated administration conveyance bundles with practical linkages between the levels of care, so the care can add to the viability of all the connected bundles.

As indicated by Royal Tropical Institute (2008), contemplates propose that high inclusion and nature of fundamental bundles of care could turn away 67% of neonatal and child passings in 60 need nations. Participatory procedures have been utilized in networks to cultivate assembly among ladies' gatherings as a way to advance interest for maternal and child health administrations, plan answers for issues, for example, crisis transport (Manandhar, 2004). The participatory procedures conveyed care nearer to the home and enhanced linkages with the health framework through renovations to the neighborhood dispensaries and health focuses, enhanced transport connections and greater responsibility by nearby health specialists to their locale.

As a major aspect of a similar arrangement of concentrates in Nepal (Barker et al. 2007), consequences of network based MNH mediations reports that more ladies got stake natal care, utilizing a prepared birth orderly, enhanced utilization of sterile practices than ladies in the control gathering. Less maternal passings were accounted for (69/100,000 live births) in the intercession territory contrasted with 341/100,000) in the control amass over a 4-year time span. This insists birth results and healthy practices can be enhanced while concentrating on a continuum of network to health office based care. Satisfactory quantities

of talented health suppliers are fundamental where center capabilities are a pre-essential to guaranteeing best practices and enhanced nature of maternal healthcare. Be that as it may, it is imperative to see that most ladies in remote provincial zones depend on family or the TBA when conceiving an offspring and the closest referral office might be hours away. In such cases and where inconveniences emerge, essential lifesaving abilities and crisis obstetric and neonatal care is pivotal to sparing the life of the mother and infant.

A subjective investigation of prepared TBA mediations in Ghana, Mexico and Bangladesh found that network individuals were happy with the administrations of prepared professionals, that pregnant ladies specially counseled prepared TBAs, and that moms in program zones will probably take press pills, look for inoculations, utilize oral rehydration arrangement, practice family arranging, and enhance their family's eating regimen. In Ghana, the examination reported a decrease in still births, maternal passings and neonatal passings in locales where prepared TBAs worked, anyway the program was additionally looked with challenges in regards to TBA proficiency levels and poor joint effort among TBAs and healing center based specialists.

Method of reasoning for Traditional Birth Attendants Training

As indicated by the information discharged by WHO (2006), seventy five percent of maternal passings in creating nations are owing to coordinate obstetric causes, for example, baby blues drain, baby blues sepsis, eclampsia, impeded work, and difficulties of perilous fetus removal. For quite a long while it has been perceived that the nearness of a specialist with professional birthing assistance expertise who can either give or guarantee access to fundamental obstetric care, has a critical part in keeping maternal passings from these causes (Interagency Group for Safe Motherhood, 2000). It has been contended that all nations where talented participation is over 80% have Maternal Mortality Rates (MMRs) of beneath 200 (WorldBank,1999). It is in acknowledgment of this relationship, and because of challenges in estimating maternal mortality, that the extent of birth with talented participation has been embraced as an extra IDT. In many creating nations, where professional birth attendants are essentially not accessible to country populaces or the urban poor, this perfect might be unachievable. Statistic Health Survey (DHS) investigation has demonstrated that of 22 nations studied in sub-Saharan Africa, just a single (Botswana)had professional birth attendants going to conveyance in excess of seventy five percent of cases (Macro International Inc. 1994).

Besides, of these, maternity specialists or different professionals direct just a little extent, around 60million conveyances for every annum are as yet gone to by a traditional birth orderly, a relative, or, in a few settings, none. Accomplishing gifted participation at conveyance for all has been a test in numerous nations. As per Walraven and Weeks (1999), it has been computed that with an accepted heap of 150 conveyances yearly for each birthing assistant, in addition to related pre-birth and postnatal care, around 400,000 maternity specialists should be prepared. These evaluations can be relied upon to increment as rising quantities of young ladies enter the regenerative age gathering.

Noteworthy costs, which incorporate compensations, lodging and country posting recompenses, are unavoidable. Notwithstanding these immediate expenses there possibly extra costs identified with supervision and support. It is against this background preparing of traditional birth attendants has been advanced on the premise that they are accessible, are now occupied with maternity care and seem to show a lower cost elective (Belsey1985).

Part of Traditional Birth Attendants

Traditional birth attendants could assume important parts in family arranging, screening of high hazard moms, richness/barrenness treatment and maternal and youngster care administrations (Imogie, Agwubike and Aluko, 2002). Hence, in a few sections of the reality where traditional birth attendants work, they offer administration next to each other with the cutting edge maternity care professionals. TBAs are found in many networks of the world in spite of the fact that their tendency and capacity shift significantly. Looks into have noted that in numerous societies TBAs are regarded individuals from their locale, perform critical social customs and give basic social help to ladies amid childbirth (Chalmers1993, Campero 1998, Carney 1996).

The remaining task at hand of TBAs differs impressively from place to put and among people. A few errands that TBAs could perform to enhance maternal health care incorporate scattering of data about how HIV can be transmitted among mother and child and clarification of powerful methodologies to forestall such transmission; ID of pregnant ladies in their networks and assistance of their utilization of accessible antenatal and maternity care; fortification of health messages and offering exhortation on decreasing the danger of HIV transmission to ladies and their accomplices. Discoveries by Ofili and Okojie (2005) on the part of TBAs in Edo State uncovered that they were found to give a wide scope of conceptive health benefits that included stake natal care, youngster

conveyance, and treatment of barrenness, administration of debilitated premature birth and circumcision of children.

As per the WHO Training Guide, the fundamental part of the part of TBAs in country life is her relationship with the lead of labour. In a few territories their administrations start well before labour and proceed all through a stated period after labour. Where perinatal care is incorporated into the practice of TBAs it is for the most part given in type of exhortation on what the pregnant lady should 'eat or do' or 'not do or eat'. This may likewise incorporate back rub, to counteract trouble amid conveyance, suggesting while amid pregnancy, sex ought to be maintained a strategic distance from.

Conveyance of ladies is often finished with certain traditional systems went for speeding the ejection of the child, snappy entry of the placenta and capture of discharge. Quickly after the child is conceived the line is cut with instrument. After labour, the TBA perceives the requirement for the mother to rest, to care for her infant, breastfeed the child, and on account of the main conceived, to figure out how to deal with and feed the infant. Exhortation may likewise be given on the most proficient method to advance lactation.

Proof of maternal mortality decrease from projects of TBA preparing

Proof from chosen national projects gives some sign of what can be accomplished of town birth attendants. China is one of only a handful couple of nations which have kept up sensibly precise records of maternal mortality over an extensive stretch of time. For around three decades (1950 to 1980) conveyance care in China was given for the most part by insignificantly prepared town birth attendants sponsored up by a solid referral arrange for ladies with difficulties. Utilizing this model China prevailing with regards to lessening the national MMR from 1500 to115(Koblinskyetal.,1999). This can be appeared differently in relation to Bangladesh where, without open fundamental obstetric care, MMR has remained by and large high in spite of many years of TBA preparing (Nessa 1995). Nations, for example, Malaysia, Sri Lanka and Thailand, which have prevailing with regards to bringing down MMR underneath 100, have all received a technique of dynamic increment in inclusion by professional attendants supported up by arrangement of basic obstetric care (Starrs,1998). Malaysia received a think arrangement of bit by bit 8 supplanting TBAs with domiciliary maternity specialists moving in the long run to an office based administration (Yadav, 1987).

There is prove from different sub-national tasks; a fundamental healthcare program in Gambia used a prospective pre and post intervention think about an arrangement with control zones to assess the impact of getting ready TBAs on the aftereffect of pregnancy. In the intervention towns, transports with arranged TBAs extended from 0to65%. Movements by means of arranged maternity experts also extended likely due to referral by the TBAs. Maternal downfall rates fell in the intercession towns (from 2716[11/405] to 1051 [13/1236]), yet falls (from 1498 [4/267] to 963[7/727]) were in like manner found in the control towns. Improvements in transport were thought to have added to the result. Reports of the TBA planning program in Pakistan credit falls in MMR to the program. Before the program MMR was assessed at 10.1/1000 live-births. This had tumbled to 1.9/1000 by1987 and to 0.64/1000 by 1993. In any case, various distinctive changes in obstetric organizations were completed over a comparative period, including an obstetric flying squad organization and enrichments for obstetric care in recuperating focus (Bashir et.al.,1995).

An examination in Nigeria dissected changes in MMR following getting ready of 75 TBAs inside a 10-mile compass of a referral mending office. Maternal passings dropped significantly (30to15) in the 3 years following the planning. Non-randomly picked connection locales were more distant from the mending focus. The maternal passings in these goals dropped by 27%, (34to25) in a comparable time. Quantifiable examination was not performed (Brennan, 1989). Another examination in Senegal has attempted to take a gander at the impact of getting ready professional birthing masters with planning TBAs. Maternal mortality was higher in regions where women considered an offspring generally in healthcare centers helped by TBAs, than in zones where women imagined an offspring in health offices helped by birthing experts. The investigators theorize that birthing experts in health offices recognized more obstetric bothers than TBAs provoking brisk care and lower-case setback rates (de Bernis et al., 2000).

Two examinations assessed prescribe that the impact of getting ready isn't most likely going to be basic. One examination in Bangladesh exhibited that though arranged TBAs will presumably practice sterile movement than untrained TBAs (45%v19.3%), there was no basic refinement in levels of postnatal depression tainting when transports by means of arranged TBAs and untrained TBAs were taken a gander at (Goodburn et al., 2000). In Ghana, an examination evaluating the impact of TBA getting ready on the health of mothers and new-borns exhibited that mothers gone to by an arranged TBA were less disposed to have experienced postnatal anxiety fever and held placenta, yet more inclined to have had a

deferred work. No basic alliance was found among getting ready and different grimness reactions or with referral rates (Smithet al. 2000). None of these examinations prompts an end that TBA getting ready as a singular mediation can altogether influence maternal mortality.

Additional Benefits from TBA planning

Moves in India have demonstrated that arrangement TBAs in care and recovery can upgrade neo-natal outcomes (Kumar,1994; Bang et al., 1999) and that they can diminish neonatal mortality following getting ready in organization of neonatal pneumonia (Bang, 1994). At one time it was fought that TBAs could diminish the recurrence of neonatal tetanus (WHO,1983). It has similarly been suggested that readied TBAs can give tolerant education and urge women to go to health living spaces for preventive care in light of their closeness to women in natural systems. A run of the mill finding in past examinations on the effect of TBA planning is the importance of referral to crucial obstetric care offices. Various ventures have had a specific focus on getting ready TBAs to imply emergency cases reasonably and some have in like manner had genuine commitments to improving obstetric organizations, frameworks for transport and the associations among TBAs and professional health staff. In a peri-urban zone in Brazil it has been shown that TBAs arranged to see pre-birth conditions and complexities of pregnancy were successful in recognizing them and in making referrals.

TBAs were given a little maternity center to work in and transport was open (Janovitzetal.1988). TBAs in Burkina Faso have been viably arranged to suggest really debilitated mothers (Wollast etal.,1993) and the Mother Care presentation stretches out in Bolivia, Guatemala, Indonesia and Nigeria have exhibited that tending to issues of referral and emergency obstetric care improved nature of referrals and diminished perinatal mortality (Kwast,1996; Kwast, 1995; Alisjahbana et al., 1995). An examination outline Guatemala has in like manner showed that recuperating focus staff getting ready can grow referrals from TBAs paying little regard to whether the TBAs are readied or untrained. In the examination, recuperating office staff were told in norms of care for managing obstetrical and neonatal patients and in the noteworthiness of being solid and cognizance of TBAs and of mothers implied by TBAs Referrals extended by over 200% (O'Rourke, 1995). These revelations and those from near examinations suggest that the critical intervention for all domiciliary birth attendants is a reliable sincerely strong system for emergencies with satisfactory transport offices open (Kwast1992), and skilled, readied and available assistance from professional maternity experts and other staff with life-saving capacities (Fleming 1994).

Factors Contributing to Seeking Traditional Birth Attendants

In most African social requests the status of women is low (Olabisi, 1998). Families are developed on a male driven preface, with men choosing key decisions. Man driven family structure laid on men's control of most or all property, starting with arrive itself; marriage relied upon property associations and it was normal that marriage, and consequently subordination to men. It is inside this social milieu of male-power that women go into marriage, child bearing and child raising. The male driven culture gives women alongside zero ability to pick when they wind up pregnant; how, when, and where to search for care in the midst of multifaceted nature (Olabisi, 1998). While man-controlled society is a socially settled in factor that spots women under men, women's nonappearance of cash related fortifying further worsens their feebleness to make sense of where, when and what they look like for health in the midst of pregnancy and complexities.

One factor which impacts health care use in Nigeria is the availability and receptiveness of health offices. There is a gross insufficiency in the transport of health offices, various systems in commonplace Nigeria don't have extraordinary access to offices staffed with qualified work drive (Ibekwe, 2010). This lack of offices may speak to the low rate of institutional movements (NDHS, 2013). Besides, roads are often closed off and transportation systems are dubious (Ibekwe, 2010; Ajaegbu, 2013). Others considers have also exhibited that the use of health-care organizations is related to the availability, quality and cost of organizations, and notwithstanding the social structure, health feelings and individual characteristics of the customers (Chakraborty, Islam, Chowdhury and Bari, 2002; Kabir, Iliyasu, Abubakar, and Sani, 2005). Cost impacts health care direct on a very basic level, in this manner do other socio-measurement factors, for instance, occupation, equity, education, maternal age, and partition to health office (Furuta and Salway, 2006; Titaley, Hunter, Dibley and Heywood, 2010).

Exhaustive antenatal care (ANC) can diminish maternal mortality, nevertheless, many don't have the capacity to pay for such organizations (Borghi, Sabina, Blum, Hogue Furuta and Salway, 2006; Ronsmans, 2006; Sambo, Abdulrazaq, Shamang Furuta and Salway, 2006; Ibrahim, 2013). In addition, an examination coordinated among women in South eastern bit of Nigeria shows that women generally report late for antenatal care (ANC) as a result of the conviction that there are no positive conditions in early holding, as ANC is seen primarily as therapeudic rather than preventive (Ndidi and Oseremen, 2010). A couple of examinations have exhibited that health-related knowledge does not mean extended utilization of

organizations in pregnancy (Akaba, Otubu, Agida, Onafowokan, 2013; Zamawe, 2013). In Nigeria, the limit of women to search for care is out and out coordinated by the cost of antenatal care (Sambo, Abdulrazaq, Shamang, and Ibrahim, 2013). Understanding social and social factors that affect health care searching for lead is fundamental for ensuring safe pregnancies and transports.

There are different obstetric health care providers, who are used in supplement: traditional birth attendants, religious providers, and customary specialists (therapeutic attendants, maternity masters, organize health workers, experts, specialists). This connotes health care decisions are influenced by social norms, saw nature of care, time of day, cash related thoughts, and transport deterrents. In this manner, the disappointment of most Nigerian women to pay for maternal health organizations drives them to other elective sources. Women tend to search for beginning care from trashy close-by sources like using herbs and directing traditional birth attendants or masters. Government recuperating focuses are for the most part put down when the aggregate of what choices have been drained. The feebleness to offset the cost of care is particularly associated dejection, which is a basic factor compelling access to maternal care. Against the landscape of endemic dejection, women are obliged from searching for care at the health center or government facility. Partition to health office is occasioned by unequal access to exhibit day health office.

Individual TBAs and their parts fluctuate. In any case, certain qualities are normally observed crosswise over mainlands and areas (Fortney and Smith, 1997). TBAs have a tendency to be more established ladies, regarded in the network for their knowledge and experience. They are often non-proficient and have taken in their aptitudes through more established more experienced TBAs. They may work autonomously, as a team with an individual supplier or office or they might be incorporated into the health framework. Their part may incorporate, notwithstanding birth participation, showering and rub, local tasks, and arrangement of care amid the later baby blues or postnatal period. TBAs may perform different parts relying upon nearby custom, their own particular advantages and aptitude. The quantity of births TBAs go to every year runs from a couple of births to upwards of 120 births for each year. Commonly, TBAs draw in customers by notoriety and verbal. Generally they get some compensation for their administrations. Today, TBAs remain a critical supplier of maternity care in creating nations (Sibley, Sipe, Brown, Diallo, McNatt and Habarta, 2007).

Practice of Universal Precautions by TBAs

Widespread precautionary measures were issued to lessen the transmission of HIV in health care settings, they are likewise proper for the decreasing the transmission of other blood borne contaminations (Okafor, Onwusulu, Okafor, Ihekwaba and Chineke, 2009). The most widely recognized course of introduction are sharps, lancets, broken glass, needles and other sharp instruments or gadgets amid strategies or when cleaning utilized instruments. These occasions additionally happen amid transfer of utilized needles and treatment of sharp instruments after strategies. Four standard practices are prescribed; these incorporate hand washing, utilization of defensive boundaries to avert coordinate contacts, safe dealing with and transfer of sharps and safe sterilization of instruments and other tainted gear (Okafor et al. 2009). Some health care labourers are not genuinely worried about contamination by sharp damage and neglect to report mischances. Numerous instances of needle stick wounds go unreported and utilization of all inclusive precautionary measures is poor (Omiepirisa, 2012).

Hand Washing

The hand is the most widely recognized vehicle for microbial transmission (David and Famurewa, 2010). Hand washing has been demonstrated as a fundamental and the absolute best strategy utilized in keeping the spread of contaminations and irresistible operators (David and Famurewa, 2010; Kalu and Odusanya, 2012). Hand washing diminishes the quantity of conceivably irresistible smaller scale life forms in the hand and reduction the rate of disease transmission in the health care office. Sterile hand washing includes the utilization of clean and/or cleansers to wash the hand for as meager as around 10-15 seconds or to utilize a liquor based operator (David and Famurewa, 2010) to purify the hands. The hands and other skin surfaces ought to be washed instantly and completely if defiled with blood and other body liquids to which widespread safeguards apply or possibly debased articles (Bamigboye and Adesanya, 2006).

Hands ought to be washed after gloves are expelled regardless of whether the gloves have all the earmarks of being unblemished. Hand washing ought to be finished utilizing the proper offices, for example, utility or bathroom sinks. Hands ought to dependably be washed with cleanser and running water following contact with blood or other conceivably irresistible body emissions regardless of whether gloves have been utilized for the undertaking. Hand washing is the best method to lessen the spread of malady (Kaur, Kaur and Walia, 2008).

Utilization of Protective Barriers

Defensive boundaries diminish the danger of presentation of the health care labourers skin or mucous layers to possibly irresistible materials and the danger of introduction to blood and other body liquids to which general precautionary measures apply by counteracting contact with conceivably pathogenic microorganisms by making a physical hindrance between the conceivably irresistible materials and the health care specialist (David and Famurewa, 2010; Vaz, et al.2010; Kaluand Odusanya, 2012). Health care labourers must undertaking to wear individual defensive hardware to make preparations for blood borne pathogens if there is a sensible foreseen introduction to blood and other conceivably irresistible materials. In the case of sprinkling is foreseen, defensive eye wear ought to be worn alongside an impenetrable outfit or cover which gives a viable obstruction to sprinkles (Oguntona, Adedeji and Ogunsola, 2010). Plastic sacks ought to be accessible for expulsion of defiled things from the site of the spill. The individual defensive gadgets incorporate gloves, smock and covers (Kalu and Odusanya, 2012).

Gloves

Since medicinal history and examination cannot dependably distinguish all patients harboring blood borne pathogens, widespread insurances amid presentation to blood and body liquids are required. Gloves which ought to be worn for coordinate contact with blood or body liquids and for coordinate contact with non-unblemished skin or mucous film, should fit well and be made of latex (Kaur et al., 2012). Gloves can be transfer or non-expendable relying upon what technique is to be completed. Various means incorporating inadvertent harm with needles can break and cut gloves.

Gloves must be worn as single utilize thing to forestall pollution of health care labourers hand if envisioning direct contact with blood or body liquids, mucous films and non-unblemished skin. Defensive gloves ought to be worn to evacuate tainted shoe covers. Gloves must be disposed of following every method in plastic packs and the hands washed (Kaur, et al., 2012). Plastic cook's garments ought to be worn amid conveyance methodology and cleaning if sprinkling is foreseen. Covers are prescribed to stay away from blood or body liquid sprinkling into the mouth and nostrils. Cuts and scraped spots on the hands and lower arms ought to be secured with waterproof dressing.

Adherence to Universal Precaution

Safety measures which direct the occupation are either missing or not clung to in many creating nations including Nigeria. All inclusive blood and body liquid safety measures envelops an extensive variety of steps taken amid consistent work day by health care specialists and must be clung to entirely in other to ensure self, patient and collabourators from contamination. All health care labourers ought to routinely take after these safety measures whenever there is the likelihood of contacting or being sprinkled with any individual's blood or body liquids on their skin. Routine instructional meetings are essential in all health offices to enhance the health specialists knowledge of the distinctive parts of all inclusive precautionary measures to request to guarantee safe practice and adherence to widespread safeguard rules. Health care professionals should be refreshed on the standards of all inclusive fundamental safeguards as it has been demonstrated that there are insufficiencies in the knowledge and utilizations of the practice of the general safety measures (Nduka, Aguwa and Nduka, 2012).

Insurance can be accomplished through adherence to work practices intended to limit or dispose of introduction and utilizing individual defensive gear that is gloves, covers and defensive attire which give a boundary between the specialist and the presentation source. There is a requirement for strict consistence to receiving safety designed gadgets which will help in the decrease of needle stick and sharp damage and danger of blood borne contaminations (Rampal, Zakaria, Sook and Zain, 2010). General safeguard mindfulness education has not been pronounced among health care suppliers particularly in creating nations (Bamigboye and Adesanya, 2006). The level of familiarity with all inclusive safety measures increments with longer years of administration in the health care area (Vaz, MCGrowder, Alexander-Linda, Gordon, Brown and Irving, 2012). Non-consistence among health care specialists could be because of their conviction that by adherence to all inclusive precautionary measures makes their methods troublesome particularly under weights. Different explanations behind poor consistence with widespread safety measures incorporate the nonappearance of punishments.

Effect of TBAs Educational Status on Knowledge and Practice of Maternal Health Care

According to Ayede (2012) TBAs are generally neighborhood ladies with minimal formal education. Their little formal education is additionally delineated in our investigation as not very many of them had more than primary school (8%) education and a huge extent

(20%) did not have any formal education. This pattern is comparable crosswise over nations were the utilization of TBA is normal. This is for the most part thought to be identified with the level of the general educational status of the subjects and the level of neediness (Sibley, Sipe, Brown, Diallo, McNatt and Habarta, 2007; Piper, 1997; Umar, Olumide and Bawa, 2003). The way that this aptitude is normally passed from an experienced TBA to another is reflected in the wellsprings of their preparation before beginning to practice as TBAs.

At present in Nigeria, TBAs are viewed as untalented and are not perceived as a feature of the formal health division. The Federal Government of Nigeria is as of now enlisting maternity specialists through the National Midwives Scheme of National Primary Health Care Development Agency. Itina (1997) detailed that the educational level of the TBAs utilized for the investigation was low, just 2 out of 52 had moved on from auxiliary school, 67.3% were uneducated people and 34 (65.4%) had no TBA preparing before setting out on free practice. An examination by Sheela (2008) uncovered that the greater part of the TBAs considered (76%) had not gone to class; of the rare sorts of people who had gotten tutoring, almost all were prepared.

The preparation of TBAs has been related with direct to-huge change in their conduct to postnatal practices and little yet critical reduction in perinatal mortality and neonatal mortality because of birth confusions, for example, asphyxia and pneumonia (Sibley and Sipe, 2006). An examination by Oshonwoh, Nwakwuo and Ekiyor (2014) demonstrated no connection between the aptitude of the TBAs and their capacity to adapt to birth intricacy, the frail relationship could be a sign that more essential preparing and abilities are required by the TBAs to handle more basic issues or a referral made for legitimate administration. Be that as it may, because of deficient information revealing and recording, there have been poor database for relationship between the preparation of TBAs and the adequacy of the administrations gave.

