THE UTILIZATION LEVEL OF ANTENATAL CARE SERVICES AMONG PREGNANT WOMEN IN DHARKENLEY DISTRICT OF MOGADISHU

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Abstract

The study investigates the utilization level of ANC services among pregnant women in Dharkenley district in Mogadishu. The main objective which guided the study was; to determine the causes of low utilization level of ANC services among pregnant women in Dharkenley district; to identify complications related to low utilization of ANC service among pregnant women in Dharkenley district and to increase awareness of pregnant women to utilize antenatal care services in Dharkenley district of Mogadishu. The study adopted cross sectional descriptive design using both qualitative and quantitative approach. The study used a purposively sampling of non-probability method to collect a data from 60 respondents from three health center in the study area. The majority of the respondents of this study was aged between the 15-24 years of age, had no education or at least completed primary education. While most of the pregnant women who had atleast four ANC visits were primipara women, because primipara women may be afraid of pregnancy complications and outcomes since they have had no prior delivery experience. Women who did not attend the required number of ANC services responded that 50% did not know they had to attend several times, while 33% did not attend antenatal care service because of no time to attend and only 16% said health facility is too far. The study concludes that the majority of the women knew that low ANC utilization could cause pregnancy complications such as (30%) infections, 23% anemia and only 21% neonatal mortality.

Keywords: *Antenatal care, Utilization Level of Antenatal care services, Dharkenley district*

1.0 Background

Antenatal care (ANC) is the care a pregnant woman receives during her pregnancy through a series of consultations with trained health care workers such as midwives, nurses, and sometimes a doctor who specializes in pregnancy and birth. Somalia is among the countries

with high maternal and neonatal mortality, therefore adequate utilization of antenatal care will reduce the mortality rate (Fagbamigbe & Idemudia, 2015). An analytical review of the recent World Health Statistics showed that countries with low ANC coverage are the countries with very high MMR.

ANC is a critical element for reducing maternal mortality, and for providing pregnant women a broad range of health promotion and preventive health services, one of the most important functions of ANC is to offer health information and services that can significantly improve the health of women and their infants (Agus & horiuchi, 2012). The risk of stillbirth in neonatal death in the first week of life is higher among new born of mother. Maternal and prenatal death and related complications can be averted by timely and adequate utilization of antenatal care service (Upadhyay *et al*, 2014).

According to Singh *et al, (*2014), the utilization of maternal healthcare is a complex phenomenon influenced by several factors. Several studies from developing countries have recognized socioeconomic factors and service delivery environment as important determinants of healthcare utilization. The coverage of full antenatal care is low among illiterate mothers.

Husbands were the most influential persons in the woman's decision to utilize ANC and delivery care, particularly in teens and young adults. Influence of the husband as the main decision maker for a woman's utilization of maternal health services found in this study was also found in previous studies in Bangladesh (Upadhya *et al*, 2014). In-adequate prenatal care has been caused preterm birth, low birth weight among pregnant Women, maternal or fetal morbidity. This result identified poor compliance of prenatal care as the main independent risk factors associate with both preterm birth and low birth weight, in both immigrants and non-immigrants of pregnant women (Zulueta *et al*, 2015).

The maternal mortality ratio (MMR) in developing regions is 15 times higher than in the developed regions (MDG Report, 2012) and sub Saharan African countries have the highest MMR in the world with an average of 500 maternal deaths per 100,000 live births, accounting for half of the world's total maternal deaths, most of women die because they give birth without the assistance of skilled birth attendant (UNFPA, 2013). Sub-Saharan Africa is the region with the lowest coverage of skilled delivery utilization, with only 45% of women having skilled delivery attendants (UNFPA, 2013).

The specific objectives of this research are:-

1. To determine the causes of low utilization level of ANC services among pregnant women in wardi health centers and badbaado Health center in dharkenley district.
2. To identify complications related to low utilization of ANC services among pregnant women in wardi health centers and badbaado Health center in dharkenley district.
3. To assess awareness of pregnant women to utilize ANC services among pregnant women in wardi health centers and Badbaado Health center in dharkenley district.

2.0 Methodology

2.1 Study design

The study adapted cross sectional descriptive design using both qualitative and quantitative approaches. The data were collected from representative sample of 60 pregnant women who had atleast one previous pregnant history.