Impact of Years of Experience on TBAs Knowledge and Practice of Maternal Health Care

While the piece of TBAs in supporting pregnant women and driving movements is acknowledged, it is noted that they are all things considered not set up to oversee bothers (WHO, 2004b). TBAs and town birthing authorities have been used in various interventions to diminish maternal mortality and improve pregnancy brings about making countries with mixed results (Gloyd et al., 2001; Ray and Salihu, 2004). According to disclosures by

Oshonwoh et al. (2014), around 63.1% of the TBAs have been had all the earmarks of being of assistance to pregnant women. In another examination, 57 traditional birth attendants were perceived by the Danfa Project in Ghana with a true objective to upgrade maternal and youth health practice and propel family masterminding (Ampofo et al., 1977).

Owigar (2000) noted that to help reduce the maternal demise rate; there is necessity for purposeful utilization of the wealth of experience of traditional birth attendants in the undertakings to supplement the immense health status of the women in the midst of pre-birth, hazard and post-natal organizations. In any case, from the examination of Oshonwoh et al. (2014), only 8.8% of the TBAs in this examination had the required gifted planning and Akpala (1994) revealed in an examination on the appraisal of the knowledge and practices of arranged TBAs in Bodinga, Sokoto State of Nigeria that out of 74 TBAs, only 43 arranged ones where prepared to see high danger pregnancies and movements for referrals to higher health foundations than the 31 untrained TBAs.

Along these lines, to help improve maternal heath especially in the nation zones of Nigeria, something must be done in domains where TBAs are missing attractive offices and getting ready. Notwithstanding the way that, the wealth of experiences of TBAs have been acknowledged (Owigar, 2000), there is need to invigorate them through getting ready and support in light of the fact that TBAs are especially elusive of standard offices and generally compelled to use what they have available which from this examination 70% are known to be substandard to offer the required organizations. Itina (1997) in an examination on characteristics of TBAs and their feelings and practices uncovered that 65.4% of the TBAs used for the examination no readiness at all in traditional birthing help before setting out on autonomous practice.

This is contrary to the experience in Bangladesh and the pervasive view that most TBAs had drawn out occasions of apprenticeship before starting free practice. As demonstrated by the maker, this nonappearance of experience is generally accountable for the ignorance appeared by the TBAs especially in cases of obfuscated pregnancy and work. Overwhelming piece of the TBAs who had pre-practice planning were set up by close relatives. The arrangement as apprenticeship persevered through one to two years under TBAs who were not relatives or two to five years under close relatives, an extensive part of whom were their mothers.

Impact of Safety Education on TBAs Knowledge and Practice of Maternal Health Care

TBAs can possibly spare lives through distinguishing dangers and leading required preventive measures even before landing in the referral site (UNFPA, 1996). In spite of the fact that there are reactions that even prepared TBAs cannot as a rule as a rule spare ladies' lives adequately on the grounds that they can't treat inconveniences, and are often unfit to allude (Carlough and McCall, 2005). Concentrates anyway show the limit of TBAs to perceive confusions and make referrals, putting the knowledge picked up in preparing into their practice in spite of their lower proficiency rate. Hand cleanliness is known to be the most essential part of disease control and can be accomplished by standard hand washing with cleanser and water (Hussein and Fortney, 2004). TBAs have been condemned for not undertaking proportions of neatness while giving care to moms and new-conceived, for example, washing their hands (Fatmi, Gulzar and Kazi, 2005); the practice is seen as a conceivable methods for lessening danger of disease Saeed Ali, Sami and Khuwaja, 2007).

Writing has created a blend result about unhygienic practices among TBAs, a few examinations demonstrate that TBAs keep on engaging in possibly unhygienic practices (Bang et al 2005; Rama Rao, Caleb, Khan and Townsend, 2001); though different investigations have demonstrated that TBAs have a lesser part to play in causing disease in moms and infants (Goodburn, Chowdhury, Gazi, Marshall and Graham 2002; Winani et al 2005). An imperative finding that rises up out of writing is that TBA practices and individual and network health and cleanliness are essential in anticipating contaminations among moms and children. This anxieties the significance of safety insurances through legitimate tidiness and cleanliness is essential not just for TBAs yet the network all in all keeping in mind the end goal to lessen the possibly hurtful maternal care practices that are embraced in home conveyances.

Appraisal of Reviewed Literature

The far reaching Health Education Model was received as calculated system for this examination. It was underscored that any intercession that would achieve positive effect must target attitudinal change. This must be accomplished by having inside and out knowledge of the socio-social factors that wins inside the network under examination. Writing has demonstrated that social practices are solid power that decides the convictions and practices of individuals. The KAP hypothetical model was additionally inspected. This theory has been utilized widely in health education research and conduct change. The theory places that

health education is directed to expand knowledge base of the objective populace which prompts an adjustment in state of mind and conduct. This examination additionally analyzed Force Field theory which centers on the procedure of progress in change in conduct. Conduct change includes arrangement of steps and every one of the means is to be considered to start the procedure of progress. Social cognitive theory was surveyed on account of the elements of human conduct. The theory places that human conduct is dynamic and impacted by the collaboration of inner and outside powers and also human association inside their condition. Since greater part of the TBAs dwell in provincial settings the earth strongly affects their safety practices and convictions.

An audit of writing and scope of studies and inquires about on the TBAs counseled in this examination uncovers that this gathering of health labourers assume huge parts in maternal health care practice particularly in this piece of the world. This is basically because of their closeness to the network where larger part of the people dwells. This is additionally a solid avocation for the combination of TBAs in the arranging and execution of maternal health care program. This survey has likewise centered on the variables affecting support of TBAs, some of which are social, socioeconomic and educational status. This examination depicted TBAs by and large as ladies, often more seasoned ladies who are for the most part non-proficient, effectively and locally open who live inside the network and have learnt their abilities through experience. They likewise have certain characteristics that the network has perceived as essential for playing out the errand of birthing assistance.

The survey likewise analyzed the knowledge and practice of the TBAs as respects widespread safety safeguards and practice of birth conveyance. They have been presented to essential preparing in health care conveyance and care for the mother and baby. They influence utilization of the aptitudes they have learnt concerning safety safeguards and conveyance practices; they have been shown techniques for leading cleanliness practices like hand washing with cleanser, clean line care and clean surface. They are additionally provided with conveyance unit that is gone for anticipating diseases amid conveyance. It likewise uncovered that a portion of these TBAs still take part in traditional practices that are unhealthy on account of their low level of education and social convictions.

CHAPTER THREE

METHODOLOGY

The focus of this study was on effect of safety education on knowledge and practice of maternal healthcare among Traditional Birth Attendants in Lagos State. This chapter presented the research design, population of the study, sample and sampling techniques, research instruments and procedure for data collection and data analysisused in this study.

Research Design

The study adopted a pretest posttest control group quasi experimental research design as it allowed the researcher to match the participants in the experimental and control group on similar variables as well as allowed to see the final difference in the outcome measured in the study which can be attributed to only the effect of the intervention given. Townsend, (2004), noted that the design allows the researcher to introduce a new intervention to the experimental groups and takes measurement for both before and after the intervention to establish the effect observed between them and the control group. The participants were randomly assigned into two groups of experimental and control group

The design is schematically represented as thus:

01 X_1 03.....1 experimental group (safety education)

02 X_2 04.....2 control group (Lassa fever education)

01 and 02 represent pre-test observations for the experimental and control groups respectively, while 03 and 04 represent post-test observations for the experimental and control groups respectively. X_1 represents training intervention on maternal safety education while the control group was exposed to placebo (Lassa fever education).

The study used a 2x2x2 factorial matrix for the analytical part which is represented in the table below

Table 3.1: Factoral matrix design

Treatment	**Educational background**		**Years of working Experience**	
Experimental (safety education)	No formal Education	Formal Education	Short1-9years	Long 10years and above
Control (diseaese prevention education)	No formal Education	Formal Education	Short1-9years	Long 10years and above

Population of the Study

The study population comprised of all both male and female Traditional Birth Attendants in Lagos State. It included both trained traditional birth attendants as well as those that were not trained.

Sample and Sampling Technique

The sample for this study was one hundred and twenty (120) Traditional Birth Attendants from two LGAs in Lagos State which was divided into experimental and control groups. The multi-stage sampling procedure was used. At the first stage, simple random sampling technique of fish bowl without replacement was used to select two out of the twenty Local Government areas in Lagos state. In the second stage, simple random sampling technique was used to place the two selected local governments into experimental and control group. In the third stage, purposive sampling technique was used to select wards that fall into rural community within the selected Local Government. In the fourth stage, four health centres were randomly selected from the selected wards. At the fifth stage, purposive sampling technique was used to select fifteen traditional birth attendants in each of the selected health centres, making a total of sixty in each local government and 120 for the two local governments.

Research Instruments

Two research instruments were used in this study; questionnaire with three sections and treatment package. The questionnaire is a self-developed instrument consisting three sections which include:

Section A: this was used to obtain information on demographic data of participants as well as training received and services rendered. This section has a total of 11 items.

Section B: Knowledge of Maternal Health Scale (KMHS)

This scale was developed by the researcher. It has 17 items; the first 14 items were constructed along three-point ratings of True, False and No Idea. All the 17 items were designed to generate information on the knowledge of participants as regards maternal health during pregnancy and during labour. The original version of the instrument had 27 items which was pre-tested and subjected to reliability analysis after which they were reduced to 17 items. The result yielded a reliability coefficient value of 0.77.

Section C: Maternal Health Practice Scale (MHPS):

This scale was self-developed and it was designed to assess the practice of TBAs as regards maternal health care. This scale has a total of 20 items; the first 13 items were constructed along four-point ratings of Never, Rarely, Sometimes and Always. All the 20 items were designed to generate information on the maternal health care practices among the participants as regards maternal health during pregnancy and labour. The original version of the instrument had 28 items which was pre-tested and subjected to reliability analysis after which they were reduced to 20 items. The result yielded a reliability coefficient value of 0.95.

Validity of the Instrument

The instrument was validated by making draft copies available to the researcher's supervisor and other experts including lecturers in Human Kinetics and Health Education and professionals in obstetrics and gynaecology for suggestions and comments. The items of the questionnaire were developed based on the preliminary exploratory discussion with expectant mothers and TBAs not from the study area. A total of 55 items were initially developed with 27 items and 28 items for maternal health knowledge and maternal health care practices respectively. A draft of the questionnaire was presented to experts in psychometrics, obstetrics and gynaecology as well as experts in Health Education.

Based on the synopsis of the views of these experts, the items were re-modified to 44 items. This was then subjected to exploratory factor analysis. A Kaiser-Meyer-Olkin (KMO) of 0.88 was obtained which is above the benchmark of 0.60. This indicates that the sample size is adequate for the conduct of factor analysis. Moreover, only 37 of the items were able to meet up with the retention criterion of 0.6. All other items that did not meet the retention criterion were extracted. The test of sphericity was statistically significant which support the factorability of the correlation matrix as the p-value stands at 0.000. Also, the inspection of the correlation matrix revealed that all the coefficient of the retained items was 0.6 and above. The items that were retained were further subjected to Cronbach Alpha and a reliability coefficient of 0.82 was obtained.

Reliability of the Instrument

To ensure the reliability of the instrument, thirty Traditional Birth Attendants from Ifo Local Government area of Ogun State were used for pilot testing. They were not part of the actual participants for the study but they possess characteristics similar to the actual

participants for the study. The data obtained was subjected to Cronbach Alpha and a reliability value of 0.82 was obtained.

Field-testing of the instrument

Field testing of an instrument is essential before the actual study is carried out in order to be sure the instrument is reliable, accurate and meaningful. The field testing of the instrument was carried out using thirty TBAs in Ifo LGA of Ogun Sate who were not part of the sample for the study. This acquainted the researcher with the procedures and problems that may be encountered during the actual study. Also errors and ambiguities were identified and corrected.

Ethical Consideration

Ethical approval for this study was obtained from the appropriate authorities; Ethics and Research Committee of University of Ibadan and the Ethics and Research Committee of Lagos state Ministry of Health, Lagos State. The researcher presented copies of the research proposal attested by researcher's supervisor, letter of introduction from the Head of Department, Human Kinetics and Health Education, researcher's curriculum vitae and evidence of certified training in research ethics to Ethics and Research Committee of University of Ibadan. Confidentiality of the participants were assured as the instruments were properly structured without making reference to personal data. Moreover, no form of risk whatsoever is envisaged in the study.

Procedure for Data Collection

The specialist gathered a letter of presentation from the Head, Department of Human Kinetics and Health Education, the University of Ibadan so as to pick up the assent of the members. The participants were randomly assigned into two groups of experimental and control to obtain their pre-test scores. The experimental group was exposed to safety education training while the control group was given a health talk on disease prevention education (Lassa fever). All these procedures were administered with the assistance of ten trained research assistants.

Training Programme for the experimental Group

Week/Time		Topic/Content	Objectives At the end of this session, participants should be able to	Methods	Teaching/Learning Resources	Evaluation Questions
One. 90 minutes		Familiarization with the participants and research assistants Conduct of pre-test Deliberation on training contact periods	succinctly state the aim, objectives, benefits and modality of the intervention programme	Guided Discussion and Brainstorming	Poster, research questionnaire	What are you likely to gain from this programme? What will the society benefit at the end of this programme?
Two	Tuesday (120 minutes: 45 minutes each and 15 minutes break)	Introduction to Maternal and New-born Health	State Nigerian's prevalence of maternal and perinatal morbidity and mortality, List direct and indirect factors that cause maternal death	Direct Instruction and Guided Discussion	Poster and charts	What is the prevalence of maternal and perinatal morbidity and mortality in Nigeria? List four direct and indirect causes of maternal death
	Thursday (120 minutes: 45 minutes each and 15 minutes break)	Factors Affecting Maternal and Perinatal Mortality and Morbidity, Current Approaches to Reduction of Maternal and Neonatal Mortality	List the three delays affecting maternal and perinatal mortality and morbidity, List the three approaches upon which efforts aimed at reducing maternal morbidity and mortality revolves	Direct Instruction and Guided Discussion	Poster and charts	List the delays that could affect maternal and perinatal morbidity and mortality State the current approaches to reduce maternal and perinatal morbidity and mortality
Three	Tuesday	Female Genital	Define Female	Direct	Poster and	Define

	(120 minutes: 45 minutes each and 15 minutes break)	Mutilation Women Friendly Care	Genital Mutilation (FGM) Describe types of FGM. Describe the obstetric effects of FGM Define woman friendly care. State cares which are woman friendly. State examples of cares which are not woman friendly	Instruction and Guided Discussion	charts	Female Genital Mutilation (FGM) Describe types of FGM. Describe the obstetric effects and global situation of FGM. Define woman friendly care. State five cares which are woman friendly. State five examples of cares which are not woman friendly
	Thursday (120 minutes: 45 minutes each and 15 minutes break)	Infection Prevention and Patient Safety Hand Hygiene, Hand Washing and Use of Hand Gloves	Describe Infection Prevention and Patient safety Describe Infection Prevention and Patient Safety goal and objectives Outline key Infection Prevention and Patient Safety practices Demonstrate appropriate hand hygiene practice and use of hand gloves	Direct Instruction, Guided Discussion and demonstration	Poster, charts and realia	What is Infection Prevention and Patient safety Describe Infection Prevention and Patient Safety goal and objectives Outline key Infection Prevention and Patient Safety practices Demonstrate appropriate hand hygiene practice and use of hand gloves

Four	Tuesday (120 minutes: 45 minutes each and 15 minutes break)	Preparation and Response to Emergencies	Describe key steps in rapid initial assessment of a sick pregnant woman	Direct instruction and social drama	Poster	Describe key steps in rapid initial assessment of a sick woman. Outline key emergency management steps for specific emergency problems Describe important elements in assessment and management of shock
	Thursday (120 minutes: 45 minutes each and 15 minutes break)	Emergency Management Principles	Outline key emergency management steps for specific emergency problems Describe important elements in assessment and management of shock	Direct instruction and social drama	Poster	Mention three Outline key emergency management steps for specific emergency problems Describe important elements in assessment and management of shock
Five	Tuesday (120 minutes: 45 minutes each and 15 minutes break)	Pregnancy Care: Ante Natal Care	Define ANC Discuss the importance of ANC State elements of ANC	Direct Instruction, Guided Discussion and demonstration	Poster	What is ANC State three importance of ANC Mention three elements of ANC

Six	Tuesday (120 minutes: 45 minutes each and 15 minutes break)	Child Birth Care (Labour, Delivery and Immediate Postpartum Care): Care of a Woman During Labour	State rapid evaluation and appropriate steps to care for a woman in labour State steps to appropriate diagnosis of labour	Direct Instruction, Guided Discussion and demonstration	Poster	State five steps to care for a pregnant woman in labour List four steps to appropriately diagnose labour
Seven	Tuesday (120 minutes: 45 minutes each and 15 minutes break)	Care and Referral for Complications during Child Birth: First and Second Stages of Labour	State signs of satisfactory and unsatisfactory progress of labour at the first stage of labour State signs of satisfactory and unsatisfactory progress of labour at the second stage of labour	Direct Instruction, Guided Discussion and demonstration	Poster	Mention three signs each of satisfactory and unsatisfactory progress of labour at the first and second stages of labour
	Thursday (120 minutes: 45 minutes each and 15 minutes break)	Basic Care during Second Stage and Assisting Normal Delivery	Outline basic care to be given to a woman during second stage of normal delivery List vital indices to monitor during delivery List steps involved in completion of delivery including handling the new born immediately after expulsion by the mother	Direct Instruction, Guided Discussion and demonstration	Poster	State five care to be given to a woman in second stage of labour What are the vital indices to monitor during labour List the steps involved in completion of delivery

Eight	Tuesday (120 minutes: 45 minutes each and 15 minutes break)	Active Management of the Third Stage: Prevention of PPH	Identify PPH as the most common cause of maternal death Identify steps necessary in managing third stage of labour and preventing PPH	Guided discussion and Direct Instruction	Poster	What is the most common cause of maternal death What are the steps required to prevent and manage PPH
Nine	90minutes	Final Revision	Mention personal benefits from the programme Mention societal benefits from the programme	Question and answer	-	-

Training Programme for the Control Group

Week/Time	Topic/Content	Objectives At the end of this session, participants should be able to	Methods	Teaching /Learning Resources	Evaluation Questions
Week One 90 minutes	Familiarization with the participants and research assistants Conduct of pre-test Deliberation on training contact periods	succinctly state the aim, objectives, benefits and modality of the intervention programme	Guided Discussion and Brainstorming	Poster, research questionnaire	What are you likely to gain from this programme? What will the society benefit at the end of this programme?
Week Two 90 minutes	Introduction to Lassa Fever	State the place where Lassa Fever originated from State the fatality rate of Lassa Fever	Direct Instruction	Poster	Lassa fever originated in .... What is the fatality rate of Lassa fever
Week Three 90 minutes	Symptoms of Lassa Fever	State the incubation period of Lassa Fever Mention signs and symptoms of Lassa Fever	Direct Instruction	Poster	What is the incubation period of Lassa fever? List five signs and symptoms of Lassa fever
Week Four 90 minutes	Treatment and Prophylaxis of Lassa Fever	State whether Lassa Fever can be treated or not State whether Lassa Fever has vaccination or not	Direct Instruction	Poster	Can Lassa fever be treated? Is there vaccination against Lassa fever?

Week Five 90 minutes	Prevention of Lassa Fever	State community hygiene as the central theme of Lassa fever prevention efforts List measures to prevent Lassa fever	Direct Instruction	Poster	What is the central theme for Lassa fever prevention? How can Lassa fever be prevented at the household level
Week Six 90 minutes	Control of Lassa Fever	State control measures against Lassa fever at homes and in the hospitals	Direct Instruction	Poster	How can Lassa fever be controlled?
Week Seven 90 minutes	Lassa Fever Prevention in TBA Homes	Mention how Lassa Fever can be prevented in a TBA home	Direct Instruction	Poster	How can Lassa fever be prevented in TBA homes
Week Eight 90 minutes	General Revisions and administration of post-test	-	Question and Answer	-	-

Procedure for Data Analysis

The completed questionnaire was coded and analysed using descriptive statistics of frequency counts, simple percentages, mean and standard deviation for the demographic data of the participants. Inferential statistics of Analysis of Covariance (ANCOVA) was used to test the formulated hypotheses at 0.05 alpha level.

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION AND DISCUSSION OF FINDINGS

This chapter focused on the analysis of data with respect to research questions and hypotheses earlier stated. The chapter is divided into three (3) sections. Section A presents the demographic information of the participants; section B provided answers to the research questions while section C provided the result of the tested hypotheses.

Section A: Demographic Information of the Participants

TABLE 4.0: Distribution of participants according to demographic characteristics

Gender	Frequency	Percentage
Male	34	28.3
Female	86	71.7
Total	**120**	**100.0**
Age		
Below 20 years	6	5.0
20-29 years	11	9.2
30-39 years	16	13.3
40-49 years	58	48.3
50 years and above	29	24.2
Total	**120**	**100.0**
Educational status		
No formal education	34	28.3
Primary education	42	35.0
Secondary Education	41	34.2
Tertiary Education	3	2.5
Total	**120**	**100.0**
Religion		
Christianity	55	45.8
Islam	38	31.7
African Religion	27	22.5
Total	**120**	**100.0**
Years of working experience		
1-9 years	38	31.7
10 years and above	82	68.3
Total	**120**	**100.0**

Table 4.0 above shows that 34 (28.3%) of the participants were male while 86 (71.7%) were female, showing that majority of the participants were female, 6(5.0%) were below 20years of age, 11(9.2%) were between the ages of 20 and 29years, 16(13.3%) were between the ages of 30 and 39 years, 58 (48.3%) were between 40 and 49years while 29 (24.2%) were 50years and above showing that majority of the participants were between the ages of 40 and 49 years. On educational status, 34 (28.3%) had no formal education, 42 (35.0%) had primary education, 41 (34.2%) had secondary education while 3 (2.5%) had tertiary education

indicating that majority of the participants had primary education. Concerning religion, 55(45.8%) were Christian, 38(31.7%) were Muslim while 27 (22.5%) were traditional worshippers showing that majority of the participants were Christian. 38(31.7%) of the participants had between 1 and 9years of working experience while 82(68.3%%) had 10years and above years of working experience, showing that majority of the participants had 10years and above years of working experience.

Section B

This section provided answers to the stated research question

Research question 1: What is the level of knowledge of safety education on maternal healthcare?

Table 4.1a:Analysis on level of knowledge of safety education on maternal healthcare

Item	True	False	No Idea	Mean	SD
Excessive vomiting at pregnancy is a normal pregnancy symptom	64 53.3%	41 34.2%	15 12.5%	1.54	0.31
Swelling of feet is normal in pregnancy	65 54.2%	32 26.7%	23 19.1%	1.55	0.35
Anaemia/paleness in pregnancy is a sign of danger	43 35.8%	68 56.7%	9 7.5%	0.94	0.46
Excessive bleeding during delivery is normal	43 35.8%	59 49.2%	18 15.0%	1.52	0.72
Excessive weakness at labour is normal	54 45.0%	51 42.5%	15 12.5%	1.51	0.51
Breathlessness in new born is normal in some cases	51 42.5%	54 45.0%	15 12.5%	1.47	0.70
Visual disturbances in pregnancy is not a danger sign	43 35.8%	51 42.5%	26 21.7%	1.45	0.62
Antenatal care is essential in pregnancy	59 49.2%	43 35.8%	18 15.0%	1.41	0.92
Ante natal care should commence once pregnancy is identified	57 47.5%	50 41.7%	13 10.8%	1.37	0.57
Counting fetal movement daily in the last stage of pregnancy is necessary	32 26.7%	67 55.8%	21 17.5%	1.35	0.73
Iron rich food is harmful during pregnancy	67 55.8%	49 40.8%	4 3.3%	1.53	0.99
Consumption of fruits and vegetables is necessary during pregnancy	34 28.4%	61 50.8%	25 20.8%	1.25	0.61
Checking blood pressure regularly is necessary in pregnancy	44 36.7%	66 55.0%	10 8.3%	1.17	0.64
Calcium supplement is required in pregnancy	38 31.7%	63 52.5%	19 15.8%	1.11	0.73
Weighted Mean= 1.37			**Criterion= 2.0**		

As indicated in table above, 64 (53.3%) respondents agreed that excessive vomiting at pregnancy is a normal pregnancy symptom, 41 (34.2%) disagreed while 15 (12.5%) were not sure. In addition, 65 (54.2%) agreed that swelling of feet is normal in pregnancy 32 (26.7%) disagreed while 23 (19.1%) were not sure. Besides, 43 (35.8%) respondents agreed that anaemia/paleness in pregnancy is a sign of danger, 68 (56.7%) disagreed while 9 (7.5%) were not sure. Moreover, 43 (35.8%) respondents agreed that excessive bleeding during delivery is normal, 59 (49.2%) agreed while 18 (15.0%) were not sure. Also, 54 (45.0%) of the respondents indicated that excessive bleeding during delivery is normal, 51 (42.5%) went for false while 15 (12.5%) were not sure. The table further shows that 51 (42.5%) agreed that excessive bleeding during delivery is normal, 54 (45.0%) while 15 (12.5%) were not sure. In addition, 32 (26.7%) of the respondents agreed that counting fetal movement daily in the last stage of pregnancy is necessary, 67 (55.8%) disagreed while 21 (17.5%) were not sure. Besides, 67 (55.8%) of the respondents agreed that iron rich food is harmful during pregnancy, 49 (40.8%) disagreed while 4 (3.3%) were not sure. Moreover, 34 (28.4%) of the respondents agreed that consumption of fruits and vegetables is necessary during pregnancy, 61 (50.8%) disagreed while 25 (20.8%) were not sure. Also, 44 (36.7%) of the respondents agreed that checking blood pressure regularly is necessary in pregnancy, 66 (55.0%) disagreed while 10 (8.3%) were not sure. Moreover, 38 (31.7%) of the respondents agreed that calcium supplement is required in pregnancy 63 (52.5%) disagreed while 19 (15.0%) were not sure.The weighted mean value of 1.37 is lower than the criterion of 2.0; hence, it could be inferred that the level of knowledge of safety education on maternal healthcare among the TBAs is low.

Research question 2: Is the practice of maternal care by TBA in line with maternal safety procedure?

Table 4.1b:Analysis on practice of maternal care by TBA

Item	Never	Rarely	Sometimes	Always	Mean	SD
I always observe hand hygiene strictly immediately on arrival at work	23 19.1%	42 35.0%	41 34.2%	14 11.7%	2.37	1.07
I always observe hygiene strictly after touching blood, body fluids, secretions and contaminated items whether I put on gloves or not	21 17.5%	53 44.2%	28 23.3%	18 15.0%	2.35	1.13
I always observe hand hygiene strictly before wearing gloves for invasive procedures and after removing gloves	21 17.5%	40 33.3%	31 25.8%	28 23.3%	2.33	.99
I always observe hand hygiene strictly between procedures on the same patient	31 25.8%	46 38.3%	35 29.2%	8 6.7%	2.25	1.10
I use liquid soap and running water when washing my hands after attending to pregnant women	29 24.2%	44 36.7%	38 31.7%	9 7.5%	1.88	1.04
I use disposable tissue paper or dry towel to dry my hands after washing	27 22.5%	36 30.0%	39 32.5%	18 15.0%	2.11	1.13
I wear mask, gown and other protective barriers whenever there is potential for splashing of blood or other blood fluids attending to pregnant women	22 18.3%	41 34.2%	24 20.0%	33 27.5%	1.99	1.11
I wear mask, gown and other protective barriers whenever there is potential for splashing of blood or other blood fluids attending to pregnant women	22 18.3%	41 34.2%	24 20.0%	33 27.5%	1.99	1.11
I decontaminate spills of blood or other body fluids by using chlorine	24 20.0%	36 30.0%	41 34.2%	19 15.8%	1.88	1.10
I ensure that domestic wastes (paper, plastics etc.) are separated from clinical wastes	22 18.3%	41 34.2%	40 33.3%	17 14.2%	2.17	1.09
Sharp objects like needles and blades are disposed safely in re-usable sharps container and later emptied into sharps pit or incinerated	11 9.2%	50 41.7%	51 42.5%	8 6.7%	1.86	1.13
I take my clients' history of pregnancy before giving service	14 11.7%	43 35.8%	41 34.2%	22 18.3%	1.86	1.16
I check the pregnant women's antenatal cards before giving service to determine gestational age and danger/risk conditions if any	10 8.3%	44 36.7%	52 43.3%	14 11.7%	1.85	1.16
Weighted Mean= 2.07 **Criterion= 2.5**						

As indicated in table above, 23 (19.1%) of the respondents never observe hand hygiene strictly immediately on arrival at work, 42 (35.0) went for rarely, 41 (34.2%) went for sometimes while 14 (11.7%) always do. Concerning observance of hygiene strictly after touching blood, body fluids, secretions and contaminated items whether I put on gloves or not, 21 (17.5%) never does, 53 (44.2%) rare do, 28 (23.3%) sometime do while 18 (15.0%) always do. On observance of hand hygiene strictly before wearing gloves for invasive procedures and after removing gloves 21 (17.5%) never do, 40 (33.3%) rarely do, 31 (25.8%) sometimes do while 28 (23.3%) always do. Besides, 31 (25.8%) of the respondents never observe hand hygiene strictly between procedures on the same patient, 46 (38.3%) rarely do, 35 (29.2%) sometimes do while 8 (6.7%) always do. On the use of liquid soap and running water when washing hands after attending to pregnant women, 29 (24.2%) never, 44 (36.7%) rarely, 38 (31.7%) sometimes do. On the issue of use of disposable tissue paper or dry towel to dry my hands after washing,27 (22.5%) never do it, 36 (30.0%) rarely do it, 39 (32.5%) sometimes do it while 18 (15.0%) always do it. Concerning decontamination of spills of blood or other body fluids by using chlorine, 24 (20.0%) never does, 36 (30.0%) rare do, 41 (34.2%) sometime do while 19 (15.8%) always do. On ensuring that domestic wastes (paper, plastics etc.) are separated from clinical wastes 22 (18.3%) never do, 41 (34.2%) rarely do, 40 (33.3%) sometimes do while 17 (14.2%) always do. As regards sharp objects like needles and blades are disposed safely in re-usable sharps container and later emptied into sharps pit or incinerated, 11 (9.2%) never do, 50 (41.7%) rarely do, 51 (42.5%) sometimes do while 8 (6.7%) always do. On if they take clients' history of pregnancy before giving service, 14 (11.7%) never do, 43 (35.8%) rarely, 41 (34.2%) sometimes do while 22 (18.3%). Concerning check the pregnant women's antenatal cards before giving service to determine gestational age and danger/risk conditions if any, 10 (8.3%) never do, 44 (36.7%) rare do, 52 (43.3%) sometime do while 14 (11.7%) always do. The weighted mean value of 2.07 is lower than the criterion of 2.5; hence, it could be inferred that the practice of maternal care by TBA is not in line with maternal safety procedure.

Research question 3: Does the educational background of TBA influence maternal healthcare practice?

Table 4.1c: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare by educational status

Dependent Variable	Educational status	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Practice	No formal education	33.117[a]	.621	31.886	34.347
	Primary education	35.359	.714	33.944	36.774
	Secondary education	35.392	.644	34.114	36.669
	Tertiary education	44.250[a]	2.209	39.872	48.628

Table 4.1cshows that participants with tertiary education obtained a highest mean score ($\bar{x}$ =44.25) followed by participants with secondary education with a mean score of ($\bar{x}$ =35.39) then participants with primary education with a mean score of ($\bar{x}$ =35.36) while participants with no formal education had the lowest mean score of ($\bar{x}$ =33.12). This shows that participants with tertiary education performed best. It then means that participants with tertiary education had better practice of maternal healthcare than participants with primary, secondary or no formal education

Research question 4: Will years of working experience interfere with the knowledge and practice of maternal healthcare?

Table 4.1d: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare by years of working experience

Dependent Variable	Years of working experience	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Knowledge	Short	33.840[a]	.637	32.577	35.103
	Long	39.039[a]	.565	37.919	40.159

Table 4.1cshows that participants with long years of working experience obtained a higher mean score ($\bar{x}$ =39.039) while participant with short years of working experience had a mean score of ($\bar{x}$ =33.84). This shows that participants with long years of working experience had better knowledge of maternal healthcare than the participants with low years of working experience.

Section C

Hypotheses testing

This section presents the result of the tested hypotheses

Ho 1a: There will be no significant main effect of treatment on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State

Table 4.2: Summary of ANCOVA showing the post-test effects of treatment, educational status and years of working experience on knowledge and practice of maternal healthcare among TBAs in Lagos State, Nigeria

Source	Dependent Variable	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	knowledge	27316.863[a]	12	2276.405	218.590	.000	.461
	Practice	30449.620[b]	12	2537.468	195.071	.000	.456
Intercept	knowledge	59117.815	1	59117.815	5676.737	.000	.481
	Practice	57442.978	1	57442.978	4416.002	.000	.476
Treatment	knowledge	12384.008	1	12384.008	1189.164	.000	.417
	Practice	13783.460	1	13783.460	1059.621	.000	.408
Educational status	knowledge	100.846	3	33.615	3.228	.056	.008
	Practice	120.404	3	40.135	3.085	.060	.008
Years of working experience	knowledge	37.510	1	37.510	3.602	.060	.008
	Practice	93.493	1	93.493	7.187	.009	.063
Treatment * years of working experience	knowledge	204.178	1	204.178	19.606	.000	.155
	Practice	209.987	1	209.987	16.143	.000	.131
Treatment * educational status	knowledge	17.454	2	8.727	.838	.435	.015
	Practice	26.482	2	13.241	1.018	.365	.019
Educational status * years of working experience	knowledge	76.578	3	25.526	2.451	.067	.006
	Practice	62.334	3	20.778	1.597	.194	.043
Treatment * educational status * years of working experience	knowledge	.141	1	.141	.014	.908	.001
	Practice	1.756	1	1.756	.135	.714	.001
Error	knowledge	1114.303	107	10.414			
	Practice	1391.847	107	13.008			
Total	knowledge	196432.000	120				
	Practice	196714.000	120				
Corrected Total	knowledge	28431.167	119				
	Practice	31841.467	119				

a. R Squared = .961 (Adjusted R Squared = .956)

b. R Squared = .956 (Adjusted R Squared = .951)

The results presented in Table 4.2 shows that there was a significant main effect of treatment on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(1,107);} = 1189.16$, $p<.05$, $\eta^2=.417$). This implies that the treatments contributed significantly to the variation in participants' scores on knowledge of maternal healthcare. The eta value of .417 shows that the treatments had a contribution of about 42% to knowledge of maternal healthcare of the participants.

Table 4.3a: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare between the treatment groups

Dependent Variable	Treatment Group	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Knowledge	Experimental	48.747[a]	.697	47.365	50.129
	Control	22.515[a]	.423	21.676	23.353

Table 4.3a showed that participants in experimental group obtained a higher mean score ($\overline{x}$ =48.747) while control had a mean score of ($\overline{x}$ =22.515). This shows that participants in experimental group had better knowledge of maternal healthcare than the control group. It then means that the treatment had better effect on knowledge of maternal healthcare of the participant in experimental group than the participants in the control group.

Ho 1b: There will be no significant main effect of treatment on practice of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was a significant main effect of treatment on practice of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(1,107);} = 1059.62$, $p<.05$, $\eta^2=.408$). This implies that the treatments contributed significantly to the variation in participants' scores on practice of maternal healthcare. The eta value of .408 shows that the treatment had a contribution of about 41% to practice of maternal healthcare among the participants.

Table 4.3b: Adjusted Marginal Mean showing the direction of difference in practice of maternal healthcare between the treatment groups

Dependent Variable	Treatment Group	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Practice	Experimental	48.976[a]	.779	47.431	50.520
	Control	21.337[a]	.473	20.400	22.274

Table 4.3b shows that participants in experimental group obtained a higher mean score ($\overline{x}$ =48.976) while control had a mean score of ($\overline{x}$ =21.337). This shows that participants in experimental group had better practice of maternal healthcare than the participants in the control group. It then means that the treatment had better effect on practice of maternal healthcare of the participant in experimental group than the participants in the control group.

Ho 2a: There will be no significant main effect of educational status on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was no significant main effect of educational status on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(3,107);} = 3.228$, $p>.05$, $\eta^2=.008$). This implies that the educational status did not contribute significantly to the variation in participants' scores on knowledge of maternal healthcare. The eta value of .008 shows that the treatments had a contribution of less than 1% to knowledge of maternal healthcare of the participants.

Table 4.4a: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare by educational status between the treatment groups

Dependent Variable	Educational status	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Knowledge	No formal education	33.494[a]	.555	32.393	34.596
	Primary education	35.955	.639	34.689	37.221
	Secondary education	35.753	.577	34.610	36.896
	Tertiary education	44.500[a]	1.976	40.582	48.418

Table 4.4a shows that participants with tertiary education obtained a highest mean score ($\overline{x}$ =44.50) followed by participants with primary education with a mean score of ($\overline{x}$ =35.955) then participants with secondary education with a mean score of ($\overline{x}$ =35.753) while participants with no formal education had the lowest mean score of ($\overline{x}$ =33.494). This shows that participants with tertiary education performed best. It then means that participants with tertiary education had better knowledge of maternal healthcare than participants with primary, secondary or no formal education

Ho 2b: There will be no significant main effect of educational status on practice of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was no significant main effect of educational status on practice of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(3,107);} = 3.085$, $p>.05$, $\eta^2=.008$). This implies that the educational status did not contribute significantly to the variation in participants' scores on practice of maternal healthcare. The eta value of .008 shows that the treatment had a contribution of less than 1% to practice of maternal healthcare of the participants.

Table 4.4b: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare by educational status between the treatment groups

Dependent Variable	Educational status	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Practice	No formal education	33.117[a]	.621	31.886	34.347
	Primary education	35.359	.714	33.944	36.774
	Secondary education	35.392	.644	34.114	36.669
	Tertiary education	44.250[a]	2.209	39.872	48.628

Table 4.4b shows that participants with tertiary education obtained a highest mean score ($\overline{x}$ =44.25) followed by participants with secondary education with a mean score of ($\overline{x}$ =35.39) then participants with primary education with a mean score of ($\overline{x}$ =35.36) while participants with no formal education had the lowest mean score of ($\overline{x}$ =33.12). This shows that participants with tertiary education performed best. It then means that participants with tertiary education had better practice of maternal healthcare than participants with primary, secondary or no formal education

Ho 3a: There will be no significant main effect of years of working experience on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was no significant main effect of years of working experience on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(1,107);}$ = 3.602, p>.05, η^2=.008). This implies that years of working experience did not contribute significantly to the variation in participants' scores on knowledge of maternal healthcare. The eta value of .008 shows that the treatment had a contribution of less than 1% to knowledge of maternal healthcare of the participants.

Table 4.5a: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare by years of working experience between the treatment groups

Dependent Variable	Years of working experience	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Knowledge	Short	33.840[a]	.637	32.577	35.103
	Long	39.039[a]	.565	37.919	40.159

Table 4.5a shows that participants with long years of working experience obtained a higher mean score ($\bar{x}$ =39.039) while participant with short years of working experience had a mean score of ($\bar{x}$ =33.84). This shows that participants with long years of working experience had better knowledge of maternal healthcare than the participants with low years of working experience.

Ho 3b: There will be no significant main effect of years of working experience on practice of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was a significant main effect of years of working experience on practice of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(1,107);} = 7.187$, $p<.05$, $\eta^2=.063$). This implies that years of working experience contributed significantly to the variation in participants' scores on practice of maternal healthcare. The eta value of .063 shows that the treatment had a contribution of about 7% to practice of maternal healthcare of the participants.

Table 4.5b: Adjusted Marginal Mean showing the direction of difference in practice of maternal healthcare by years of working experience between the treatment groups

Dependent Variable	Years of working experience	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Practice	Short	32.778[a]	.712	31.366	34.189
	Long	39.169[a]	.631	37.918	40.421

Table 4.5b shows that participants with long years of working experience obtained a higher mean score ($\overline{x}$ =39.169) while participant with short years of working experience had a mean score of ($\overline{x}$ =32.778). This shows that participants with long years of working experience had better practice of maternal healthcare than the participants with low years of working experience.

Ho 4a: There will be no significant interaction effect of treatment and educational status on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was no significant interaction effect of treatment and educational status on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(2,107);}$ = .838, p>.05, η^2=.015). This implies that the interaction effect of treatment and educational status did not contribute significantly to the variation in participants' scores on knowledge of maternal healthcare. The eta value of .015 shows that the interaction effect of treatment and educational status had a contribution of about 2% to knowledge of maternal healthcare of the participants

Table 4.6a: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare by interaction of treatment and educational status between the treatment groups

Dependent Variable	Treatment	Educational status	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Knowledge	Experimental	No formal education	55.400[a]	1.020	53.377	57.423
		Primary education	49.348	.990	47.384	51.311
		Secondary education	49.066	.897	47.289	50.844
		Tertiary education	44.500	1.976	40.582	48.418
	Control	No formal education	22.542	.659	21.236	23.848
		Primary education	22.563	.807	20.963	24.162
		Secondary education	22.439	.725	21.002	23.877
		Tertiary education	.[b]	.	.	.

Table 4.6a shows that participants in control group with primary education obtained the highest mean score ($\bar{x}$ =22.563), followed by those with no formal education with a mean score ($\bar{x}$ =22.542) and participants with secondary education in the control group has the lowest mean score of ($\bar{x}$ =22.439). This shows that participants in control group with no formal education performed better in knowledge of maternal healthcare than the participant in control group with primary and secondary education. Also from the table participants in experimental group with no formal education obtained the highest mean score ($\bar{x}$ =55.40), followed by participants with primary education with a mean score ($\bar{x}$ =49.348), then participants with secondary education with a mean score ($\bar{x}$ =49.066) while participants with tertiary education in experimental group had the lowest mean score ($\bar{x}$ =44.50). This shows that participants in experimental group with no formal education performed best in knowledge of maternal healthcare across the groups.

Ho 4b: There will be no significant interaction effect of treatment and educational status on practice of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was no significant interaction effect of treatment and educational status on practice of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(2,107);} = 1.018$, $p>.05$, $\eta^2=.019$). This implies that the interaction effect of treatment and educational status did not contribute significantly to the variation in participants' scores on practice of maternal healthcare. The eta value of .019 shows that the interaction effect of treatment and educational status had a contribution of about 2% to practice of maternal healthcare of the participants

Table 4.6b: Adjusted Marginal Mean showing the direction of difference in practice of maternal healthcare by interaction of treatment and educational status between the treatment groups

Dependent Variable	Treatment	Educational status	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Practice	Experimental	No formal education	56.600[a]	1.141	54.339	58.861
		Primary education	49.217	1.107	47.023	51.412
		Secondary education	49.647	1.002	47.660	51.634
		Tertiary education	44.250	2.209	39.872	48.628
	Control	No formal education	21.375	.736	19.916	22.834
		Primary education	21.500	.902	19.713	23.287
		Secondary education	21.136	.811	19.530	22.743
		Tertiary education	.[b]	.	.	.

Table 4.6b shows that participants in control group with primary education obtained the highest mean score ($\bar{x}$ =21.50), followed by those with no formal education with a mean score ($\bar{x}$ =21.375) and participants with secondary education in the control group has the lowest mean score of ($\bar{x}$ =21.136). This shows that participants in control group with no formal education performed better in practice of maternal healthcare than the participant in

control group with primary and secondary education. Also from the table participants in experimental group with no formal education obtained the highest mean score ($\bar{x}$ =56.60), followed by participants with secondary education with a mean score ($\bar{x}$ =49.647), then participants with primary education with a mean score ($\bar{x}$ =49.217) while participants with tertiary education in experimental group had the lowest mean score ($\bar{x}$ =44.25). This shows that participants in experimental group with no formal education performed best in practice of maternal healthcare across the groups.

Ho 5a: There will be no significant interaction effect of treatment and years of working experience on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was a significant interaction effect of treatment and years of working experience on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(1,107);} = 19.606$, $p<.05$, $\eta^2=.155$). This implies that the interaction effect of treatment and years of working experience contributed significantly to the variation in participants' scores on knowledge of maternal healthcare. The eta value of .155 shows that the interaction effect of treatment and years of working experience had a contribution of about 16% to knowledge of maternal healthcare of the participants.

Table 4.7a: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare by interaction of treatment and years of working experience between the treatment groups

Dependent Variable	Treatment	Years of working experience	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Knowledge	Experimental group	Short	45.417[a]	1.120	43.197	47.636
		Long	51.245	.885	49.491	52.998
	Control group	Short	22.264[a]	.608	21.059	23.469
		Long	22.765[a]	.588	21.599	23.932

Table 4.7a shows that participants with long years of working experience in control group obtained a higher mean score ($\overline{x}$ =22.765) than the participants with short years of experience in the control group with a mean score of ($\overline{x}$ =22.264). This shows that participants with long years of working experience in control group performed better than the participants with short years of working experience in control group. Also, from the table participants with long years of working experience in experimental group obtained a higher mean score ($\overline{x}$ =51.245) than the participants in experimental group with short years of working experience with a mean score of ($\overline{x}$ =45.417). This shows that participants with long years of working experience in experimental group performed best in knowledge of maternal healthcare across the groups.

Ho 5b: There will be no significant interaction effect of treatment and years of working experience on practice of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was a significant interaction effect of treatment and years of working experience on practice of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(1,107);} = 16.143$, $p<.05$, $\eta^2=.131$). This implies that the interaction effect of treatment and years of working experience contributed significantly to the variation in participants' scores on practice of maternal healthcare. The eta value of .131 shows that the interaction effect of treatment and years of working experience had a contribution of about 13% to practice of maternal healthcare of the participants.

Table 4.7b: Adjusted Marginal Mean showing the direction of difference in practice of maternal healthcare by interaction of treatment and years of working experience between the treatment groups

Dependent Variable	Treatment	Years of working experience	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Practice	Experimental group	Short	44.833[a]	1.251	42.353	47.314
		Long	52.082	.989	50.122	54.042
	Control group	Short	20.722[a]	.679	19.375	22.069
		Long	21.952[a]	.658	20.648	23.256

Table 4.7b shows that participants with long years of working experience in control group obtained a higher mean score ($\overline{x}$ =21.952) than the participants with short years of experience in the control group with a mean score of ($\overline{x}$ =20.722). This shows that participants with long years of working experience in control group performed better than the participants with short years of working experience in control group. Also, from the table participants with long years of working experience in experimental group obtained a higher mean score ($\overline{x}$ =52.082) than the participants in experimental group with short years of working experience with a mean score of ($\overline{x}$ =44.833). This shows that participants with long years of working experience in experimental group performed best in practice of maternal healthcare across the groups.