2.2 Study site and Target Population

The study is carried out in dharkenley district of Mogadishu. Mogadishu is the capital city of Banadir region and consists of seventeen districts. Dharkenley district has four villages namely Dhama-yasiin artan, dhagahtuur, saeed roraye and hanano bulsho. Mogadishu is the most popular city in Somalia, Although no official census has been carried out, the united nations development program projects that the estimated population of Dharkenley district in 2014 is about 75,047.(UNDP, 2014).

The study is carried out three health centers in dharkenley district: (2) Wardi Health centers and (1) badbaado health center. These health centers provide primary health care services including maternal and child health services, these health services are provided by team of nurses, doctors, pharmacists, midwifes, laboratory technicians and community health workers. The study subjects were pregnant women seeking antenatal care who gave atleast one birth.

2.3 Sample Size and Instrument for data collection

All patients attending antenatal care with in the period of survey and who gave consent were recruited until a total of 60 women were recruited using purposive sampling. 10 participants were non respondents as they did not provide full information regarding the utilization level of ANC services, hence total sample size were 60 respondents. Only women with previous antenatal experience were enrolled so as to capture their antenatal experiences. The number of days for data collection was 10days, from 1st to 10th July, 2016.

Questionnaire was used to collect data from respondents. The questionnaire was translated into local Somali language, in order to maintain the quality of data collected, the supervisor trained the researchers and pre-test is performed before the actual data collection.

2.4 Data Processing and Analysis

Data collected was compiled, and then analyzed using the statistical package for social scientists (SPSS) version 17.

2.5 Ethical Consideration and Approval

The research was done in the way that no one can harm or suffer adverse consequences from research activities. Respondents will not be forced to respond. The research will be conducted with respect to ethical values, confidentiality and moral expectation. The Ethical approval was obtained from Ethical Review Committee of Jamahiriya University of Science and Technology (JUST). Informed consent was obtained from all participants, they were informed about their right not to participate or withdraw anytime at the time of data collection.

3.0 Results

The results of the study were presented using frequency tables and figures.

3.1 Respondents by the outcome of last delivery

Outcome of last delivery	Frequency	Percent %
live birth	38	63.3
still birth	11	18.3
Abortion	11	18.3
Total	**60**	**100.0**

Table 3.1: Respondents by the outcome of the last delivery in three health centers in dharkenley district

From the Table 3.1 Majority of respondent 63% had delivered live birth while only 18% equally had both abortion and still birth during their last pregnancy.

3.2 Respondents by the mode of last delivery

The mode of your last delivery	Frequency	Percent %
spontaneously vaginal delivery	27	45.0
Assisted vaginal delivery	21	35.0
c\section	12	20.0
Total	**60**	**100.0**

Table 3.2: Respondent by the mode of last delivery in three health centers in dharkenley district

From the Table 3.2: Nearly 45% respondents had spontaneously vaginal delivery, while 35% of the respondents were assisted vaginal delivery and only 20% undergone c/section during last pregnancy.

3.3 Respondents by the Number of ANC visits during last pregnancy

ANC Visits during last pregnancy	Frequency	Percent %
less than four	22	36.7
four visits	26	43.3
no visits	12	20.0
Total	**60**	**100.0**

Table 3.3: Respondents by the number of ANC visits during last pregnancy in three health center in dharkenley district

From the Table 3.3 the majority of the respondents (43%) had four ANC visits, while 37% had less than four ANC visits and only 20% had no ANC visits.