Ho 6a: There will be no significant interaction effect of educational status and years of working experience on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was no significant interaction effect of educational status and years of working experience on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(3,107);}$ = 2.451, p>.05, η^2=.006). This implies that the interaction effect of educational status and years of working experience did not contribute significantly to the variation in participants' scores on knowledge of maternal healthcare. The eta value of .006 shows that the interaction effect of treatment and

educational status had a contribution of less than 1% to knowledge of maternal healthcare of the participants

Table 4.8a: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare by interaction of educational status and years of working experiencebetween the treatment groups

Dependent Variable	Educational status	Years of working experience	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Knowledge	No formal education	Short	22.333[a]	.932	20.487	24.180
		Long	39.075	.691	37.705	40.445
	Primary education	Short	33.563	1.092	31.397	35.728
		Long	38.348	.662	37.035	39.661
	Secondary education	Short	33.792	.970	31.870	35.714
		Long	37.714	.624	36.476	38.952
	Tertiary education	Short	43.000[a]	2.282	41.476	50.524
		Long	46.000[a]	3.227	36.603	49.397

Table 4.8a shows that participants with long years of working experience and no formal education obtained a higher mean score ($\overline{x}$ =39.075) than those with short years of working experience and no formal education with a mean score of ($\overline{x}$ =22.33). This shows that participants with long years of working experience and no formal education performed better than those with short years of working experience and no formal education. Also, participants with long years of working experience and primary education obtained a higher mean score ($\overline{x}$ =38.348) than those with short years of working experience and primary education with a mean score of ($\overline{x}$ =22.33). This shows that participants with long years of working experience and primary education performed better than those with short years of working experience and primary education. Participants with long years of working experience and secondary education obtained a higher mean score ($\overline{x}$ =37.714) than those with short years of working experience and secondary education with a mean score of ($\overline{x}$ =33.792). This shows that participants with long years of working experience and secondary education

performed better than with short years of working experience and secondary education. Also, from the table participants with long years of working experience and tertiary education obtained a higher mean score ($\bar{x}$ =46.00) than those with short years of working experience and tertiary education with a mean score of ($\bar{x}$ =43.00). This shows that participants with long years of working experience and tertiary education performed better than with short years of working experience and tertiary education. In all participants with long years of working experience and tertiary education performed best in knowledge of maternal healthcare across the groups.

Ho 6b: There will be no significant interaction effect of educational status and years of working experience on practice of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was no significant interaction effect of educational status and years of working experience on practice of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(3,107);} = 1.597$, $p>.05$, $\eta^2=.043$). This implies that the interaction effect of educational status and years of working experience did not contribute significantly to the variation in participants' scores on practice of maternal healthcare. The eta value of .043 shows that the interaction effect of treatment and educational status had a contribution of about 4% to practice of maternal healthcare of the participants

Table 4.8b: Adjusted Marginal Mean showing the direction of difference in practice of maternal healthcare by interaction of educational status and years of working experiencebetween the treatment groups

Dependent Variable	Educational status	Years of working experience	Mean	Std. Error	95% Confidence Interval	
					Lower Bound	Upper Bound
Practice	No formal education	Short	20.667[a]	1.041	18.603	22.731
		Long	39.342	.772	37.811	40.872
	Primary education	Short	33.250	1.221	30.830	35.670
		Long	37.467	.740	36.000	38.935
	Secondary education	Short	32.500	1.084	30.352	34.648
		Long	38.283	.698	36.900	39.667
	Tertiary education	Short	44.000[a]	2.550	39.444	49.556
		Long	44.500[a]	3.607	36.850	51.150

Table 4.8b shows that participants with long years of working experience and no formal education obtained a higher mean score ($\bar{x}$ =39.342) than those with short years of working experience and no formal education with a mean score of ($\bar{x}$ =20.667). This shows that participants with long years of working experience and no formal education performed better than those with short years of working experience and no formal education. Also, participants with long years of working experience and primary education obtained a higher mean score ($\bar{x}$ =37.467) than those with short years of working experience and primary education with a mean score of ($\bar{x}$ =33.25). This shows that participants with long years of working experience and primary education performed better than those with short years of working experience and primary education. Participants with long years of working experience and secondary education obtained a higher mean score ($\bar{x}$ =38.28) than those with short years of working experience and secondary education with a mean score of ($\bar{x}$ =32.50). This shows that participants with long years of working experience and secondary education performed better than with short years of working experience and secondary education. Also, from the table participants with long years of working experience and tertiary education obtained a higher mean score ($\bar{x}$ =44.50) than those with short years of working experience and tertiary

education with a mean score of ($\overline{x}$ =44.00). This shows that participants with long years of working experience and tertiary education performed better than with short years of working experience and tertiary education. In all participants with long years of working experience and tertiary education performed best in practice of maternal healthcare across the groups.

Ho 7a: There will be no significant interaction effect of treatment, educational status and years of working experience on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was no significant interaction effect of treatment, educational status and years of working experience on knowledge of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(1,107);}$ = .014, p>.05, η^2=.001). This implies that the interaction effect of treatment, educational status and years of working experience did not contribute significantly to the variation in participants' scores on knowledge of maternal healthcare. The eta value of .001 shows that the interaction effect of treatment, educational status and years of working experience had a contribution of less than 1% to knowledge of maternal healthcare of the participants

Table 4.9a: Adjusted Marginal Mean showing the direction of difference in knowledge of maternal healthcare by interaction of treatment, educational status and years of working experiencebetween the treatment groups

Dependent Variable	Treatment	Educational status	Years of working experience	Mean	Std. Error	95% Confidence Interval	
						Lower Bound	Upper Bound
Knowledge	Experimental	No formal education	Short	.[a]	.	.	.
			Long	55.400	1.020	53.377	57.423
		Primary education	Short	45.000	1.863	41.307	48.693
			Long	53.696	.673	52.362	55.030
		Secondary education	Short	45.250	1.614	42.051	48.449
			Long	52.882	.783	51.331	54.434
		Tertiary education	Short	46.000	2.282	41.476	50.524
			Long	43.000	3.227	36.603	49.397
	Control	No formal education	Short	22.333	.932	20.487	24.180
			Long	22.750	.932	20.903	24.597
		Primary education	Short	22.125	1.141	19.863	24.387
			Long	23.000	1.141	20.738	25.262
		Secondary education	Short	22.333	1.076	20.201	24.466
			Long	22.545	.973	20.617	24.474
		Tertiary education	Short	.[a]	.	.	.
			Long	.[a]	.	.	.

Table 4.9a shows that participants in control group with long years of working experience and no formal education obtained a higher mean score ($\bar{x}$ =22.75) than those with short years of working experience and no formal education with a mean score of ($\bar{x}$ =22.33). This shows that participants in the control group with long years of working experience and no formal education performed better than those in the same group but with short years of working experience and no formal education. Also, in the control group, participants with

long years of working experience and primary education obtained a higher mean score ($\overline{x}$ =23.00) than those with short years of working experience and primary education with a mean score of ($\overline{x}$ =22.125). This shows that participants in the control group with long years of working experience and primary education performed better than those with short years of working experience and primary education in the control group. Participants with long years of working experience and secondary education in the control group obtained a higher mean score ($\overline{x}$ =22.545) than those with short years of working experience and secondary education with a mean score of ($\overline{x}$ =22.33). This shows that participants in control group with long years of working experience and secondary education performed better than with short years of working experience and secondary education in the same group. In the experimental groups, participants in with long years of working experience and no formal education obtained a mean score ($\overline{x}$ =55.40). Also, in the same group, participants with long years of working experience and primary education obtained a higher mean score ($\overline{x}$ =53.696) than those with short years of working experience and primary education with a mean score of ($\overline{x}$ =45.00). This shows that participants in the experimental group with long years of working experience and primary education performed better than those with short years of working experience and primary education in the control group. Participants with long years of working experience and secondary education in the experimental group obtained a higher mean score ($\overline{x}$ =52.88) than those with short years of working experience and secondary education with a mean score of ($\overline{x}$ =45.25). This shows that participants in experimental group with long years of working experience and secondary education performed better than with short years of working experience and secondary education in the same group. Also, from the experimental group, participants with short years of working experience and tertiary education obtained a higher mean score ($\overline{x}$ =46.00) than those with long years of working experience and tertiary education with a mean score of ($\overline{x}$ =43.00). This shows that participants in experimental group with short years of working experience and tertiary education performed better than with long years of working experience and tertiary education. In all participants with long years of working experience and no formal education in the experimental group performed best in knowledge of maternal healthcare across the groups

Ho 7b: There will be no significant interaction effect of treatment, educational status and years of working experience on practice of maternal healthcare among Traditional Birth Attendants in Lagos State

The results presented in Table 4.2 shows that there was no significant interaction effect of treatment, educational status and years of working experience on practice of maternal healthcare among Traditional Birth Attendants in Lagos State ($F_{(1,107);} = .135$, $p>.05$, $\eta^2=.001$). This implies that the interaction effect of treatment, educational status and years of working experience did not contribute significantly to the variation in participants' scores on practice of maternal healthcare. The eta value of .001 shows that the interaction effect of treatment, educational status and years of working experience had a contribution of less than 1% to practice of maternal healthcare of the participants

Table 4.9b: Adjusted Marginal Mean showing the direction of difference in practice of maternal healthcare by interaction of treatment, educational status and years of working experiencebetween the treatment groups

Dependent Variable	Treatment	Educational status	Years of working experience	Mean	Std. Error	95% Confidence Interval	
						Lower Bound	Upper Bound
Practice	Experimental	No formal education	Short	.[a]	.	.	.
			Long	56.600	1.141	54.339	58.861
		Primary education	Short	45.000	2.082	40.872	49.128
			Long	53.435	.752	51.944	54.926
		Secondary education	Short	45.000	1.803	41.425	48.575
			Long	54.294	.875	52.560	56.028
		Tertiary education	Short	44.000	3.607	36.850	51.150
			Long	44.500	2.550	39.444	49.556
	Control	No formal education	Short	20.667	1.041	18.603	22.731
			Long	22.083	1.041	20.019	24.147
		Primary education	Short	21.500	1.275	18.972	24.028
			Long	21.500	1.275	18.972	24.028
		Secondary education	Short	20.000	1.202	17.617	22.383
			Long	22.273	1.087	20.117	24.428
		Tertiary education	Short	.[a]	.	.	.
			Long	.[a]	.	.	.

Table 4.9b demonstrates that members in control aggregate with long years of working experience and no formal education got a higher mean score (=22.083) than those with brief years of working experience and no formal education with a mean score of (=22.667). This demonstrates members in the control aggregate with long years of working experience and no formal education performed superior to those in a similar gathering however with brief years of working experience and no formal education. Likewise, in the control gathering, members with long years of working experience and essential education got a similar mean score (=21.50) with those with brief years of working experience and

essential education. Members with long years of working experience and auxiliary education in the control assemble got a higher mean score (=22.273) than those with brief years of working experience and optional education with a mean score of (=20.00). This demonstrates members in control assemble with long years of working experience and optional education performed superior to with brief years of working experience and auxiliary education in a similar gathering. In the exploratory gatherings, members in with long years of working experience and no formal education got a mean score (=56.60). Additionally, in a similar gathering, members with long years of working experience and essential education got a higher mean score (=53.435) than those with brief years of working experience and essential education with a mean score of (=45.00). This demonstrates members in the test aggregate with long years of working experience and essential education performed superior to those with brief years of working experience and essential education in the control gathering. Members with long years of working experience and auxiliary education in the exploratory gathering got a higher mean score (=54.294) than those with brief years of working experience and optional education with a mean score of (=45.00). This demonstrates members in trial amass with long years of working experience and optional education performed superior to with brief years of working experience and auxiliary education in a similar gathering. Likewise, from the exploratory gathering, members with long years of working experience and tertiary education acquired a higher mean score (=44.50) than those with brief years of working experience and tertiary education with a mean score of (=44.00). This demonstrates members in trial aggregate with long years of working experience and tertiary education performed superior to those with brief years of working experience and tertiary education. In all members with long years of working experience and no formal education in the exploratory gathering performed best in practice of maternal healthcare over the gatherings

Discussion of findings

The aftereffect of this investigation which uncovered that there was a noteworthy fundamental impact of treatment on knowledge and practice of maternal health care among traditional birth attendants in Lagos State is in accordance with the perspective of Moronkola and Okanlawon (2003) who stated that maternal and kid mortality can be anticipated and decreased through powerful health and safety education. They stated further that the huge part of health and safety education in the execution of health mediations went

for lessening mortality among individuals from the network particularly ladies cannot be over-stressed. Additionally, this outcome is upheld by Bryce, Daelmans, Dwivedi, Faureau, Lawn and Masonet, (2008) who presumed that insufficient access to and under-usage of value maternal health care administrations could be real purposes behind weakness of the ladies in the creating nations. Along these lines, the danger of maternal demise might be extraordinarily decreased if the ladies use talented participation for maternal health care administrations. This is in opposition to the perspective of Sibley, Sipe, and Koblinsky (2004) who stated that a survey of the preparation of TBAs with the point of enhancing the health conduct of pregnant ladies found that such preparing did not enhance maternal results.

Davis (2004) states that any finding that the preparation of TBAs has little impact on decreasing maternal mortality are not bolstered by great quality proof. He notes that either the on-going help or the incorporation with existing health administrations did not shape some portion of past preparing of traditional birth attendants. This suggests the preparation itself was not broken but instead the inability to incorporate, screen and oversee the TBAs in their practices. In perspective of this, Asghar (1999) notes that supervision of TBAs establishes the significant connection among them and the formal healthcare framework. Support for this is offered by Bergstrom and Goodburn (2001), who contend that TBAs have a place in obstetric care, the same number of nations do not have the administrations of gifted professional healthcare suppliers and TBAs might be ladies' solitary wellspring of care. The creators communicated solid conviction that prepared TBAs would decrease maternal mortality, in spite of the fact that they can give socially proper sustaining in the network setting and offer a first-connect line with the formal healthcare framework. Imogie, Agwubike and Aluko, (2002) additionally underpins the finding of this examination when they stated that traditional birth attendants could assume significant parts in family arranging, screening of high hazard moms, ripeness/barrenness treatment and maternal and youngster care administrations. Discoveries by Ofili and Okojie (2005) on the part of TBAs in Edo State uncovered that they were found to give a wide scope of conceptive health benefits that included stake natal care, youngster conveyance, and treatment of fruitlessness, administration of debilitated premature birth and circumcision of infants.

The outcome on educational status which demonstrated that there was no noteworthy principle impact of educational status on knowledge and practice of maternal health care among traditional birth attendants in Lagos State is in help of Ayede (2012) who found that

TBAs are generally neighborhood ladies with minimal formal education. Their little formal education is additionally portrayed as not very many of them had more than primary school (8%) education and a substantial extent (20%) did not have any formal education. This pattern is comparative crosswise over nations where the utilization of TBA is normal. This is for the most part thought to be identified with the level of the general educational status of the subjects and the level of destitution. Likewise upheld by this finding is Sibley, Sipe, Brown, Diallo, McNatt and Habarta, (2007) who stated that the way that this aptitude is typically passed from an experienced TBA to another is reflected in the wellsprings of their preparation before beginning to practice as TBAs. As of now in Nigeria, TBAs are viewed as incompetent and are not perceived as a major aspect of the formal health division. Because of the absence of education in some TBAs, the manner in which many went to the conveyance is dangerous for ladies and their infants, prompting weakness results and even demise. In their investigation, Mfrekemfon and Okere, (2015) found that traditional birth attendants have awesome effect in the country network, they are near the general population and the rustic ladies accept and have trust on them so much that they cannot be effectively abrogated in the network. They inferred that, allots ought to be helped to enhance their abilities through health instructing them and sorting out courses. Balogun and Odeyemi, (2010) additionally found that the educational status of TBAs is one of the most grounded factors influencing the conveyance of their administration. They reasoned that if TBAs could get essential education, it will enhance their support of an awesome measure. Inyang and Anucha, (2015) found that TBAs with higher years of experience perform better in conveyance of their administration than those with bring down years of experience. They along these lines inferred that there is a critical contrast in conveyance of administration among TBAs in light of years of experience.

Inyang and Anucha (2015) noted that TBAs may not get formal education and preparing in health care arrangement, and there are no particular professional imperatives, for example, accreditation or permitting. Likewise, because of absence of education with some TBAs, the manner in which they take care of conveyance is unsafe for ladies and their infants, prompting weakness results and even demise. Obsolete and unseemly obstetrical practices among TBAs were likewise announced by Bucher et al., (2016) in a review of self-detailed obstetrical practices among TBAs. Bucher et al., (2016) is of view that these negative practices, notwithstanding, past analysts anyway reasoned that since TBAs have had incredible effect in the provincial networks, their parts cannot be nullified

or neglected accordingly viable measures to prepare and enhance their abilities and characterize their parts is fundamental.

Brennan (1989) stated that an examination in Nigeria analyzed changes in MMR following preparing of 75 TBAs inside a 10-mile range of a referral doctor's facility. Maternal passings dropped by half (30to15) in the 3 years following the preparation. Non-haphazardly chose examination regions were more removed from the healing center. The maternal passings in these locales dropped by 27%, (34to25) in a similar era. Measurable examination was not performed. Another investigation in Senegal has endeavored to think about the effect of preparing professional birthing specialists with preparing TBAs. Maternal mortality was higher in territories where ladies conceived an offspring for the most part in healthcare focuses helped by TBAs, than in regions where ladies conceived an offspring in health offices helped by birthing specialists. The specialists propose that birthing assistants in health offices distinguished more obstetric complexities than TBAs prompting quick care and lower-case casualty rates.

Goodburn et al. (2000) found that two investigations analyzed propose that the effect of preparing isn't probably going to be imperative. One investigation in Bangladesh demonstrated that albeit prepared TBAs will probably practice sterile conveyance than untrained TBAs (45%v19.3%), there was no huge contrast in levels of baby blues contamination when conveyances via prepared TBAs and untrained TBAs were looked at. In Ghana, an investigation assessing the effect of TBA preparing on the health of moms and new-borns demonstrated that moms gone to by a prepared TBA were more averse to have experienced baby blues fever and held placenta, yet more prone to have had a drawn out work. Smithet al. 2000 affectionate no noteworthy affiliation was found among preparing and other dreariness indications or with referral rates. None of these investigations prompts an end that TBA preparing as a solitary mediation can significantly affect maternal mortality.

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

This section presented the summary, conclusion and recommendations which were drawn in view of the aftereffect of the discoveries. Also, the contributions of this thesis to knowledge as well as suggestions for further studies were documented.

Summary

The study investigated the effect of safety education on knowledge and practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria. The study was carried out using quasi-experimental research design of pretest-posttest control group type using 2x2x2 factorial matrix. One hundred and twenty participants were selected as sample for the study using multi-stage sampling procedures that involve purposive and simple random sampling techniques. The participants were placed in two groups; experimental and control group. Participants in experimental group were exposed to nine weeks training using the manual developed by the researcher while the participants in the control group were given placebo (disease prevention education). Data were collected before and after the intervention programme using self-developed questionnaire as instrument for data collection. Data were analysed using both descriptive and inferential statistics. The descriptive statistics used were frequency count, simple percentage and pie chart while Multivariate Analysis of Covariance was the inferential statistics used to determine the main as well as the interaction effects of the independent, dependent and moderating variables

The study provided answers to three research questions and tested seven hypotheses each with two sub variables, making it fourteen sub variables. Nine of the sub variables were rejected while the remaining were accepted. The result of the study shows that safety education was effective on knowledge and practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria. There was a main significant impact of treatment on knowledge and practice of maternal health care among Traditional Birth Attendants in Lagos State. There was no significant main effect of educational status and years of working experience on knowledge and practice of maternal health care among Traditional Birth Attendants. The result also showed that the interaction effects of treatment and years of working experience on knowledge and practice was significant while the interaction effect of

treatment and educational status were not significant on knowledge and practice of maternal health care among Traditional Birth Attendants.

Conclusion

In light of the discoveries of this examination, it was inferred that safety education had effects on knowledge and practice of maternal health care among Traditional Birth Attendants in Lagos State. Gender has no significant effect on knowledge and practice of maternal health care among Traditional Birth Attendants in Lagos State. The study also concluded that the collabouration impacts of treatment and long periods of working knowledge was significant on knowledge and practice while the interaction effect of treatment and educational status was not significant on knowledge and practice of maternal health care. There was no critical association impact of educational status and years of working experience on knowledge and practice of maternal health care. The 3-way association impact of treatment, educational status and years of working knowledge were not also significant on knowledge and practice of maternal health care among Traditional Birth Attendants in Lagos State.

Recommendations

In view of the discoveries of this investigation and the conclusion drawn thereof, the accompanying suggestions were made:

1. Efforts should be made through practice and policy by government on how to improve the practice of TBA
2. Government should ensure that there is continuous training and retraining for Traditional Birth Attendants so as to improve their services
3. There should be periodic organization of seminars and workshop which will lead to improve service delivery of TBA which will not only contribute to improved health conditions be that as it may, will likewise add to building more beneficial families and network.
4. Multidisciplinary and interdisciplinary research, which would advise the improvement regarding mediation procedures, is additionally required. Both essential and connected research is fundamental, just as an interdisciplinary coordinated effort to create intuitive models that may lead to improved service delivery of TBAs
5. Traditional Birth Attendants should be fully integrated into health care delivery system at all levels

6. There should be an establishment of institutions where Traditional Birth Attendants can be trained formally.

Contribution to knowledge

This study has made the following contribution to knowledge;

1. Safety education provided better facilitating knowledge and practice of maternal health care.
2. Established that Traditional birth attendants with long years of working experience had better knowledge and practice of maternal health care.
3. Majority of TBAs had no formal training and they got into the job though family handed down practice.
4. Fortified that educational status and years of working experience has no significant interaction effect on knowledge and practice of maternal health care among TBAs.
5. Established that Traditional birth attendants with formal educational background had better knowledge and practice of maternal health care.
6. Established that Traditional birth attendants in Lagos State takes an average of ten (10) deliveries in a month.
7. Provided that The interaction of safety education, educational status and years of working experience was not effective on knowledge and practice of maternal health care among TBAs.

Suggestions for further studies

Based on the findings and limitations of the study, the following studies are suggested to be considered worth investigating by researchers;

1. A study of this nature can also be replicated using either time series or longitudinal research design.
2. Effect of educational intervention on myths and misconceptions of TBAs on maternal healthcare can be looked into.
3. Multidisciplinary and interdisciplinary research on maternal healthcare, which would inform the development of intervention strategies to improve service delivery of TBAs is also needed.
4. Knowledge and compliance with safety precautions and standard precautions among traditional birth attendants can also be worked on.

REFERENCES

Abiodun, O., Sotunsa, J., Olu-Abiodun, O., Ani, F., Taiwo, A., and Taiwo, O. 2015 The Effect of Training on Traditional Birth Attendants' Related Knowledge and Care Practices in Nigeria. *Journal of Aids and Clinical Research* 6: 498-505

Adewemimo A, Musa N, Olaiyan B and Adegoke M 2014.Knowledge and practice of prevention of mother-to-child transmission of HIV among traditional birth attendants in Lagos State, Nigeria.*Pan African Medical Journal*.; 5(7): 1-12.

Ajaegbu, O.O. 2013.Perceived Challenges of Using Maternal Healthcare Services in Nigeria. *Arts and Social Sciences Journal*.;3(4): 45-61.

Akaba, G. O., Otubu, J. A. M., Agida, E. T. And Onafowokan, O. 2013.Knowledge and Util ization of Malaria Preventive Measures among Pregnant Women in FCT, Nigeria: *Ni gerian Journal of Clinical Practice*: 16(2): 201-206

Akpala, C.O. 1994.An evaluation of knowledge and practices of trained traditional birth att endants in Bodinga, Sokoto State, Nigeria. *Journal of Tropical Medicine and Hygie ne;* 97(2): 46-50.

Alisjahbana, Williams C, Dharmayanti R, Hermawan D, Kwast B.E. and Koblinsky M 199 5. An integrated village maternity service to improve referral patterns in a rural are a in WestJava. *International Journal of Gynaecology and Obstet*rics48(2):83-94

Amoti Kaguna, B, and Nnwaha, F. 2002.Factors influencing choice of delivery sites in Rak ai distinct of Uganda, *Social Science and medicine* 50 (1): 203-213.

Ampofo, D.A., Nicholas, D.D., Amonoo-Acquab M.B., Ofosu
Amiah S, andNuemann A.K. 1977. The Training of Traditional Birth Attendants in Ghana: Experience of the Danfa Rural Health Project. *Tropical Geographical Med*ic ine 29(2):197-203

Amutah-Onukagha N, Rodriguez M., Opara I., Gardner M., Assan M., Hammond R., Plata J., Pierre K., Farag E., 2017. Progresses and challenges of utilizing traditional birth attendants in maternal and child health in Nigeria; *International Journal of Medicine Candidacies' Heps and AIDS*;, 6(2): 130-138. Available online at www.mchandaids.org

Armstrong, I, Schellenberg, S, Mushi, A. Obrist, D, Mshinda, P, Tanner, S, and Schellenberg, G. 2007.The role of traditional birth attendants in the reduction of maternal mortality. Studies in health and reproduction; 1 7(1): 8 5 – 8 9. Av a i l a b l e f r o m :http://www.itg.be/ITG/GeneralSite/InfSe

Asghar, R. 1999. Obstetric complications and role of Traditional Birth Attendants in Develo ping Countries. *Journal of College of Physicians and Surgeons Pakistan*, 9 (2): 55-57.

Ayede, A. I. 2012. Persistent Mission Home Delivery in Ibadan: Attractive Role of Traditio nal Attendants. *Annals of Ibadan Postgraduate Medicine* 10 (2): 15-19

Balogun, M., and Odeyemi, K. 2010. Knowledge and practice of prevention of mother-to-child transmission of HIV among traditional birth attendants in Lagos State, Nigeria . *Pan African Medical Journal* 5: 7-13.

Bamigboye, A. P., andAdesanya, A.T. 2006.Knowledge and Practice of Universal Precautio ns among Qualifying Medical and Nursing Students: A Case of Obafemi Awolowo University Teaching Hospital Complex, IleIfe. *Research Journal of Medicine and M edical Science* 1(3): 112-116.

Bandura, A. 2002. *Social Cognitive Theory in Cultural Context*. International Association f or Applied Psychology Blackwell Publishers, USA pp 23-29

Bandura,A. 2004.Health Promotion by Social Cognitive Means. *Health Education and Beha viour* 31:143–64

Bang, A. T., Bang, R.A., Baitule, S.B., Reddy, H. M. AndDeshmukh, M. D. 2005. Manage ment of Birth Asphyxia in Home Deliveries in Rural Gadchiroli: The Effect of Two Types of Birth Attendants and of Resuscitation with Mouth-to-Mouth, Tube-Mask: *Journal of Perinatology*, 25, 82-91

Bergstrom, E. And Goodburn, E. 2001. The role of traditional birth attendants in the reducti on of maternal mortality, *Studies in Health Services Organisation and Policy*, 17(1): 77-96.

Bij de Vaate, S, Coleman, R, Manneh, X, and Walraven, H 2002.How the integration of traditional birth attendants with formal health systems can increase skilled birth attendance. *International Journal of Gynaecology and Obstetrics* 115 (2):127–34

Borghi, J., Sabina, N. Blum, L. S., Hogue, M. E. and C Ronsmans, C. 2006. Household Cost s of Healthcare during Pregnancy, Delivery, and the Postpartum Period: A Case Stud y from Matlab, Bangladesh. *Journal of Health, Population and Nutrition*; 24:446455.

Brouwere, D., Tonglet, R. andLerberghe, W. 1998. Strategies for reducing maternal mortalit y in developing countries: what can we learn from the history of the industrialized West? *Tropical Medicine and International Health*, 3(10):771-782.

Bryce N, Daelmans H, Dwivedi T, Faureau W, Lawn Qand Masonet L, 2008. Impact of training of traditional birth attendants on maternal health care: a community-based study. *The Journal of Obstetrics and Gynecology of India*. ; 63(6):383-387

Bucher, S., Konana, O., Liechty, E., Garces, A., Gisore, P., Marete, I., Tenge, C., Shipala, E., Wright, L and Esamai, F. 2016. Selfreported practices among traditionalbirth attendants surveyed in westernKenya: a descriptive study. *Pregnancy and Chil dbirth* 16(1):27-38

Bultery, M., Fowler, M., Shaffer, N., Tih, P., Greenberg, A., Karita, E., Coovadia, H. and D e Cook, K.2002. Role of traditional birth attendants in preventing perinatal transmiss ion of HIV.*British Journal of Medicine*, 324,222-225.

Campbell L and Graham Y, 2006.*Training and Supervision of Traditional Birth Attendants at the Primary Health Care Centre Level.*New York, In Primary maternal and neonatal health: a global concern (eds). F DelMondo, E Ines-Cuyegkeng and DM Aviado), Plenum, pp 483-493.

Carlough, M. and McCall, M. 2005. Skilled Birth Attendance: What does it mean and how c an it be measured? A Clinical Skills Assessment of Maternal and Child Health Workers in Nepal, *International Journal of Gynaecology and Obstetrics,* 89, 200-208

Carroli V, Rooney P and Villar G, 2001.Practices and beliefs of traditional birth attendants: lessons for obstetrics in the north.*Tropical Medicine and. International Health*. 2: 1175–1179

Chakraborty, N., Islam, A., Chowdhury, R. I., and Bari, W. 2002. Utilization of post-natal care in Bangladesh: evidence from a longitudinal study. Health Social Care Co mmunity

Choguya V, 2014. Low Use of Rural Maternity Service in Uganda: Impact of Women's Status,Traditional Beliefs and Limited Resources, *Reproductive Health Matters, 11***,** 16-26.

Crowe C, Utley W, Costello H, and Pagel Y, 2012.Practices and beliefs of traditional birth attendants: lessons for obstetrics in the north. *Trop. Med. Int. Health*. 2: 1175–1179.

David O.M., andFamurewa ,O. 2010. Toward Effective Management of Nosocomial Infecti ons in Nigerian Hospitals- A Review.*Academic Arena*, 2(5): 1-7.

Davis, B. 2004. An Intervention Involving Traditional Birth Attendants in Pakistan: *The New England Journal of Medicine*(Website)

Denler, R. Wolters, P and Benzon, L 2009. Social cognitive theory. Dee publisher, Ohio Retrieved from http://www.education.com/reference/article/social-cognitive-theory

de Sharrat N and Abouzahr S, 2003. Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature. *Journal of Advanced Nursing*, 61 (3): 244–260.

Ejikeme U, Umeora I and Obuna R, 2014. Socio-demographic determinants of maternal health-care service among rural women in Anambra State, South East Nigeria.*Annals of Medical and Health Sciences Research*; 4(3)376-382.

Essien, D. 2006. Reduction of Maternal Mortality in AkwaIbom State. Nigeria, AkwaIbom State Council for Health

Fatmi, Z., Gulzar, A.Z. andKazi, A. 2005. Maternal and NewbornCare:Practices and Beliefs of Traditional Birth Attendants in Sindh, Pakistan *Eastern Mediterranean Health Journal,* 11(1/2), 226-234

Federal Ministry of Health 2004.*Revised National Health Policy*, Nigeria.

Fortney, J.A, and Smith, J.B. 1997. Training of traditional birth attendants: issues and controversies. Durham, NC: Family Health International and United Nations Children's Fund.

Furuta, M. and Salway, S. 2006 Women's Position within the Household as a Determinant o f Maternal Health Care Use in Nepal. *International Family Planning Perspectives*; 3 2(1):17–27.

Gloyd S, Florano F, Seunda M, Chadreque MA, Nyangezi JM, andPlatas A 2001. Impact of Traditional Birth Attendant Training in Mozambique: A Controlled Study. *Journal of Midwifery Womens Health* 46:210–216

Goldman P and Glei T, 2003.The role of traditional birth attendants in the reduction of maternal mortality. Studies in HSO&P.2 0 0 1 ; 1 7 : 8 5 – 8 9 . Retrieved f r o m : http://www.itg.be/ITG/GeneralSite/InfServices on 11/04/2016

Goodburn, E.A., Chowdhury, M., Gazi, R., Maeshall, T. and Graham, W. 2002. Training Traditional Birth Attendants in Clean Delivery does not Prevent Postpartum Infection , *Health Policy and Planning*, 15(4), 394-399

Health Reform Foundation of Nigeria (HERFON) 2006. Nigerian Health Review 2006. Abuja, Nigeria: HERFON.

Hussein, J. and Fortney, J. A. 2004. Puerperal Sepsis and Maternal Mortality: What Role can new Technologies Play?,*International Journal of Gynecology and Obstetrics*, 85, (Suppl.1), 52-61

Ibekwe, P. C. 2010. Healthcare Problems in Developing Countries. *Medical Practice and Re views* 1(1): 9-11.

Idowu, A.E. 2013.The SocioCultural Context of Maternal Health in Lagos State, Nigeria Ph .D thesis submitted to the Department of Sociology, Covenant University Ota, Ogun State

Imogie, A. 2014.The practice of Traditional Birth Attendants and Women's Health in Nigeria.*Journal of Community Medicine and Primary Health Care* 17 (1): 55-60. http://mwa.regional.org.an/ papers/full/28_/mogie.htm.

Imogie, A. O., Agubuike, E. O., and Aluko, K. 2002. Assesing the role of traditional birth a ttendants (TBAs) in health care delivery in Edo state, Nigeria.*African Journal of Reproductive Health*, 6 (2):94 – 100.

Islam, M. and Yoshida, S. 2009. MDG 5: How close are we to success? *BJOG*116 (Suppl. 1):2-5

Itina, S. M. 1997. Characteristics of Traditional Birth Attendants and their Beliefs and Practi ces in the Offot Clan, Nigeria.*Bulletin of The World Health Organization,* 75(6), 563 -567

Inyang, M.P. and Anuch, O.U. 2015. Traditional Birth Attendants and Maternal Mortality. *I OSR Journal of Dental and Medical Sciences (IOSR-JDMS)* 14(2): 21-26

Izugbara, C. andUkwayi, J. 2004. An Intercept Study on Person Attending Traditional Birth Homes In Rural Southern Nigeria, *Culture, Health and Sexuality*, 2,101-114.

Izugbara C, Eze U and Fotso G, 2009.Traditional birth attendance and the pursuit of maternal and child health in Nigeria.*Journal of Tropical Medicine and Hygiene*, 97, 46-50.

Jamison C, Shahid-Salles R, Jamison U, Lawn J, and Zupan E, 2006.How the integration of traditional birth attendants with formal health systems can increase skilled birth attendance. *Int J GynaecolObstet* 1: 115 (2): 127–34. doi:10.1016/ j.ijgo..06.019. PMID 21924419

Kabir, M., Iliyasu, Z., Abubakar, I. S., andSani, A. A. 2005. Determinants of Utilization of Antenatal Care Services in Kumbotso Village, Northern Nigeria.*Tropical. Doctors*; 1 0: 492-502.

Kalu, F.T.U., andOdusanya, O.O. 2012. Universal Precautions Study of Knowledge and Co mpliance amongst Doctors in Private Medical Practice in Lagos State, Nigeria. *Nigeria Journal of General Practitioners* 10 (2): 50-58.

Kaur, R., Kaur, B., andWalia, L. 2008. Knowledge, Attitude and Practice Regarding Univer sal Precautions among Nursing Students.*Nursing Midwifery Research Journal* 4(4): 115-127

Kruske S,and Barclay L. 2004. Effect of shifting policies on traditional birth attendant training.Journal of Midwifery & Women's Health; 49(4)-306-311.

Lagos State Ministry of Health 2012.Maternal Mortality Study in the 20 Local Government Areas. Lagos.

Manual of Primary Health Care 1988.Preventing Maternal Deaths. World Health Organization, Geneva.

Maternal Mortality Estimation Inter-Agency Group 2014.Partnership for Maternal, Newborn and Child Health. http:// www.who.int/topics/millennium_development_ goals/maternal_health/en/. February 27 2015

MDGs, 2000.Maternal Health. Available from:http://www.who.int

Mekonnen, Y. And Mekonnen, A. 2003. Factors influencing the use of maternal healthcare services in Ethiopia, *Journal of Health Population and Nutrition*,21**,** 374-282.

Mfrekemfon C and Okere C, 2015.Factors associated with the use of maternity services in Enugu, South Eastern Nigeria. *Social Science and Medicine*. 63:1870–1878.

Moronkola O.A and Okanlawon F.A. 2003Essays on issues in health. Ibadan; Royal People Nigeria Ltd. pp.23-41

Ministry of Economic Development 2005.AkwaIbom State Economic Empowerment and D evelopment Strategy, Uyo, Nigeria, Ministry of Economic Development.

National Population Commission, Nigeria (NPC) 2000.1999 Population census of the Federal Republic of Nigeria, Analytical Report at the National level. Federal Capital Territory, Abuja, Nigeria: NPC, 1 – 18.

Ndidi, E. P. And Oseremen, I. G. 2010. Reasons Given by Pregnant Women for Late Initiati on of Antenatal Care in the Niger Delta.*Ghana Medical Journal* 44(2) 46-54

Nduka, I., Aguwa, E. N., and Nduka, E. C. 2012. Training on Universal Basic Precautions and Provision of Personal Protective Equipment: Effect on Prevention of Transmissi on of HIV in Hospital Setting. *Gazette Medical 1*(1): 41-49

Nigeria Demographic and Health Survey.Caverton, Maryland: National Population Commis sion and ORC/Macro. 2013

NISER 2008 MidPoint Assessment of Millennium Development Goals in Nigeria. Ibadan: Nigeria Institute of Social and Economic Research.

Ofili AN andOkojie OH 2005. 'Assessment of the role of traditional birth attendants maternal health care in Oredo Local Government Area, Edo State, Nigeria' *Journal of Community Medicine and Primary Health Care* 17 (1): 55-60.

Ogbolu, Y., Iwu, E.N., Zhu, S., and Johnson, J.V. 2013. Translating Research into Practice in LowResource Countries: Progress in Prevention of Maternal to Child Transmission of HIV in Nigeria. *Nursing Research Practical*; 8(4)85-167

Okafor, C.I., Onwusulu, D.N., Okafor, C.O., Ihekwaba, E.C., and Chineke, H.N. 2009. Prevalence of and Attitude towards Needle Stick Injuries among Medical Practitioners in Nnewi, South Eastern Nigeria. *Tropical Journal of Medicine* 12 (1): 26-29

Olabisi, A. I. 1998. "Women, Culture and Society" in AmaduSesay and AdetanwaOdebiyi (eds.) Nigerian Women in Society and Development; Ibadan, Dokun Publishing House

Omiepirisa, Y. B. 2012.UniversalPrecautions: A Review. *The Nigerian Health Journal*, 12 (3) 78-83

Oshonwoh, E.,Nwakwuo G. C. and Ekiyor, C. 2014.Traditional Birth Attendants and Women's Health Practices: A Case Study of Patani in Southern Nigeria. *Journal of Public Health and Epidemiology* 6(8) 102-127

Owigar R.A. 2000. Traditional Birth Attendants (TBAs): An Alternative Health. Resources in the Book of Abstract, Gender and Science and Technology (GASAT) 29 October -3 November, 2000; 50.43-56

Paul, B. K. and Ramsey, J. J. 2003. Utilization of health facilities and trained birth attendants for childbirth in rural Bangladesh: An empirical study, *Health Promotion International,* 18 (4):327-37.

Piper C.J. 1997. Is There a Place for Traditional Midwives in the Provision of Community-Health Services? *Annual Tropical. Medicine Parasitol* 91(3):237-245.

Population Reference Bureau. 2010. World Population Data Sheets. Washington: United Nation Economic Commission for AfricaPopulation Report 2007. Improving quality, Series J. No. 41 xxvi (3):101-126

Prata N, Ejembi C, Fraser A, Shittu O, and Minkler M. 2012. Community mobilization to reduce postpartum haemorrhage in home births in northern Nigeria. *Soc Sci Med* 74 : 1288-1296.

Rama Rao, S., Caleb, L., Khan, M. E. and Townsend, J. W. 2001. Safer Maternal Health in Rural Uttar Pardesh: Do Primary Health Services contribute?, *Health Policy and Planning*, 16(3), 256-263

Rampal, L., Zakaria, R., Sook, L.W., andZain, A. N. 2010. Needle Stick and Sharps Injuries and Factors Associated among Health Care Workers in a Malaysian Hospital. *European Journal of Social Science* 13(3): 353-362.

Ransom, E. andYinger, N. 2002.*Marking Pregnancy Safer, Overcoming Obstacles on the Pathway to Care*, Washington DC: Population Reference Bureau.

Reproductive Health Studies 2003. Report on Intervention to Improve Women's Reproductive

Roost, M., Johnsdotter, S., J. And Essien, B. 2004. A qualitative study of conception and Attitudes regarding maternal mortality among traditional birth attendants in rural Guatemala, BJOG, An International Journal of Obstetrics and Gynaecology,111**,** 137 2-1377.

Saeed Ali, T., Sami, N. andKhuwaja, A.K. 2007. Are unhygienic Practices during the Menstrual, Partum and Postpartum Periods risk factors of Secondary Infertility? *Journal of Population and Nutrition*, 25(2), 189-194

Safe Motherhood, 2006. Traditional Birth Attendants in maternal health programmes. Retrieved on Line from http://216.109.125.130/search/cache?p = preference + of + traditional + birth + attendants andei = u. On 21st June, 2016

Sambo, M., Abdulrazaq, G. A., Shamang, A. F. and Ibrahim, A. A. 2013.Household Cost of Antenatal Care and Delivery Services in a Rural Community of Kaduna State, North-Western Nigeria. *Nigeria Med*ical Journal. 54:87-91.

Sheela, S. 2008. Training of Traditional Birth Attendants: An Examination of the Influence of Biomedical Frameworks of Knowledge on local Birthing Practices in India.Ph.D Thesis Submitted to the School of Public Health, Queensland University of Technology, Kelvin Grove, and Brisbane, Australia.

Sibley LM, Sipe TA, Brown CM, Diallo MM, McNatt K, andHabarta N. 2007. Traditional Birth Attendant Training for improving Health Behaviours and Pregnancy Outcomes Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No.: CD005460.

Sibley, L., andSipe M. 2006. Theresa Ann. Transition to skilled birth Attendance: is there a Future Role for Trained Traditional Birth Attendants? *Journal of Health Population and Nutrition.* 24(4):472-478.

Sibley, L., Sipe, T. andKoblinsky, M. 2004. Does Traditional Birth Attendant Training Increase Use ofAntenatal Care? A Review of the Evidence.*J. Midwifery Women's Health,* 49,298-305.

Smith M, 2008. Bacterial contamination of women in the labour supervised by traditional birth attendants.International Journal of Gynaecology and Obstetrics.2006; 92:126-127.

Sullivan, R. B. 1973. *Health Education Theories and Models*.Mosaic int. Printers and Publishers, pg75-79

Titaley, C. R., Hunter, C. L., Dibley, M. J. and Heywood, P. 2010. Why Do Some Women s till Prefer Traditional Birth Attendants and Home Delivery? A Qualitative Study on Delivery Care Services in West Java Province, Indonesia. BMC Pregnancy and Child birth 2010, 10:43

Udoh, C. O. and Haastrup, A. 2006. Safe living in today's environment.Ibadan: Chris Rose Ventures Ltd

Ugal, D. B**.,** Ushie, B. A., Ushie, M. andIngwu, J. 2012.Utilisation of Facilities and Maternal Health Outcome among Urban Dwellers of Obudu and Ogoja Local Gover nment Areas of Cross River State, Nigeria. *Afro Asian Journal of Social Sciences*, 3 (3) 32-51

Umar U.S., Olumide E.A., andBawa S.B. 2003.Village Health Workers and Traditional Birth Attendants' Record Keeping Practices in Two Rural LGAs in Oyo State, Nigeria.*African. Journal for Medical Science.* 32(2):183- 192.

UNFPA 1996.Support to Traditional Birth Attendants, Evaluations Findings (Office of Over sight and Evaluation).

UNICEF 2001. Maternal Care: End Decade Database: http://www.childinfo.org/eddb/mat_mortal/index.htm,.

United Nations 1994 Report of the International Conference on Population and Development, Cairo.

Vaz, K., McGrowder, D., AlexanderLindo, R., Gordon, L., Brown, P., and Irving, R. 2010. Knowledge, Awareness and Compliance with Universal Precautions among Healthcare Workers at the University Hospital of the West Indies, J a m a i c a. *International Journal of Occupational and Environmental Medicine* 1 (4): 171-181.

WHO 1999.Reduction of Maternal Mortality, Geneva, Switzerland, A joint WHO/UNFPA/UNICEF/WORLD BANK Statement, WHO Publications.

WHO 2006. Reproductive Health Indicator: Guidelines for their Generation, Interpretation a nd Analysis for Global monitoring. Source: www.searo.who.int/linkfiles/publication

WHO 2004b.Global Action for Skilled Attendants for Pregnant Women. Geneva.

WHO 2007 Maternal Mortality in 2005; Estimates Developed by WHO, UNICEF, UNFPA and The World Bank.

WHO, 2004. Making pregnancy safer: the critical role of the skilled attendant: A joint state ment by WHO, ICM and FIGO Geneva, WHO Making Pregnancy Safer Department of Reproductive Health and Research.

WHO, UNFPA, UNICEF, 2004.*Evaluation f i n d i n g s, S u p p o r t t o t r a d i t i o n a l b i r t h a t t e n d a n t s* 1 9 9 6 : R e t r i e v e d f r o m http://www.unfpa.org/monitoring/pdf/nissue7.on 14/02/2016

WHO, UNICEF, UNFPA and World Bank 2005. Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Africa, Geneva, and World Health Organization.

Winani, S., Coffey, P., Wood, S., Mosha, F., Chirwa, T. andChangalucha, J. 2005. Evaluation of a Clean Delivery Kit Intervention in Preventing Cord Infection and Puerperal Sepsis in Mwanza, Tanzania (Seattle USA, Program for Appropriate Technology in Health (PATH) and United States Agency for International Development (USAID).

World Health Organization 2005.*World Health Report 2005: Make Every Mother and Child Count*. Geneva: WHO;2005. http://www.who.int/whr/2005/whr2005_en.pdf.Assessed March 17, 2016.

World Health Organization, 2008 Making Pregnancy Safer: Maternal Mortality and Morbidity Case Review. Retrieved from; http//www.euro.who.int/infopages.

World Health Organization 2010.*Classifying health workers*.WHO, Geneva. Available from:12/05/2016 on
h t t p : / / w w w.w h o. i n t / h r h / s t a t i s t i c s/Health_workers_classification.pdf

World Health Organization 2012.Preventing Maternal Deaths. World Health Organization, Geneva.

Yayla, M. 2003. Maternal Mortality in Developing Countries, *Journal of Perinatal Medicine*, 31, 386-391.

Zamawe, C. O. F. 2013. Factors that Affect Maternal Care Seeking Behaviour and the Choice of Practitioner(s) during Complications: the Case of Mang'anja Tribe in Malawi. Research on Humanities and Social Sciences www.iiste.org ISSN 2222-1719 3(18) doi:10.1371/journal.pone.0069569

APPENDIX I

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION

UNIVERSITY OF IBADAN, IBADAN

QUESTIONNAIRE

I am a doctoral student in the above named Department specializing in Health and Safety Education. I am carrying out a study on effect of safety education on knowledge and practice of maternal health care among Traditional Birth Attendants in Lagos State, Nigeria.