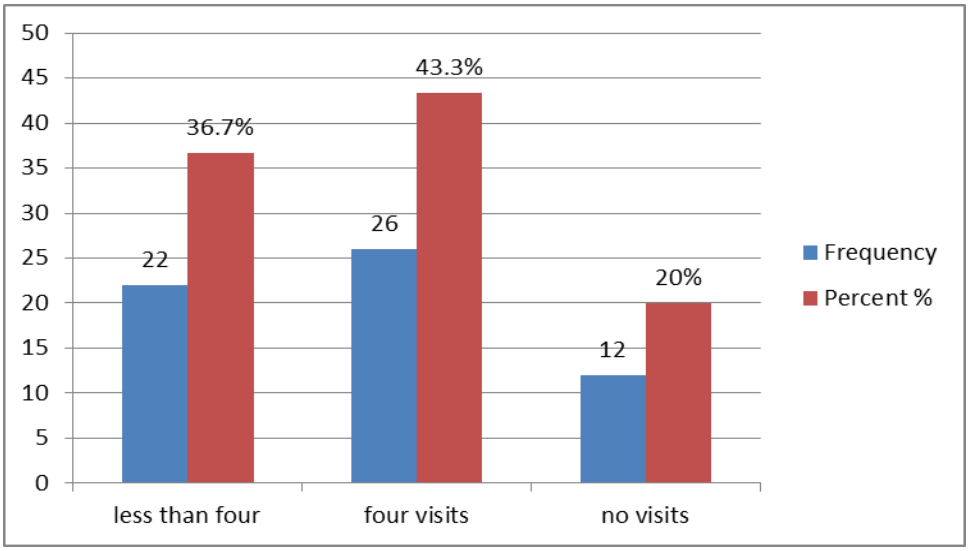

Figure 3.3 Respondents by the number of ANC visits during last pregnancy in three health center in dharkenley district

3.4 Respondents by the Reasons of not attending the required number of ANC visits

The reasons of not attending required number of ANC visits	Frequency	Percent%
I don't know I had to attend several times	30	50.0
No time to attend	20	33.3
health facility is too far	10	16.7
Total	**60**	**100.0**

Table 3.4: Respondents by not attending number of ANC visits in three health centers in dharkenley district

From Table 3.4: Majority of respondents (50%) said I don't know I had to attend many times, while 33% said no time to attend and 17% said health facility is too far

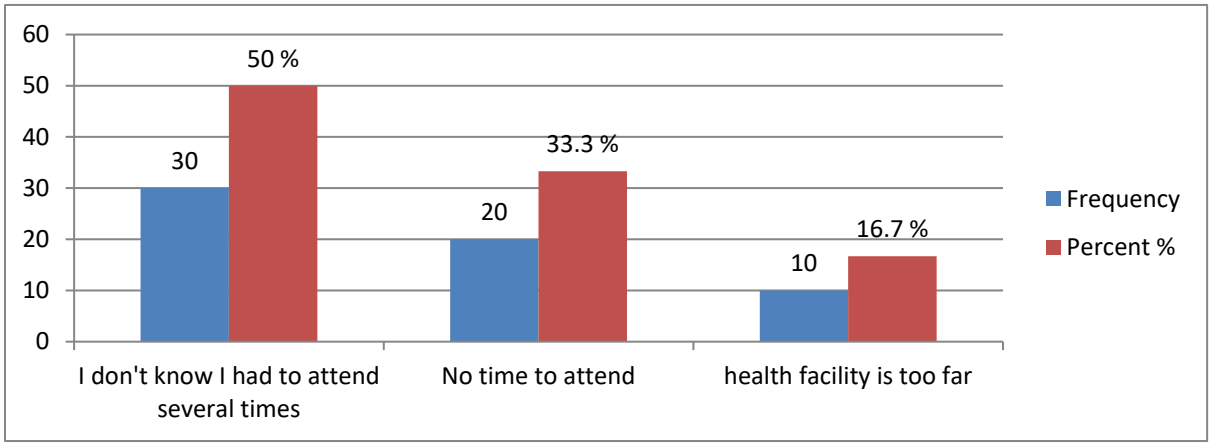

Figure 3.4 Respondents by not attending number of ANC visits in three health centers in dharkenley district

4.0 Discussion

Educated women will be more knowledgeable on the importance of maternal health services (Mengesha *et al*, 2013). Similar study indicated Women whose husbands completed at least secondary school were more likely to use ANC than women of husbands with no education this result is also similar to those reported by Pallikadavath (2004) and Nielsen (2000).

Majority of respondents (90%) believed ANC utilization can benefit both the mother and infant and will decrease pregnancy related complications (76%). The Majority of the respondents who had used antenatal care have experienced less pregnant related complications.