I therefore solicit for your cooperation by responding sincerely to this questionnaire. Information supplied is purely for research purpose. The outcome of this study would help in developing a feedback process in safety education and training situations in Health Education. It would also be of help in developing programmes that would assist Traditional Birth Attendants in professional practice towards improving maternal health care.

I therefore solicit for kind cooperation by responding to the measurement instrument honestly and endeavor to provide answers to all items.

Thanking you for your anticipated cooperation.

OGUNADE A.I.
Researcher

SECTION A: DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Age: Below 20 ( ) 20-29 ( ) 30-39 ( ) 40-49 ( ) 50 and above ( )
2. Sex: Male ( ) Female ( )
3. Educational Qualification: No formal education ( ) Primary education ( ) Secondary Education ( ) Tertiary Education ( )
4. Religion: Christianity ( ) Islam ( ) African Religion ( ) Others ( )
5. How did you train to become a TBA? No formal training ( ), Apprenticeship with a relation other than parents ( ) Apprenticeship with non-relation ( ) Family handed down practice ( ) Religious-based training ( )
6. Years of working experience: 1-4 ( ) 5-9 ( ) 10-above ( )
7. Have you ever undergone any government funded or international agency sponsored formal training on TBA practice? Yes ( ) No ( )
8. Have you been trained on preventing mother-child HIV transmission? Yes ( ) No ( )
9. If no, will you be willing to undergo this training? Yes ( ) No ( )
10. Will you be willing to pay for this service? Yes ( ) No ( )

11. If yes, when? Last 3 months ( ) Last six months ( ) Last one year ( ) Last three years ( ) Never ( )
12. What are the various services you render as a TBA? (Tick more than one if applicable)

    Conveyance ( ) Treatment of barrenness ( ) Ante-natal consideration ( ) Circumcision of infants ( ) Management of compromised premature birth ( ) Treatment of spasm in kids ( ) Abdominal back rub for ladies with
    Stomach torment ( )
13. Average delivery per month ……..

SECTION B: KNOWLEDGE OF MATERNAL HEALTH CARE

Item	True	False	No Idea
Excessive vomiting at pregnancy is a normal pregnancy symptom			
Swelling of feet is normal in pregnancy			
Anaemia/paleness in pregnancy is a sign of danger			
Excessive bleeding during delivery is normal			
Excessive weakness at labour is normal			
Breathlessness in new born is normal in some cases			
Visual disturbances in pregnancy is not a danger sign			
Antenatal care is essential in pregnancy			
Ante natal care should commence once pregnancy is identified			
Counting fetal movement daily in the last stage of pregnancy is necessary			
Iron rich food is harmful during pregnancy			
Consumption of fruits and vegetables is necessary during pregnancy			
Checking blood pressure regularly is necessary in pregnancy			
Calcium supplement is required in pregnancy			

15. What move ought to be made after amniotic liquid breaks? Continue lying ( ) continue sitting ( ), no unique consideration ( ) No Idea ( )
16. At which phase of pregnancy does newly conceived disfigurement well on the way to occur? Under 12 weeks ( ), 12– 28 weeks ( ), 28 weeks or more ( ) No thought ( )
17. Which strategy is better for nourishing new-borns? Bosom sustaining ( ) milk powder encouraging ()

SECTION C: MATERNAL HEALTH CARE PRACTICES SCALE

Item	Never	Rarely	Sometimes	Always
I always observe hand hygiene strictly immediately on arrival at work				
I always observe hygiene strictly after contacting blood, body liquids, discharges, and polluted things whether I put on gloves or not				
I always observe hand hygiene strictly before wearing gloves for invasive procedures and after removing gloves				
I always observe hand hygiene strictly between procedures on the same patient				
I use liquid soap and running water when washing my hands after attending to pregnant women				
I use disposable tissue paper or dry towel to dry my hands after washing				
I wear mask, gown and other protective barriers whenever there is potential for splashing of blood or other blood fluids attending to pregnant women				
I wear mask, gown and other protective barriers whenever there is potential for splashing of blood or other blood fluids attending to pregnant women				
I decontaminate spills of blood or other body fluids by using chlorine				
I ensure that domestic wastes (paper, plastics etc.) are separated from clinical wastes				
Sharp objects like needles and blades are disposed safely in re-usable sharps container and later emptied into sharps pit or incinerated				
I take my clients' history of pregnancy before giving service				
I check the pregnant women's antenatal cards before giving service to determine gestational age and danger/risk conditions if any				

14. What do you do when there is an obstructed labour? Encourage maternal effort in pushing ( ) Herbal preparations ( ), Manual manipulation of womb ( ) Referral to another TBA ( ) Referral to a health facility ( ) Suggest bed rest ( ) Never experienced by me ( )
15. How do you manage placenta retention? Give herbal preparation ( ) Apply pressure to the abdomen by pressing ( ) Referral to another TBA ( ) Referral to a health facility ( ) Suggest bed rest ( ) Never experienced by me ( )
16. How do you manage severe bleeding? Use of ice pack on the genital tract ( ) Adjust head position of expectant woman ( ) Use clean cloth to pack the vagina ( ) Put on

charms on the woman ( ) Referral to another TBA ( ) Referral to a health facility ( ) Suggest bed rest ( ) Never experienced by me ( )

17. What are the various diagnostic and therapeutic measures you use for your clients? Tick more than one if applicable) Leaves ( ) Roots ( ) Prayer and fasting ( ) Incantations ( ) Scarrification marks ( ) Alligator pepper ( ) Snail ( ) Hot drink ( ) Ashes ( ) Palm kernel pomade ( ) Wood ( ) Sacrifice ( ) Lizard ( ) Animal dung ( ) Fresh fish ( ) Flies ( ) Cow urine ( ) Native chalk ( ) Dry rabbit ( ) Petroleum jelly ( ) Human urine e.g. mother's urine to treat convulsions ( )
18. Have you carried out circumcision for a female child? Yes ( ) No ( )
19. If yes, when last was this done? Last 3 months ( ) Last six months ( ) Last one year ( ) Last three years ( ) Never ( )
20. What action would you take to control excessive bleeding resulting from circumcision? Nothing ( ) Consulted another TBA ( ) Used herbs and other means to control it ( ) referred to a hospital ( )

AFIKUN APA KINNI

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION
UNIVERSITY OF IBADAN, IBADAN

IBEERE

Mo je Akeko Dokita ni Eka ti Ile-Eko ti mo daruko loke yi, eyiti o ni se pelu ilera ati eko abo. Mo nse iwadi lori abajade eko abo ati imo lori ilera awon eniyan laarin awon Olutoju lona ibile ni Ipinle Eko, Naijaria.

Nitori idi eyi, mo nfe ifowosowopo yin pe ki e dahun awon ibeere yi pelu otito inu yin. Awon alaye ati idahun ti e ba fun mi yoo wa fun iwadi nikansoso. Abajade eko iwaadi yi yoo ran wa lowo fun eko abo ati imo lori eko ilera. Yoo situn fun wa lanfani lati ran awon Olutoju awon alaboyun ati awon omo lona ibile lati le jeki won ni imo si lori ise won.

Lekan si, mo nfe ifowosopo yin fun idahun ti e ma fun ibeere mi yoo je tokantokan ati otito ponbele.

E se fun ifowosopo yin, eyi ti mo nfoju sona fun.

OGUNADE, A. I.
AKEKO OLUWADI

ABALA A
ABUDA IBI TI OLUDAHUN IBEERE

1. Ojo Ori:
Ogun odun ( ) Ogun Odun si Ogbon Odun o din eyo kan ( )
Ogbon odun si Ogoji odun o din eyo kan ( ), Ogoji odun si Aadota odun o din eyo kan ( ) Aadoto odun soke ( )

2. Imo Ako/Abo:
Okunrin ( ) Obinrin ( )

3. Imo Eko:
Ko le ko, ko si le ka ( ), Ile-Iwe Alakobere ( ) Ile Eko Giga ( ) Ile Eko Akeko Gboye ( )

4. Esin Re:
Kristiani ( ) Musulumi ( ) Abalaye ( ) Esin miran ( )

5. Iru Eko Imo wo le ni bi Onisegun/Agbebi Ibile:
Ko si eko rara ( ) Omo ekose labe oga ojulumo Obi ( ) , Omo Ekose labi Elomiran ( ) Ajogunba ( ) Eko lona Esin ( )

6. Nje e ti je anfani Eko eyi ti Ijoba seto re fun awon Onisegun tewe-tegbo fun Onitoju Ibile:
Beeni ( ), Beeko ( )

7. Nje e ti ni Eko lori bi a se le dena arun kogbogun lati odo iya si omo: Beni ( ), Beeko ( )

8. Ti idahun re ba je beeko, se e ti setan lati lo fun idanileko yi: Beeni ( ), Beeko ( )

9. Nje e ti se tan lati san owo fun idanileko yi: Beeni ( ), Beeko ( )

10. Ti idahun si ibere keje baje Beeni, o ti to igba wo: Bi osu meta sehin ( ) Bi osu mefa sehin ( ), Bi odun kan sehin ( ), Bi odun meta sehin ( )

11. Awon ise wo tabi itoju wo ni e nse gegebi Olugbebi ati Olutoju lona ibile (e le mu ju eyo kan lo, ti e ba nse ju ikan lo.): Igbebi ( ), Sise itoju fun ati ri oyun ni ( ), Itoju lehin oyun nini ( ), Didabe fun awon omo ( ), Didabobo Oyun to fe jabo ( ), Titoju omo ti o ni arun Giri tabi Aiperi ( ), Sise itoju fun obinrin ti inu nkan ( )

ABALA B
IMO NIPA ILERA ALABOYUN

ONKA	ITOKA	BEENI	BEEKO	KO YEMI
1.	Ebibi gburu je amin to dara nigbati eniyan ba loyun			
2.	Ese wiwu je ami iloyun			
3.	Airorun sun ati Riru fun alaboyun je ami ti ko dara ati ewu			
4.	Eje yanturu nigba irobi je ami to dara			
5.	Rire fun alaboyun nigba irobi je ami to dara			
6.	Ni igba miran aimi rara omo tuntun je ami to dara			
7.	Oyi oju tabi airiran daadaa in ipo iloyun ki se ami ti ko dara			
8.	Sise itoju alaboyun lehin ti oyun ti duro se Pataki			
9.	Itoju Alaboyun gbodo bere ni kete ti oyun ba ti duro			
10.	Kika isipopada omo ninu alaboyun ni ojojumo ni igba ti akoko ati bimo ba sunmo se Pataki			
11	Ounje to kun fun okun le je akoba ninu oyun			
12.	Jije Eso ati Ewebe dara pupopupo ninu Oyun			
13.	Sise ayewo ifupa wa ninu Oyun se Pataki			
14.	Afikun Kalisiomu dara, o si pon dandan ninu Oyun			

15. Kini isise to ye lati gbe nigbati Apo Ile-Omo ba ti fo:

    Ki alaboyun sun sile ( ), Ki alaboyun joko ( ), Ko si abojuto kankan ( ) Ko ye mi si ( )

16. Ni akoko wo ni Omo le ni abuku ninu Oyun: O din ni ose mejila ( ), Ose mejila si ose mejidinlogbon ( ), Ose mejidinlogbon soke ( ), Ko tile ye mi si ( )

17. Ona wo lo dara lati fun omo Ikoko ni Ounje: Fifun Omo ikoko loyan ( ), Fifun Omo ikoko ni wara Maalu ( )

ABALA D
IWON FUN ITOJU ILERA FUN IYA ATI OMO

ONKA	ITOKA	RARA	O SOWON	NIGBA MIRAN	NIGBA GBOGBO
1.	Ni igba gbogbo ni mo ma nfowo mi ni kete ti mo ba ti de ibi ise				
2.	Mo ma nri daju pe imototo je mi logun ti mo ba ti fi owo kan eje, oogun, idoti ara ati ohun egbin kan, boya mo lo ibowo tabi nko lo.				
3.	Mo ma nri daju pe mo nfowo mi ki nto wo ibowo ati lehin ti mo ba ti bo kurop fun ilera ti o peye				
4.	Mo nfowo mi nigbakugba ti mo ba ntoju alaisan kanna fun itoju kan tabi ekeji				
5.	Ose olomi ati omi je ohun elo ifowo mi lehin itoju alaboyun				
6.	Awon ohun elo inu owo eyi ti a sonu lehin ilo re ni mo fin nu owo mi.				
7.	Ni igba itoju alaboyun, mo ma nfi won iboju, mo si ma nwo aso idabobo tori airotele eje ti o le ta simi lara.				
8.	Ni igba itoju alaboyun, mo ma nfi won iboju, mo si ma nwo aso idabobo tori airotele eje ti o le ta simi lara.				
9.	Mo ma nba agbara eje tabi oogun ti o fan jade nipa lilo chlorine.				
10.	Mo ma nri daju pea won ohun elo ti ko wulo pupo (bi iwe ati ike) ni mo ya soto kuro ninu ohun elo ti ile iwosan ti a ti lo.				
11	Awon ohun elo oloro bi abere ati abe ni a se lojo si ohun elo ti ati pese fun iru won, ki a to lo danu patapata				
12.	Itan ilera onibara mi se Pataki fun iwadi ki a to bere itoju.				
13.	Sise ayewo Kaadi fun itoju alaboyun ki a to bere itoju se pataki, ki a le mo nipa ewu tabi ojo ori omo ti o wa ninu oyun.				

14. Kinni ohuh ti a ma se nigbati omo ko ba tete jade:
Gba alaboyun ni iyanju lati gbin dada ( ), Pipese agbo ( ), Ki a fi owo fa omo jade ( ), Ki a gbe lo si ile alagbo miran (TBA), Ki a gbe Alaboyun lo si ile iwosan igbalode ( ), Ki alaboyun sun dada ( ), Eyi ko ti sele si mi ri ( )

15. Bawo la se nse olobi omo to ni idaduro ati jade:

Pipese Agbo ( ); Tite inu alaboyun diedie ( ); Ki a gbe lo sodo elewe omo miran ( ); Ki a gba Alaboyun lo si ile iwosan igbalode ( ); Ki alaboyun sun die ( ); Eyi ko ti sele si mi ri ( ).

16. Bawo lo se nse amojuto eje ti o nya lai mowoduro lara alaboyun:
Lilo ohun elo to tutu si ibi ti eje ti nya ( ); Ti tun ori alaboyun na se ( ); Lilo aso ti o mo lati fi di oju ara obinrin na ( ); Siso oogun mo alaboyun lara ( ); Ki a gbe lo sodo Onitoju Ibile miran ( ); Ki a gbe lo si ile iwosan igbalode ( ); Ki alaboyun sun die ( ); Eyi ko sele si mi ri ( ).

17. Kini awon ohun elo fun ayewo fun awon onibara yin. E le mu ju eyokan lo:
Ewe ( ); Egbo ( ); Awe ati Adura ( ); Ofo pipe ( ); Sinsin gbere ( ); Atare lilo ( ); Igbin ( ); Oti ibile ( ); Eeru ( ); Epo pupa ( ); Igi ( ), Gbigbe ebo ( ); Alangba ( ); Igbe eran ( ); Eja tutu ( ); Esinsin ( ); Ito maalu ( ); Osun ( ); Eku gbigbe ( ); Ikunra ( ); Ito eniyan, papa julo ti Iya fun aisan Giri/Aiperi. ( ).

18. Nje e ti da abe fun omo obinrin ri:
Beeni ( ); Beeko ( ).

19. Ti idahun yin ba je beeni, lati igbwo le ti se:
Nkan bi osu meta sehin ( ); Osu mefa sehin ( ); Odun kan sehin ( ); Odun meta sehin ( ); Rara ( ).

20. Lehin ti e ti dabe fun omobinrin, eje ko mowo duro, kinik awon igbese ti e ma gbe:
Ko si isise kankan ti ma gbe ( ); Iranlowo lati odo Onisegun Ibile miran ( ); Lilo agbo ati awon nkan miran lati da eje na duro ( ); Mo ma gbe lo si Ile-Iwosan Igbalode ( ).

Appendix II

CONSENT FORM FOR PARTICIPANTS IN THE RESEARCH

I willingly and voluntarily consent to participate in the research which is aimed at helping at helping Traditional Birth Attendants to improve their professional competence and practice. I understand the purpose of the research and I am aware I will be asked questions pertaining to my professional practice. I also understand that I will be completing paper and pencil questionnaires and take part in training sessions. I understand my participation is completely voluntary and I may choose not to participate any time I wish.

All my responses will be kept confidential, my name will not appear on any of the results and no individual responses will be reported. I understand that there are minimal risks involved in participating in this study. I might have reservations over any of the questions asked of me or during any of the training activities. If I experience any of emotional discomfort while participating I am free to quit.

I understand there are benefits of participating in this study and that this consent may be withdrawn at any time without prejudice. I understand that I may contact the researcher or the project supervisor for answers to questions about this research or my rights.

I have read and understand this consent form.

…… ……..

Participant's Name and Signature **Date**

Appendix III

Preparing PROGRAM FOR THE EXPERIMENTAL GROUP

Span of Program: 9 weeks

Setting:

Program Goal: To improve protective social insurance information plus practices Amongst TBAs in Lagos, Nigeria utilizing a blend of direct instructing, talk plus exhibit techniques encouraged by required plus sufficient guides plus assets.

Explicit Objectives of the Program: At the end of this program partakers be compelled by a sense of honor to have the capacity to:

- Demonstrate improved dimension of information of protective medical problems by accurately portraying plus dissecting nurturing medical problems
- Show proof of improved information of the lady-tyke HIV transmission by expressing methods for avoiding this transmission
- Demonstrate improved nurturing wellbeing practices plus injury care
- State when plus the ladyto allude nurturing wellbeing cases past their capacities
- Identify issue side effects in incubation plus child bearing pain Amongst the lady.
- Identify hurtful nurturing plus kid care rehearses plus cite motivations to dissipate them

WEEK 1: Introduction

- Familiarization with the members plus research associates.
- Administration of pre-test
- Fixing of preparing contact periods
- Highlight of the different themes to be instructed in the intercession bundle

WEEK 2: Module 1: Introduction to The lady plus new conceived Health

a) Module Objectives

b) Overview of The lady plus New conceived Health

c) Worldwide plus National Situation of Postpartum plus The lady wellbeing plus Demise

d) Factors Affecting Postpartum plus The lady wellbeing plus Demise

e) Recent Methods Gone for Reducing Postpartum plus The lady wellbeing plus Demise

f) Evaluation of the Module

WEEK 3: Module 2: Child Delivery Care (Child bearing pain, Delivery of a child(ren) plus Immediate Postpartum Care)

. a) Module Objectives

b) Valuation of Female in kid Child bearing pain

c) Supportive Care for Woman in Child bearing pain

d) Basic Care amid Second plus Third Stage of Child bearing pain

e) Immediate Care of the New Born, New Born Resuscitation plus Immediate Postpartum Care

WEEK 4: Module 3: Rapid Initial Assessment plus Trauma Management

a) Module Objectives.

b) Preparation plus Response to Traumas

c) Rapid Initial Assessment

d) Trauma Management Principles

e) Evaluation of the Module

Week 5: Module 4: Gestation Care

a) Module Objectives

b) ANC plus PMTCT

c) Care for Diseases plus Infections In the process Gestation

- Anaemia In the process Gestation
- Vaginal Blood gushing in Initial plus Late Gestation
- Face ache, Blurred Sighting, Seizures or Miss of Consciousness, Elevated Blood Pressure
- Fever In the process Gestation plus Child bearing pain
- Stomach Discomfort in Initial Gestation
- Stomach torment in cutting edge incubation plus later work
- Pre-Child bearing pain Rupture of Membranes

d) Evaluation of the Module

Week 6: Module 5: Female Genital Mutilation, Women Friendly Care plus Infection Prevention

a) Module Objectives

b) Female Genital Mutilations

c) Women Friendly Care

d) Infection Prevention

- Plus Hygiene
- Personal Protective Devices
- Antiseptics plus Basic Principles
- Plus Sharp Instruments plus Injection needles
- The lady Health Care Waste Management

e). Assessment of the Module

Week 7: Module 6: Caring plus exaltation for afflictions just as various illnesses in the process the time spent kid bearing

a) Module Objectives

b) Symptoms of Satisfactory plus Unsatisfactory Progress of Child bearing pain at First Stage of Child bearing pain

c) Symptoms of Satisfactory plus Unsatisfactory Progress of Child bearing pain at Phasetwo of Child bearing pain

d) Rudimentary Carefulness in the midst of Moment Phase plus Supporting Regular Childdelivery

e) Evaluation of the Module

Week 8: Module 7: Lively Administration of the 3rd Phase of Child delivery child bearing pain

a) Module Objectives

b) Postpartum Hemorrhage

c) Steps to Preventing PPH plus Managing of third Phase of Delivery of a child(ren)

- Quick association of uterotonic administrators; (This is whenever prepared wellbeing supplier who can oversee this accessible or the TBA is talented to manage)
- Controlled string balance; plus
- Uterine back massage (later the transport of the placenta).

Week 9: Final Sighting of Training Package, Summing Up plus Post-test Administration

a) Sighting of Training Package

b) Administration of post-test

c) Presentation of Certificate to Participants

Preparing PACKAGE FOR EXPERIMENTAL GROUP

Presentation

Week 1 - Introduction

: Familiarization with the members plus research child bearing pains.

Lead of pre-test

Pondering on preparing contact periods

WEEK 2: Module 1: Introduction to The lady plus Newborn Health

FIRST CONTACT (TUESDAY)

Presentation

Nurturing plus new conceived wellbeing speaks to the consideration introduced to ladies amid growth, work plus later child bearing pain. It additionally means the quick consideration introduced to the new conceived child. This module is intended to open you to these fundamental consideration dependent on the downplayed destinations.

Targets of the Module

At the end of this module, partakers ought to be skilled to:

1. State the worldwide commonness of Postpartum plus The lady wellbeing plus Demise by naming the quantity of ladies that pass on ordinarily because of incubation related complexities
2. Situate Nigeria in the worldwide predominance of protective Demise by depicting its lopsided commitment to the commonness
3. List immediate plus aberrant factors that reason protective Demise

Unit One:

Review of The lady plus new conceived Health

Nurturing plus baby blues social insurance is a fundamental pointer of the general prosperity status of any country. The amount of women that kick the basin as a result of development related troubles prior delivery or inside 42 days after the fact the finish of incubation shows how strong the prosperity plus budgetary territory of a country is. Worldwide protective Demise is unsuitably high. As shown by Global Healthcare Data 2012 released by the Global Healthcare Organization: reliably some place in the scope of 287 000 women fail horrendously of burdens in the midst of incubation or work all around, for instance around 800 nurturing passing every single day or 1 protective destruction predictably. Making countries speak to ninety nine percent (two hundred plus eighty four thousand) of the worldwide protective passings, the mainstream of which are in Africa (sub-Saharan part) (One hundred plus sixty two thousand) as well as Asia (Southern part part) (Eighty three thousand). These 2 areas spoke to eighty five percent of the overall weight, with Africa (sub-Saharan) alone speaking to fifty six percent. Regardless of a basic lessening in the amount of nurturing passings by around half – as of a normal five hundred plus forty three thousand out

of one thousand nine hundred plus ninety to two hundred plus eighty seven thousand out of two thousand plus ten – the rot degree (three point one percent consistently) is essentially above an expansive segment of that normal to attain the significant goal-five of MDG (five point five consistently).

The ordinary nurturing Demise extent in making nations in two thousand plus ten stood at two hundred plus forty for every one hundred thousand delivery's against sixteen for every one hundred thousand in made nations replicating aberrations in Contact to prosperity organizations, plus empisizing the opening Amongst poor plus rich. Africa (sub-Saharan) had the most astonishing protective Demise extent at 500 nurturing passing's of every one hundred thousand alive deliveries. Agreeing to an efficient examination of progression towards goal-five of MDG); over portion of each nurturing devour food in two thousand plus eight stood in simply 6 nations.