Majority of the respondents 45% had one birth, 28% had 2-3 births and only 21% had 4-5 births. Primi Para women may be afraid of pregnancy complications and outcomes since they have had no prior delivery experience A study in Bangladesh has shown a similar result which found that a woman is more likely to seek maternal health care services for first order than higher-order births because of perceived risk associated with first pregnancy. (Chakraborty *et al*, 2003).

47% of the pregnant women all had positive attitude towards the health care providers and said they were conducted in good manner. Other studies described such findings to the fact that the previous personal experiences with ANC facility staff, or experiences narrated by women's friends or family members, may affect the care-seeking behavior (Glei *et al*, 2003 & Kyei *et al*, 2012).

When asked the exposure of the mass media had influence on the ANC utilization, most of the women answered NO 42% and 30% said YES. A study in Nigeria has shown that community media saturation was found to be a strong predictor of maternal health service utilization (Babalola & fatusi, 2009). However 70% of the respondents believed ANC health education to pregnant women can increase awareness to ANC Utilization.

5.0 Conclusion

45% of the respondents were between the age of 15-25 years and 40%, were between age 26-34 years and only 15% above the age of (>35) years. The majority of the respondents by location were dhagaxtuur 40 respondents 66% and xanaano bulsho 20 respondents 33%. Mother's level of education the majority of respondents 30% had no education or completed primary school and 22% had under on higher education and only 18% had secondary education. Hence: - the level of education is 42% and level of none educated 18%. Place of the last delivery

53% of the respondents delivered their previous pregnancy at health facility (public, private) and only 47% delivered at home. How many ANC Visits during last pregnancy 43% ANC visits during last pregnancy at four visits were 37% less than four visits and 20% had no visits. Decision on the health of the women in your household 52% of the respondents had husband and women making the decision on health of women, while 30% women only, while 10 husband only and 8% others.

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THE FACTORS INFLUENCING OBSTETRIC FISTULA ON WOMEN OF CHILDBEARING AGE IN DAYNILE HOSPITAL MOGADISHU-SOMALIA

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Abstract

The Aim of the study explores factors influencing obstetric fistula on women of childbearing age at daynile hospital. The specific objectives are; to determine factors influencing obstetric fistula on women of childbearing age at daynile hospital, to determine the complications of obstetric fistula on women of childbearing age at daynile hospital, in addition to identify barriers preventing women from accessing fistula repair at daynile hospital. This study adopted desk review for medical records of 40 patients who underwent obstetric fistula repair campaign on December 2015 at Daynile hospital. Majority of the women were young under 20 years of age, with no education (53%). The major cause of Obstetric fistula for these patients was prolonged labor at the time of delivery had labored for at least (10-24) hours, 35% of these women assisted by traditional birth attendant during labor at home, in addition 68% of the patients had FGM type of circumcision. The majority of the patients were vesico-vaginal type of fistula with previous unsuccessful repair. 83% of the patients had urine incontinent, 13% stool incontinent for almost one yea. The reason of delaying their access to fistula repair was economic reason and lack of access to good obstetric care during pregnancy and labor. The study concludes that community health workers should provide awareness to pregnant women not to deliver at home and to improve the availability of good obstetric care at the district health centers in addition to provide training for local junior doctors to perform fistula repair

Keywords: Obstetric fistula on child bearing age, Somalia, cause, complication, barrier to fistula repair,

1.0 Background

UNFPA (2012) estimated that 2 to 3.5 million women are currently living with fistula worldwide, with at least 50,000 to 100,000 new cases occurring every year. The exact prevalence rates in Somalia are not known, but the estimated obstetric fistula incidence for Somalia extrapolated from figures for East Africa is 1-5/1,000 deliveries (UNFPA, 2005)

Obstructed labor is the result of a girl's pelvis being too small to deliver a fetus. The fetus's head passes into the vagina, but its shoulders cannot fit through the mother's pelvic bones. Without a cesarean section, the neonate dies, & the mother is fortunate if she survives. If sepsis or hemorrhage does not occur & the girl does survive, the tissue & bones of the neonate will eventually soften & the remains will pass through the vagina. Many times, obstructed labor leads to fistulas; the pressure of the fetal head on the vaginal wall causes tissue necrosis, & fistulas develop between the vagina & the bladder or rectum after the necrotic tissue sloughs. More than 2 million adolescents are living with fistulas, & fistulas develop in ≈100,000 more each year. (Nawal *et al*, 2006)

Access to a health institution is a major problem for fistula patients, chiefly because of the long distances to reach care, poor transportation networks & lack of money because parturition is regarded as something that can be managed at home A report from Ghana identified obstructed labor as a cause of fistula in 91.5% of cases & difficult of gynecological surgery in the remaining 8.5% of cases. Approximately 53% of these women were under 25 years of age, & 43% developed a fistula during their first delivery (Muleta, 2013).