Elements capable of The lady Demise

The five imperative overall purposes behind protective end are:

1. chronic passing on (generally depleting postnatal anxiety),
2. infections (also generally not long later transport),
3. unsafe incited embryo evacuation,
4. hypertensive disarranges in incubation (eclampsia) plus
5. obstructed work (See Chart 1)

Source: WHO 2010. *Ninitial all (99%) untimely delivery passings are a result of hazardous baby expulsion.

**This arrangement consolidates passings on account of blocked work or slightness

Universally, of 80% of nurturing passings are a direct result of these components mindful. Release alone records for 33% of each protective going in Africa, yet a noteworthy number of these passings are preventable.

Underplused Factors mindful

Among the Underplused variables mindful (20%) of protective passing are infections that obfuscate development or are chafed by growth, for instance,

1. HIV/AIDS related reason
2. malaria
3. anaemia plus
4. Heart illness.

Assessment of Unit One

1. How numerous ladies kick the bucket every day on the planet because of incubation related reason?
2. What is the rate of protective Demise in Nigeria contrasted with devour foodnations of the world?

SECOND CONTACT

Sighting of Previous Units

Savvies Aims

At the end of these units, partakers have an obligation to be competent to:

1. List the three defers influencing nurturing plus baby blues Demise plus sick wellbeing
2. List the three Methods which lady upon endeavours went for decreasing protective sick wellbeing plus Demise ordinary pins

Unit Two:

Segments Affecting The lady plus Postpartum Demise plus Ill wellbeing

Numerous elements influence nurturing plus baby blues Demise plus sick wellbeing. These variables can be caught in deferral, which essentially implies neglecting to do what ought to be done on schedule. Three deferrals have been perceived plus recorded underendeavour food:

Three delays in thought searching for impact the survival of the two the ladys plus infants.

1. Deferrals in seeing issues plus searching for thought
• Complications not saw as real
• Relatives people concede care pursuing
• Spiritual or social experiencings may sustain deferrals in another lady manner add up to various prescriptions
2. Delays in development toachieve reasonable thought
• Dearth of development just as resources
• Distance plus travel time to accomplish prosperity workplaces
3. Deferrals in getting reasonable thought at the prosperity office
• Lack of fittingly arranged workforce plus undesirable dispostions of prosperity experts
• Dearth of fundamental parapthe ladynalia, prescriptions plus materials

Unit Three:

Ongoing Methods to Ameliorating of The lady plus Neonatal period Demise

The present approaches to manage reducing nurturing plus baby blues devour food plus dreariness are three:

1) Contact to relatives organizing,

2) A capable prosperity capable present at every movement plus

3) Contact to emergency obstetrical plus new imagined thought

Assessment of Units 2-3

1. List the postpones that could influence Postpartum plus The lady wellbeing plus Demise

2. State the Recent Methods to enhance Postpartum plus The lady wellbeing plus Demise

WEEK 3: Module 2: Kid Delivery of a child(ren) Upkeep (Delivery of a child(ren), Conveyance plus Instantaneous Postpartum Care)

Component One: Care of a Woman amid Child bearing pain

Instructional Purposes

Prior the finish of this component partakers ought to remain competent toward:

- State fast assessment plus proper strides to think of a lady in child bearing pain
- State ventures to suitable conclusion of work

Fast Assessment plus Management

To guarantee legitimate plus viable conveyance of consideration for a lady in child bearing pain initially do Rapid evaluation plus the executives. This is guaranteed by:

- Making a fast assessment of the general circumstance of the lady including crucial side effects (bdevour food, circulatory strain, brdevour foodh, temperature).
- Assessing the fetal circumstance through the accompanying advances:
- o Be attentive to the fetal pulse promptly later a withdrawal:
- − Count the fetal pulse for an entire moment in any event once like clockwork for a parturient with no hazard or each fifteen minutes meant for hazard circumstance amid the dynamic stage plus each fifteen minutes for generally safe hatchling or each five minutes for high-chance baby amid the phasetwo.
- − On the off chance that tthe ladye is fetal pulse variations from the norm (under at least 100 than 180 bdevour foods of every moment), suspicious fetal trouble plus plan for referral
- − If the films busted, annotate the shade of the depleting amnionic liquid:
- − Existence of thick fecal issue shows the requirement for close observing plus conceivable intercession for the board of fetal misery;

- − Lack of liquid depleting later crack of the films means that improved capacity of amnionic liquid, which might be related thru fetal pain

Conclusion plus Child bearing pain Affirmation:

• Suspicious or foresee work if the lady is:

- Sporadic stomach torment later 28 weeks incubation;
- Pain frequently connected with blood-recolored bodily fluid release (appear);
- Water systemy vaginal release or an unexpected spout of water framework.

• Affirm the beginning of work if tthe ladye is:

- Agonizing stplusard compressions of something like 2 constrictions in 10minute
- Cervical destruction—the dynamic curbing plus diminishing of the womb amid work; plus
- Cervical dilatation—the expansion in width of the genital access estimated in centimeters.

Steady Care of the Woman amid Child bearing pain plus Delivery of a child(ren)

Correspondence

• Hot plus well disposed acknowledgment at lplusing plus affirmation.

• Insure devour food correspondence plus backing by worker:

• Narrate all methods, gaze for consent, plus examine discoveries with the lady.

• Handle the lady educated of the advancement of work.

• Encomium the lady, energize plus promise the lady issues will be fine devour food.

• Insure plus regard security amid observation plus exalterations.

Ndevour foodness

• Maintain ndevour foodness of the lady plus the lady condition:

o Encourage the lady to Clear the lady body or bath or bath at the beginning of work;

o Clear the female genital organ plus vagina regions prior every observation;

o Clearyour pluss with clearser previously plus later every observation;

o Insure ndevour foodness of working plus vagina part(s);;

o Clear up all litters right away

■ Note: DON'T routinely acquaint a douche with ladies in child bearing pain.

Portability

• Insure portability:

Urge the lady to move of openly; amid the principal Phase of work.

Bolster the lady's decision of position (left horizontal, hunching down, stooping, stplusing upheld by the partner) of every Phase of work plus conveyance. (See diagram four to eight)

Diagram 3:- Postions that a lady may embrace amid work

Pee

• Encourage the lady to discharge the lady bladder normally/as often as possible. Remind the lady at regular intervals.

Devour fooding, take watering

• all in all energize oral admission of fluid devour fooding routine (tea, juice) all through work however not hard sustenances.

• Consider liquid devour fooding regimen as a wellspring of water framework plus vitality for those moms remaining longer prior conveyance (for example little tastes of improved coffee or H20 framework)

• If the lady is noticeable constant squplusering or exhausted amid work, Insure the lady take waters.

Respiratory system

• Educate the lady to see the lady typical Respiratory.

• Prompt the lady to inhale out more gradually, making a murmuring clamor, plus to unwind with every brdevour foodh.

• on the off chance that the lady thinks bleary eyed, not experiencing fine, is experiencing ordinary pins-plus-injection needles (shivering) in the lady eyes, pluss plus leg, Prompt the lady to inhale all the more gradually.

• To avert pushing toward the finish of first Phase of work, Educate the lady to gasp, to inhale with mouth open, to taking two fast brdevour foodhs pursued by a extended respiration out.

• In the process conveyance of the face, instruct the lady not to force however to but ratthe lady to inhale relentlessly or to gasp.

Agony plus uneasiness alleviation

• Recommend alteration of position.

• Encourage portability, as agreeable for the lady.

Urge buddy to:

→massage the lady's back on the off chance that the lady discovers this accommodating.

→handle the lady's plus plus wipe the lady eyes amid compressions.

• Prompt the lady to utilize the Respiratory strategy.

• Encourage steaming bath or bath, if accessible.

Assist the lady in child bearing pain who is on edge, frightful or in agony

o Find out the reason

o Introduce the lady recognition, consolation plus consolation;

o Introduce the lady data on the procedure plus advancement of the lady work;

o Be attentive to the lady plus be delicate to the lady sentiments

Individual assist (delivery buddy)

• Encourage the lady to have individual assist from an individual of the lady decision all through work plus delivery:

- Encourage support from the picked delivery friend;
- Arrange sdevour fooding for the sidekick beside the lady;
- Encourage the sidekick to acquaint sufficient assist with the lady amid work plus child bearing pain

• Narrate to the delivery friend what the lady or he ought to do:

- At record-breaking be around thewoman.
- Prompt the lady.
- Assist the lady to inhale plus unwind.
- Massage the lady back, wipe the lady foreface with a wet fabric, do otthe lady strong activities.
- Introduce bolster utilizing neighborhood rehearses which Don't botthe lady work or conveyance.
- Encourage lady moving of openly as the lady withe ladys plus to receive the lady preferred situation.
- Prompt the lady to take water liquids plus devour food as the lady withe ladys.

Assist the lady to the latrine when required.

• Ask the delivery friend to call for assist if:

- The lady is hunkering afflicted compressions.
- Tthe ladye is vaginal dying.
- The lady is all of a sudden in considerably more agony.
- The lady loses awareness or is fits.
- Tthe ladye is some otthe lady concern.

• Tell the delivery partner what the lady or he SHOULDN'T ACT plus clarify why:

- DON'T urge lady to push.
- DON'T present guidance otthe lady than that introduced by the TBA.
- DON'T handle lady in bed whetthe lady the lady needs moving of.

WEEK Four: Module 3: Rapid Initial Assessment plus Trauma Management

FIRST CONTACT

Unit One: Preparation plus Response to Traumas

Learning Objectives:

Prior the finish of this unit, members ought to have the capacity to:

- Narrate key strides in quick introductory evaluation of a wiped out lady.

Arrangement plus Response to Traumas

Each TBA obligatory should prepared to assist if a lady touches base with an obstetrical injury or indications plus manifestations of cutting edge work for example a worker individual ought to have the capacity to recognize a lady with thrdevour food indications of incubation or in cutting edge work, take the lady to the trdevour foodment territory, plus require the talented supplier. To make this conceivable the gifted supplier ought to present worker the data plus preparing they should most likely play out their occupations if tthe ladye is an injury. All worker at the TBA focus ought to have the capacity to play out a Quick MONITORED

Snappy MONITORED

• Gaze at the lady:

- Did somebody convey the lady into the wellbeing post? (conceivable indication of stun)
- Is tthe ladye blood on the lady garments or on the floor underndevour foodh the lady? (Indication of seeping in incubation.)
- Is the lady snorting, groaning, or hunkering down? (potential side effects of development work)

• Ask the lady or somebody who is with the lady whetthe lady the lady is now or is as of late had:

- Vaginal dying
- Chronic migraine/obscured locating
- Gaspings or miss of cognizance
- Problem Respiratory
- Fever
- Chronic stomach torment
- Labour torments

• If the lady is or as of late had ANY of these thrdevour food side effects, or side effects plus side effects of cutting edge work, right away:

- Shout for assist, if need be.

- Stay quiet. Concentrate on the lady.
- Don't disregard the lady.

Fast Initial Assessment

At the point when a lady of childbearing age presents with an issue, play out a fast beginning evaluation to diagram out what is required for prompt adjustment, the board, plus referral. Quickly evaluate the lady circumstance with a speedy examination including circulatory strain, bdevour food, brdevour foodh, temperature, plus skin shading to decide the lady level of ailment. The lady additionally needs brief consideration in the event that the lady is any of the accompanying side effects: blood-recolored bodily fluid release (appear) with discernable withdrawals; cracked films; whiteness; shortcoming; blacking out; constant cerebral pains; obscured locating; retching; fever or respiratory trouble.

SECOND CONTACT

Unit Two: Trauma Management Principles

Learning Objectives

Prior the finish of this unit, members ought to have the capacity to:

- Outline key injury the board ventures for explicit injury issues
- Narrate significant components in appraisal plus the board of stun

Injury Management Principles

Injuries can happen all of a sudden, similarly as with a heaving, or they can crdevour foode because of an intricacy that isn't legitimately overseen or checked. Injuries can be overseen by counteractive action, reacting to them when they happen plus referral.

Forestalling Traumas

Most injuries can be forestalled by:

- cautious arranging;
- following clinical rules;
- close observing of the lady.

Reacting to a Trauma

Reacting to an injury speedily plus successfully necessitates that the TBA knows his/the lady job plus the ladyhis/the lady aptitude stops. The TBA should know clinical circumstances plus their judgments plus what to do including referral. In dealing with an injury, the TBA must:

- Stay quiet. Think sensibly plus center around the necessities of the lady.
- Not leave the lady unattended.

• Take charge.

• If the lady is oblivious, survey the aviation route, Respiratory plus dissemination.

• If stun is suspicioused, promptly start trdevour foodment. Regardless of whetthe lady manifestations of stun are absent, handle stun as a primary concern as you assess the lady furtthe lady in light of the fact that the lady status may decline quickly. In the event that stun crdevour foodes, it is essential to start trdevour foodment right away.

• Position the lady resting on the lady left side with the lady leg raised. Extricate tight apparel.

• Talk to the lady plus assist the lady to remain quiet. Ask what occurred plus what side effects the lady is encountering.

• Perform a speedy examination including indispensable side effects (circulatory strain, bdevour food, brdevour foodh, temperature) plus skin shading. Gauge the measure of blood lost plus evaluate side effects plus side effects.

Alluding The Woman For Care

• Later injury the board, talk of choice to allude with lady plus relatives.

• Quickly compose transport plus conceivable budgetary guide.

• Inform the referral focus by telephone.

• Introduce the lady a referral slip containing the accompanying data:

- Name, age, address
- Obstetrical history (equality, gestational age, antenatal intricacies)
- Relevant past obstetrical intricacies
- Specific issue for which the lady is alluded
- Care connected up to this point plus results
- If tthe ladye is an infant, send with the the lady if tthe ladye is a relatives part who can go with the the lady to think of the neonate.

• In the process adventure:

- Maintain IV mixture.
- Handle the lady (plus infant, whenever conceived) hot yet Don't overhdevour food.
- If venture is long, present proper consideration in transit.
- Handle record of all IV liquids, meds introduced, time of organization, plus lady's circumstance.

Dealing with a Patient in "Stun"

Stun is described by disappointment of the circulatory framework to keep up sufficient perfusion of the fundamental organs. Stun is a dangerous circumstance that requires quick plus escalated trdevour foodment.

Suspicious or envision stun if no less than one of coming up next is available:

• Blood gushing in beginning incubation (for example premature delivery, ectopic or molar growth);

• Blood gushing in late growth or work (for example placenta praevia, abruptio placentae, cracked womb);

• Blood gushing later child bearing pain (for example burst womb, uterine atony, tears of genital tract, held placenta or placental pieces);

• Infection (for example risky or septic premature delivery, amnionitis, metritis, pyelonephritis);

• Trauma (for example damage to womb or entrail amid premature delivery, cracked womb, tears of genital tract).

Indications plus Symptoms of Shock

Analyze stun if the accompanying indications plus manifestations are available:

• Fast, powerless heartbdevour food (110 every moment or more);

• Low circulatory strain (systolic under 90 mm Hg).

Different indications plus side effects of stun include:

• Pallor (particularly of inward eyelid, palms or around mouth);

• Swdevour foodiness or cold sticky skin;

• Rapid Respiratory (rate of 30 brdevour foodhs of every moment or more);

• Anxiousness, disarray or obviousness;

• Scanty pee yield (under 30 mL of every hour).

The board of Shock at the TBA

Guarantee the accompanying:

• Monitor indispensable side effects (bdevour food, circulatory strain, brdevour foodh, temperature).

• Turn the lady onto the lady side to limit the danger of desire in the event that the lady regurgitates plus to guarantee that an aviation route is open.

• Handle the lady hot however Don't overhdevour food the lady as this will build fringe dissemination plus enhance blood supply to the essential focuses.

• Elevate the legs to build return of blood to the heart (if conceivable, raise the foot end of the bed).

Assessment

1. Narrate key strides in fast beginning appraisal of a wiped out lady.
2. Outline key injury the executives ventures for explicit injury issues
3. Narrate significant components in appraisal plus the board of stun

Week 5: Module 4: Gestation Care

Presentation

Devour food consideration amid incubation is significant for the wellbeing of the the lady plus the improvement of the baby. Incubation is a critical time to advance sound conduct plus child rearing abilities. Devour food ANC joins the lady plus the lady relatives with the formal wellbeing framework, builds the opportunity of utilizing a talented specialist in the process childdelivery plus adds to devour food wellbeing through the existence cycle. Insufficient consideration amid this time breaks a basic connection in the continuum of consideration, plus influences the two ladies plus children.

Unit One: Ante Natal Care

Learning Objectives

Toward the finish of this unit, members ought to have the capacity to:

- Define ANC
- Discuss the significance of ANC
- State components of ANC

Bet Natal Care

ANC is characterized as the complex of mediations that a pregnant lady gets from sorted out human services administrations with the goal of guaranteeing each development to come full circle in the conveyance of a sound tyke without weakening the strength of the the lady.

Significance of ANC

The objective of the ANC bundle is to get ready for delivery plus parenthood just as anticipate, identify, lighten, or deal with the three kinds of medical issues amid incubation that influence moms plus children:

• Complications of development itself,

• Pre-existing circumstances that intensify amid incubation,

• Effects of undesirable ways of life.

Components of ANC

ANC likewise furnithe ladys ladies plus their families with proper data plus guidance for a solid growth, safe child bearing pain, plus postnatal recuperation, including care of the infant, advancement of beginning, restrictive breastfeeding, plus assist with choosing future pregnancies so as to improve development results. The consideration ought to be fitting, financially savvy plus dependent on individual needs of the the lady. A powerful ANC bundle relies upon capable social insurance suppliers in a working wellbeing framework with referral administrations plus satisfactory supplies plus lab support. ANC improves the survival plus soundness of infants straightforwardly by diminishing stilldeliverys plus neonatal period Demises plus in a roundof way by giving a section point to wellbeing contacts with the lady at a key point in the continuum of consideration.

Week 6: Module 5: Female Genital Mutilation, Women Friendly Care plus Infection Prevention

Unit One: Female Genital Mutilation

FIRST CONTACT

Learning Objectives

Prior the finish of this unit members will have the capacity to:

• Define Female Genital Mutilation (FGM)

• Narrate kinds of FGM.

• Narrate the obstetrical impacts of FGM.

Female Genital Mutilation

Female circumcision, otthe ladywise called female genital mutilation (FGM) comprises of all techniques that include incomplete or absolute expulsion of the outside female genitalia or otthe lady damage to the female genital organs whetthe lady for social or otthe lady non-remedial reasons. Usually in a few nations, dominatingly in Africa, plus around 140 million young ladies plus ladies worldwide are Recently living with the results of FGM.

Sorts of FGM

As per the WHO (2008), FGM are grouped:

Type I: Partial or absolute evacuation of the clitoris or potentially the prepuce (Clitoridectomy).

Type II: Partial or all out expulsion of the clitoris plus the labia minora, with or without extraction of the labia majora (Excision).

Type III: Narrowing of the vaginal hole with production of a covering seal by cutting plus a situating the labia minora as well as the labia majora, with or without extraction of the clitoris (Infibulation).

Type IV: All otthe lady destructive systems to the female genitalia for non-restorative purposes, for instance: pricking, penetrating, etching, scratching plus searing (Unclassified).

Impact of FGM

FGM is no medical advantages, plus it hurts young ladies plus ladies from multiple points of view. It includes expelling plus harming solid plus typical female genital tissue, plus meddles with the characteristic elements of young ladies' plus ladies' bodies. Prompt intricacies can incorporate constant torment, stun, drain (dying), lockjaw or sepsis (bacterial contamination), pee maintenance, open bruises in the genital area plus damage to adjacent genital tissue. Also, long haul results can include: reRecent UTI; fruitlessness; an expplused danger of child bearing pain entanglements plus infant Demises plus the requirement for later medical procedures.

As indicated by a WHO ponder bunch on female genital mutilation plus obstetrical result done at 28 obstetrical focuses in Burkina Faso, Ghana, Kenya, Nigeria, Senegal, plus Sudan amid November, 2001, plus March, 2003, conveyances to ladies who have experienced FGM are altogetthe lady bound to be muddled by cesarean segment, baby blues discharge, episiotomy, expplused protective medical clinic remain, revival of the newborn child, plus inpatient baby blues Demise, than conveyances to ladies who have not had FGM. Ladies with FGM II plus FGM III were essentially bound to have a cesarean segment plus baby blues blood miss of 500 mL or more prominent than were ladies who had not had FGM. Tthe ladye was no huge relationship among FGM plus the danger of having a low-delivery weight newborn child. Tthe ladye is proof that FGM is related with expplused rates of genital plus urinary-tract contamination, which could likewise have repercussions for obstetrical Outcomes.

The system by which FGM may cause unfavorable obstetrical results is hazy. Despite the fact that rehearses differ from nation to nation, FGM is commonly done in young ladies more youthful than 10 years plus prompts fluctuating measures of scar arrangement. The presence of this scar tissue, which is less versatile than the vagina plus vaginal tissue would regularly be, might cause contrasting degrees of block plus tears or episiotomy. A long stage two of work, alongside direct consequences for the perineum, could underlie the discoveries of an

expplused danger of vagina damage, baby blues drain, revival of the newborn child, plus new stilldelivery related with FGM.

Unit Two: Women Friendly Care

Learning Objectives

Prior the finish of this unit members will have the capacity to:

• Define lady benevolent consideration.

• State cares which are lady well disposed.

• State instances of considerations which are not lady well disposed

Ladies Friendly Care

Ladies neighborly consideration is life-sparing as studies have demonstrated that ladies may reject to gaze for consideration from a supplier who "manplusles" them or does not trdevour food them well, regardless of whetthe lady the supplier is gifted in anticipating plus overseeing of inconveniences.

Lady well disposed consideration is a consideration that:

- Provides administrations that are worthy to the lady:
- Respects convictions, conventions, plus culture
- Includes relatives, accomplice, or otthe lady assist individual in consideration
- Provides applicable plus plausible exhortation

A few instances of consideration that is ladies agreeable:

- Individualizes care to lady's needs
- Recognizes the wealth plus otthe ladyworldly importance of network plus culture
- Is mindful of conventional convictions with respect to incubation plus child bearing pain
- Cooperates plus liaises with conventional human services framework when conceivable
- Provides socially touchy consideration
- Respects plus supports the the lady-infant dyad:
- Encourages handleing
- Handles infant with the lady
- Places infant on the lady's midriff (at bosom) promptly later delivery
- Speaks to the lady in the lady own language
- Observes guidelines plus stplusards of the lady way of life as fitting

- Is mindful of who settles on choices throughout the lady life plus includes that individual in discourses plus choices

A few instances of consideration that isn't ladies benevolent:-

- Does not regard lady or the lady way of life or foundation
- Rude, hostile, belittling language by wellbeing work force
- Physically controls, puthe ladys or hits the lady
- Insists on routine strategies that are advantageous for the medicinal services supplier however might be despicable or nausdevour fooding to the lady, for example lithotomy position just, routine episiotomy, visit vaginal tests, mechanical production system design of consideration
- Excludes accomplice or buddy from consideration
- Separates the lady plus infant

Assessment:

1. Define Female Genital Mutilation (FGM)
2. Narrate kinds of FGM.
3. Narrate the obstetrical impacts plus worldwide circumstance of FGM.
4. Define lady well disposed consideration.
5. State five considerations which are lady well disposed.
6. State five instances of considerations which are not lady well disposed

SECOND CONTACT

Unit Three: Infection Prevention plus Patient Safety

Learning Objectives

Prior the finish of this unit members will have the capacity to:

o Narrate Infection Prevention plus Patient security

o Narrate Infection Prevention plus Patient Safety objective plus targets

o Outline key Infection Prevention plus Patient Safety rehearses

Disease Prevention plus Patient Safety

The protective focus can be a round the ladythe TBA can contract disease or even uncover patient or hopeful the lady to contamination. Disease aversion includes the wellbeing Methods taken to shield oneself from contamination while giving consideration to ladies requiring regenerative wellbeing administrations plus care. Then again, patient's security alludes to the wellbeing insurance taken by the TBA to keep customers from contracting disease or having their case intensified.

Objective of Infection Prevention plus Patient Safety

The objective of IP plus PS is to make the protective wellbeing focus a superior plus safe spot for the customer plus supplier.

Destinations of IP plus PS

Disease aversion (IP) plus Patient Safety (PS) have two essential destinations:

• Prevent real contaminations while giving administrations;

• Minimize the danger of transmitting genuine maladies, for example, hepatitis B plus HIV/AIDS to the lady, the network plus to specialist co-ops plus worker, including clearing plus househandleing work force.

Contamination Prevention plus Patient Safety Practices

The recommended first dimension IP rehearses depend on the accompanying stplusards:

• Every individual (patient or worker) necessary should considered possibly irresistible;

• Plus clearing is the most down to earth technique for avoiding cross-defilement;

• Wear gloves prior contacting anything wet—broken skin, mucous films, blood or otthe lady body liquids (discharges or discharges);

• Use hindrances (defensive goggles, eyes covers or covers) if sprinkles plus litters of anyone liquids (discharges or discharges) are foreseen;

• Use germ-free specialists prior intrusive systems

• Use safe work rehearses, for example, not recapping or bowing injection needles, appropriate instrument preparing plus legitimate transfer of restorative waste.

• Vaccinate worker who are in direct contact with patients/customers for: hepatitis B, massageella, measles, mumps, plus flu.

Unit Four: Plus Hygiene, Plus Clearing plus Use of Plus Gloves

Learning Objective

Prior the finish of this unit members ought to have the capacity to:

o Demonstrate suitable plus clearliness practice plus utilization of plus gloves.

Plus Hygiene

This is the most single significant disease counteractive action methodology. Plus clearliness is a general term alluding to any activity of plus purging. It incorporates care of pluss, nails plus skin. Appropriate Plus clearliness is one of the key exercises of limiting the spread of sickness plus keeping up a disease free condition.

Plus Hygiene methods include:

• Routine Plus clearing

• Plus Antisepsis
• Antiseptic Plus massage
• Surgical Plus scour

Plus Clearing

The motivation behind plus clearing is to precisely expel soil plus flotsam plus jetsam from the skin plus enhance the quantity of transient microorganisms. Proper plus clearliness, for example energetically massage togetthe lady all sureyess of the pluss cleared with plain or antimicrobial clearser for 15– 30 seconds plus flush with a surge of running or poured water framework, obligatory ought to completed:

• Prior gazeing at (coming in direct contact with) a customer/tolerant
• Prior plus later expelling gloves
• Later any circumstance in which pluss might be polluted, for example,

o Plus debased items/instruments, later contact with mucous film body liquids ,blood, emissions or discharges (aside from perspiration) plus ruined instruments
o Upon touching base at plus prior leaving work place

Germicide Plus Massage/Alcohol Based Solution for Plus Massage

The utilization of germicide plus massage is increasingly viable in slaughtering transient plus occupant verdure than plus clearing with antimicrobial operators or plain clearser plus water framework except if pluss are unmistakably dirty. It is fast plus advantageous to perform plus presents a more noteworthy beginning Ameliorating close by verdure.

A non-chafing disinfectant plus massage can be made by including eitthe lady Glycerin, Propylene glycol or Sorbitol to liquor (2ml. in 100ml. of 60 to 90% Ethyl or Isopropyl liquor arrangement) (Larson, 1990 plus Pierce, 1990). Utilize 5ml. (around one teaspoonful) for every application plus keep scouring the arrangement over the pluss until they are dry (15 to 30 seconds). Clearing pluss with clearser plus water framework later every 5-10 utilization of the arrangement is for the most part prescribed.

Utilization of Plus Gloves

Tthe ladye are three sorts of gloves:

• Surgical glove
• Examination glove
• Utility or hard core glove

Wear gloves:

• When tthe ladye is a sensible possibility of pluss interacting with blood or otthe lady body liquids, mucous films or non-unblemithe ladyd skin;

• Prior performing intrusive restorative systems (e.g., embeddings vascular gadgets, for example, fringe venous lines); or

• Prior taking care of polluted waste things or contact defiled sureyess.

What sort of gloves to utilize?

• Disposable clear examination gloves are liked (High-level sanitized reusable gloves are adequate) when tthe ladye is contact with mucous layer plus non-unblemithe ladyd skin (e.g., performing medicinal observation plus methods, for example, pelvic examination).

• Sterile careful gloves ought to be utilized when performing surgeries.

• High-level sterilized careful gloves are the main satisfactory option if clear careful gloves are not accessible, when performing surgeries.

• Clear, uncompromising family (utility) gloves ought to be utilized for clearing instruments, gear, debased sureyess, plus keeping in mind that taking care of or discarding tainted waste.

Twofold Gloving:

Albeit twofold gloving is of little advantage in counteracting blood introduction if needle sticks or different wounds happen, it might diminish the danger of blood plus contact. Twofold gloving is prescribed in the accompanying circumstances:

• For methods that includes interacting with substantial measure of blood or otthe lady body liquid (for example vaginal conveyances plus cesarean segments).

Assessment

1. What is Infection Prevention plus Patient wellbeing
2. Narrate Infection Prevention plus Patient Safety objective plus goals
3. Outline key Infection Prevention plus Patient Safety rehearses
4. Demonstrate fitting plus clearliness practice plus utilization of plus gloves

Week 7: Module 6: Care plus Referral for Complications amid Child Delivery

FIRST CONTACT

Unit One: Symptoms of Satisfactory plus Unsatisfactory Progress of Child bearing pain

Learning Objectives

Prior the finish of this unit members ought to have the capacity to:

 State side effects of acceptable plus unsuitable advancement of work at the principal Phase of work

 State manifestations of attractive plus unsuitable advancement of work at the stage two of work

 State vital moves to make when gazeed with indications of unacceptable advancement of work

Advancement OF FIRST STAGE OF Child bearing pain

Side effects of Satisfactory Progress of Child bearing pain at the First Stage of Child bearing pain

Side effects recommendive of palatable progressin first Phase of work are:

− Regular compressions of continuously expplusing recurrence plus term;

− Rate of cervical dilatation something like 1 cm of every hour amid the dynamic period of work

− Womb very much connected to the introducing part.

Indications of Unsatisfactory Progress of Child bearing pain at the First Stage of Child bearing pain

Indications recommendive of inadmissible progressin first Phase of work are:

− Irregular plus rare withdrawals;

− OR rate of cervical dilatation slower than 1 cm for every hour amid the dynamic period of work;

− OR womb ineffectively connected to the showing part.

Unsuitable advancement in child bearing pain can prompt delayed work. In the event that unsuitable advancement of labouror delayed labouris suspicioused, deal with the reason for moderate advancement or allude promptly to a stplusard medical clinic.

Advancement OF PHASETWO OF Child bearing pain

Manifestations of Satisfactory Progress of Child bearing pain at the Phasetwo of Child bearing pain

Manifestations recommendive of tasteful advancement in stage two of work are:

- Steady plummet of baby through delivery channel;
- Onset of expulsive (pushing) stage.

Manifestations of Unsatisfactory Progress of Child bearing pain at the Phasetwo of Child bearing pain

Manifestations recommendive of unsuitable progressin stage two of work are:

- Lack of plummet of baby through delivery channel;
- Failure of removal amid the late (expulsive) stage.

On the off chance that stage two is delayed without unmistakable relentless plummet of the facerefer direly to medical clinic.

SECOND CONTACT

Unit Two: Basic Care amid Phasetwo plus Assisting Normal Delivery of a child(ren)

Learning Objectives

Prior the finish of this unit members ought to have the capacity to:

- Outline essential consideration to be introduced to a lady amid stage two of typical conveyance
- List crucial files to screen amid conveyance
- List steps engaged with finish of conveyance including taking care of the new brought into the world quickly later ejection by the the lady

Essential CARE IN THE PROCESS PHASETWO PLUS ASSISTING NORMAL CHILDDELIVERY

- Notify worker that conveyance is approaching.
- Insure all conveyance gear plus supplies are accessible, plus spot of conveyance is perfect plus hot (25°C).
- Insure bladder is unfilled.
- Assist the lady preferred lady into an agreeable position, as upstplusing as could reasonably be expected.

Avoid recumbent position till face is noticeable.

- Stay with the lady plus offer the lady enthusiastic plus physical assist.
- Allow the lady to push as the lady withe ladys with constrictions staying away from beginning push; it should begin precipitously.
- Wait until face noticeable plus perineum distending.
- Clearpluss with clear water framework plus clearser. Put on gloves just prior conveyance.
- Clear the female genital organ plus perineum with disinfectant (descending plus far from the introitus). In the event that bits of dung get removed, wipe them descending.

− Attendant ought to be dressed plus gloved suitably (gloves, outfits, cover, covers, tops, eye security)

− Sterile hanging so that just the prompt zone of the female genital organ is uncovered.

Screen:

• For injury manifestations, utilizing quick appraisal (RAM).

• Frequency, force plus length of compressions.
• Fetal pulse at regular intervals for typical work.
• Evaluate the level of plummet each 1 hr.
• Perineum diminishing plus swelling.
• Visible plummet of fetal face or amid constriction.
• Mood plus conduct (botthe ladyed, on edge).
• Introduce Supportive consideration.
• Never disregard the lady.

Diagram 4:Postions that a lady may receive amid child bearing pain

Assist DELIVERY OF A CHILD(REN) OF THE BABY:

- If the rope is tight around the neck, doubly cinch plus cut it prior loosening up it from around the neck.

Fulfillment of conveyance:

• Allow the fetal face to turn immediately.

• Later the face turns, place a plus on each side of the baby's face. Advise the lady to push tenderly with the following compression.

• Ameliorate tears by conveying one shoulder at any given moment. Move the embryo's face posteriorly to convey the shoulder that is front.

Note: If tthe ladye is issue conveying the shoulders:

• Lift the fetal face anteriorly to convey the shoulder that is back.

• Support the remainder of the hatchling's body with one plus as it slides out.

• Place the infant on the the lady's belly.

Note: If putting infant on stomach area isn't worthy, or the the lady can't handle the infant, place the infant in a perfect, hot, safe spot near the the lady.

• Clamp plus cut the string: Clamp the string at around 3 cm from the umbilicus plus apply second brace 2cm separated, tie safely among clips plus cut with sterile scissors or sharp edge

• Thoroughly dry the infant plus survey Respiratory. In the event that child does not inhale promptly, start resuscitative measures.

• Remove wet towel plus guarantee that the infant is kept hot, utilizing skin-to-skin contact on the the lady's chest. Spread the infant with a fabric or cover, including the face (with cap if conceivable).

• Palpate the the lady's midriff to discount the presence of extra child (ies) plus continue with dynamic administration of the third stage.

Week 8: Module 7: Active Management of the Third Stage

UNIT ONE: Prevention of PPH

Learning Objectives:

Prior the finish of this unit, members ought to have the capacity to:

- Identify PPH as the most widely recognized reason for protective Demise
- Identify steps important in overseeing third Phase of work plus forestalling PPH

Dynamic MANAGEMENT OF THE THIRD STAGE

Baby blues discharge is the most significant single reason for protective Demise on the planet. Most of these Demises (88%) happen inside 4 hours of conveyance, demonstrating that they are a result of occasions in the third Phase of work. Baby blues drain is an inconvenience which happens at the alteration among work plus the baby blues period. The variables capable of discharge are uterine atony plus held placenta in most of cases; vaginal or cervical slathe ladys plus (periodically) uterine burst or reversal additionally assume a job.

The main hours baby blues are particularly basic in the analysis plus the executives of unusual dying.

Dynamic administration of the third stage (dynamic conveyance of the placenta) counteracts baby blues drain plus this administration incorporates:

- Immediate organization of uterotonic specialists; (This is whenever prepared wellbeing supplier who can regulate this accessible or the TBA is gifted to oversee)

- Controlled rope footing; plus

- Uterine massage (later the conveyance of the placenta).

Utilization of Uterotonic Agents

• Within 1 moment of conveyance of the infant, palpate the guts to discount the presence of an extra fetus(s) plus present oxytocin 10 units IM.

• Oxytocin is favored on the grounds that it is compelling 2 to 3 minutes after the fact infusion, is negligible symptoms plus can be utilized in all ladies.

• If oxytocin isn't accessible:-

− Otthe lady uterotonics can be utilized, for example, ergometrine 0.2 mg IM, syntometrine (1 ampoule) IM ;or

− Misoprostol 400-600 mcg orally. Oral organization of misoprostol ought to be saved for circumstances when safe organization as well as proper stockpiling circumstances for injectable oxytocin plus ergot alkaloids are impractical.

Controlled Cord Traction

Brace the line near the perineum utilizing wipe forceps. Handle the clasped string plus the finish of forceps with one plus.

• Place side of one plus (generally left) above symphysis pubis with palm gazeing towards the the lady's umbilicus. This applies counter footing to the womb amid controlled line footing. In the meantime, apply enin the process, continued controlled rope footing. This forestalls reversal of the womb.

• Handle slight pressure on the string plus anticipate a solid uterine withdrawal (2– 3 minutes).

• With the solid uterine constriction, urge the the lady to push plus in all respects delicately dismantle descending on the rope to convey the placenta. Keep on applying counter footing to the womb with the otthe lady plus.

• If the placenta does not slip amid 30– 40 seconds of controlled line footing (for example tthe ladye are no side effects of placental partition), Don't keep on pulling on the string:

− Gently handle the string plus handle up until the womb is very much contracted once more. On the off chance that fundamental, utilize a wipe forceps to clip the line nearer to the perineum as it stretches;

− With the following constriction, reish controlled string footing with counter footing.
NOTE: - If, later 30 minutes of giving oxytocin, the placenta isn't conveyed plus the lady isn't dying:

→ Empty bladder

→ Encourage breastfeeding

→ Repdevour food controlled rope footing.

− If lady is dying, oversee as baby blues drain.

− If placenta isn't conveyed in an additional 30 minutes (after 1 hour conveyance):

→ Remove placenta physically

− If in 1 hour unfit to expel placenta:

→ Refer the lady to medical clinic

Try not to apply inordinate footing on the line.

Try not to press or push the womb to convey the placenta.

NB: Never apply string footing (pull) without applying counter footing (push) over the pubic bone with the otthe lady plus

As the placenta conveys, the flimsy layers can detach. Handle the placenta in two pluss plus delicately turn it until the layers are curved.

• Slowly destroy to finish the conveyance.

• If the films tear, tenderly gaze at the upper vagina plus womb wearing abnormal state cleared gloves plus utilize a wipe forceps to evacuate any bits of layer that are available.

• Gaze cautiously at the placenta to make certain none of it is absent. In the event that a segment of the nurturing sureyes is missing or tthe ladye are torn layers with vessels, suspicious held placental parts.

• If uterine reversal happens, reposition the womb.

• If the line is pulled off, manual evacuation of the placenta might be fundamental.

Uterine Massage

- Immediately knead the fundus of the womb through the lady's guts until the womb is contracted.

- Repdevour food uterine back massage like clockwork for the initial 2 hours.

- Insure that the womb does not wind up loose (delicate) later you stop uterine back massage.

(Adjusted from WHO Training Manual for The lady plus Child Care 2013).

LASSA FEVER PREVENTION PACKAGE

Week One: General introduction plus organization of pre-test

Week Two: Introduction to Lassa Fever

Targets: At the finish of this session, members ought to have the capacity to:

1. State the ladyLassa Fever started from

2. State the casualty rate of Lassa Fever

Prologue to Lassa Fever

Stage One

Portrayal of Lassa Fever

It was first found in 1969 in Lassa, Nigeria when two minister attendants kicked the bucket. Lassa fever is a zoonotic malady, implying that people become contaminated from contact with tainted crdevour foodures. The crdevour foodure store, or host, of Lassa infection is a

rat of the sort Mastomys, normally known as the "multimammate rodent." Mastomys rodents tainted with Lassa infection Don't turn out to be sick, however they can the ladyd the infection in their pee plus dung. Since the clinical course of the illness is so factor, recognition of the ailment in influenced patients is been troublesome.

Stage Two

Casualty Rate of Lassa fever

Of 80% of individuals who become tainted with Lassa infection have no indications. 1 out of 5 contaminations outcome in perpetual illness, the ladythe infection influences a few organs, for example, the liver, spleen plus kidneys. At the point when presence of the illness is asserted in a network, be that as it may, brief disconnection of influenced patients, devour food disease counteractive action plus control rehearses, plus thorough contact following can stop flare-ups. Lassa fever is known to be endemic in Benin, Ghana, Guinea, Liberia, Mali, Sierra Leone, plus Nigeria, however most likely exists in otthe lady West African nations also. The casualty rate of Lassa fever is 1%.

Shutting Remark

1. The facilitator outlines the exercise plus fdevour foodures the primary concern

2. Questions will be engaged later which the exercise will be assessed

3. The facilitator will assist members to remember the following session

4. Snacks will be served to end the procedure

Week Three: Symptoms of Lassa Fever

Goals

Toward the finish of this session, members ought to have the capacity to:

1. State the hatching time of Lassa Fever

2. Mention side effects plus manifestations of Lassa Fever

3. State the wellbeing screeched of Lassa fever for survivors

Manifestations plus Symptoms of Lassa Fever

The brooding time of Lassa fever ranges from 6– 21 days. The beginning of the infection, when it is symptomatic, is typically slow, beginning with fever, general shortcoming, plus discomfort. Later a couple of days, migraine, sore throat, muscle torment, chest torment, queasiness, retching, looseness of the bowels, hack, plus stomach torment may pursue. In endless cases facial swelling, liquid in the lung pit, seeping from the mouth, nose, vagina or gastrointestinal tract plus low pulse may crdevour foode.

Stun, seizures, tremor, confusion, plus trance like state might be found in the later stages. Deafness happens in 25% of patients who endure the illness. In half of these cases, hearing returns in part later 1– 3 months. Transient hair miss plus step unsettling influence may happen amid recuperation. Destruction for the most part happens inside 14 days of beginning in deadly cases. The sickness is particularly constant late in incubation, with nurturing Demise as well as fetal miss happening in over 80% of cases amid the third trimester.

Shutting Remark

1. The facilitator abridges the exercise plus fdevour foodures the primary concern

2. Questions will be engaged later which the exercise will be assessed

3. The facilitator will assist members to remember the following session

4. Snacks will be served to end the procedure

Week Four: Trdevour foodment plus Prophylaxis of Lassa Fever

Targets:

Toward the finish of this session, members ought to have the capacity to:

1. State whetthe lady Lassa Fever can be dealt with or not

2. State whetthe lady Lassa Fever is inoculation or not

Trdevour foodment plus prophylaxis

The antiviral medication ribavirin is by all accounts a viable trdevour foodment for Lassa fever if introduced beginning on over the span of clinical disease. Tthe ladye is no proof to assist the job of ribavirin as post-presentation prophylactic trdevour foodment for Lassa fever. Tthe ladye is Recently no antibody that Insures against Lassa fever.

Shutting Remark

1. The facilitator condenses the exercise plus fdevour foodures the primary concern

2. Questions will be engaged later which the exercise will be assessed

3. The facilitator will assist members to remember the following session

4. Snacks will be served to end the procedure

Week Five: Prevention of Lassa Fever

Destinations

Toward the finish of this session, members ought to have the capacity to:

1. State people group clearliness as the focal topic of Lassa fever aversion endeavors

2. List measures to counteract Lassa fever

Counteractive action of Lassa fever depends on advancing devour food "network clearliness" to debilitate rodents from entering homes. Powerful measures include:

1. storing grain plus different foodstuffs in rat evidence handleers,

2. disposing of waste a long way from the home,

3. maintaining clear family units plus handleing felines.

Shutting Remark

1. The facilitator outlines the exercise plus fdevour foodures the primary concern

2. Questions will be engaged later which the exercise will be assessed

3. The facilitator will assist members to remember the following session

4. Snacks will be served to end the procedure

Week Six: Control of Lassa Fever

Goals

Toward the finish of this session, members ought to have the capacity to:

1. Mention annihilation of irresistible rodent as real advance to controlling Lassa fever

2. State control measures at homes plus medical clinics

Control of Lassa Fever

Since the rodent in charge of Lassa fever are so inexhaustible in endemic zones, it is beyond the realm of imagination to totally dispose of them from nature. Relatives individuals ought to dependably be mindful so as to keep away from contact with blood plus body liquids while thinking of debilitated people.

In medicinal services settings, worker ought to dependably apply stplusard disease avoidance plus control safeguards when thinking of patients, paying little respect to their assumed determination. These incorporate essential plus clearliness, respiratory clearliness, utilization of individual defensive hardware (to square sprinkles or otthe lady contact with tainted materials), safe infusion practices plus safe internment rehearses.

Medicinal services specialists thinking of patients with suspicioused or avowed Lassa fever ought to apply additional disease control measures to counteract contact with the patient's blood plus body liquids plus tainted sureyess or materials, for example, attire plus bedding. At the point when in close contact (inside 1 meter) of patients with Lassa fever, social insurance child bearing painers should wear eyes assurance (a eyes shield or a restorative cover plus goggles), a clear, non-clear since a long time ago sleeved outfit, plus gloves (sterile gloves for certain strategies).

Research facility specialists are additionally in danger. Tests taken from people plus crdevour foodures for examination of Lassa infection contamination ought to be dealt with via prepared worker plus plusled in reasonably prepared research centers under most extreme natural regulation circumstances.

Shutting Remark

1. The facilitator condenses the exercise plus fdevour foodures the primary concern

2. Questions will be engaged later which the exercise will be assessed

3. The facilitator will assist members to remember the following session

4. Snacks will be served to end the procedure

Week Seven: Lassa Fever Prevention in TBA Homes

Destinations

Toward the finish of this session, members ought to have the capacity to:

1. Mention Lassa fever as a huge risk to nurturing wellbeing

2. Mention how Lassa Fever can be anticipated in a TBA home

Lassa Fever Prevention in TBA Homes

Lassa fever presents incredible peril plus risk to protective wellbeing. This is particularly the situation in late pises of incubation the ladycasualty rate is as high as 80%. TBAs have unique jobs in avoiding flare-up plus spread of Lassa fever. This accomplishment can be accomplithe ladyd through:

1. Sensitizing pregnant ladies on the presence plus thrdevour foods of Lassa fever

2. Handleing the TBA home encompassing spotless plus free from rodents

3. Discouraging the utilization of rodents as sustenance

4. Ensuring legitimate clearliness in dealing with misuse of protective moms previously, amid plus later conveyance

Shutting Remark

1. The facilitator abridges the exercise plus fdevour foodures the primary concern

2. Questions will be engaged later which the exercise will be assessed

3. The facilitator will assist members to remember the following session

4. Snacks will be served to end the procedure

Week Eight: Rounding Off

This session will involve:

1. Summary of Lassa Fever Education program

2. Taking last inquiries plus answers

3. Administration of posttest

Issue of authentication of support to members

Appendix III

Researcher with a cross section of the participants in the experimental group during one of the sessions

Researcher with a cross section of the participants in the experimental group during one of the sessions

Researcher demonstrating one of the safety skills with a cross section of the participants in the experimental group

One of the research assistants with a cross section of the participants during administration of instrument

One of the researchassistants demonstrating one of the safety skills with a cross section of the participants in the experimental group

One of the participantsdemonstrating one of the safety skills with the supervision of the researcher and one of the research assistants

Researcher, two of the research assistants with a cross section of the participants in the experimental groupduring one of the sessions

Cross section of the participants during administration of instrument