Other causes of Obstetric fistula is early marriage, in some parts of sub-saharan Africa, many women become pregnant soon after menarche occurs, before a women's pelvic fully developed in childbearing (INFO, 2004). The reasons for not seeking skilled care at the time of pregnancy vary according to context such as educational level, socio-economic status, culture as well as accessibility to functioning health care facilities (Justus *et al*, 2014). In addition to that fistula was common for women who delivered at home assisted by traditional birth attendants because some of the family members did not allow them to go to health facility to delivery (Landr, 2013).

Women who develop obstetric fistula secondary to prolonged obstructed labor are affected by multiple devastating medical & psychosocial problems. Along with urinary and/or feces incontinence, they are also at risk for other disorders like urologic diseases such as renal failure, gynecologic disorder such as vaginal stenos & infertility, as well as neurologic disorders. These women are subject to depression due to constant dribble of urine down their legs, they are physically isolated from rest of family, sometimes divorced and forced to leave their villages and become beggars these led some women to commit suicide (Semere *et al*, 2008).

The physical effects of the bad smell were even worse for those who leaked feces in addition to urine. They felt the situation of bad smell would drive away any body they encountered. They often took a much time cleaning themselves to reduce on the smell. One woman who leaked faces narrated her ordeal in delaying her husband every morning, as she would be in the toilet cleaning herself *(*Barageine *et al*, 2015*).*

Living with fistula interfered with women's daily lives, including the ability to attend community gatherings (85.3%), have sexual relations (85.2%), attend religious gatherings (83.6%), earn money (80.0%), work (72.1%), & eat with others (68.7%). Women who had lived with fistula for over a year were more likely to say that their condition interfered with their ability to work & earn money (Landry *et al*, 2013)**.**

Transportation & its costs were repeatedly cited as a barrier to care. A majority of women living with fistula are from remote, rural areas, & most fistula services are in urban centers. Women report that transportation is costly or sometimes non-existent, Even when transportation is available or affordable, women may experience too much pain or discomfort to travel, or may be turned away from public transportation due to their condition (Bellows *et.al* 2014).

The specific objectives which guided this research were:

1. To determine the factors influencing Obstetric Fistula on women of childbearing age at Daynile hospital.
2. To determine the complications of Obstetric fistula on women of childbearing age at Daynile hospital.
3. To identify the barriers preventing women from accessing fistula repair on women of childbearing age at Daynile hospital

2.0 Methodology

2.1 Research design and Study Site

This study adopted both qualitative & quantitative cross sectional approach using desk review of secondary data from medical records for fistula repair conducted on December 2015 at daynile hospital. The study is carried at Daynile Hospital in daynile district of Mogadishu-Somalia. Daynile general hospital is referral hospital with CEMOC facility with 160 beds which conducts campaigns for fistula repair.

2.2 Sampling and data collection procedure

This was secondary data from medical records for fistula repair conducted on December 2015 at daynile hospital. The study data were reviewed during the period of May to July 2016.

The medical record library of daynile hospital were not kept the surgery forms who were filled before or during the patient undergone the surgery. We acknowledge the number of obstetric fistula patients undergone the surgery during this campaign period were 116 patients, but we received during our desk review only 40 surgery files.

Our study shows that the number of the cases we were expected were not 100% due to none availability of the surgery files at daynile hospital. For instance we tried to communicate few of the cases who undergone fistula repair residing Mogadishu & its surrounding. Those accepted our call, were invited at our university for interview after accepting the informed consent.

2.3 Data Collection Instrument

A questionnaire was used to collect data from the surgery files of the patient undergone fistula repair. Few of the patients who were invited at the university were interview.

2.4 Data analysis

The research collected was compiled & analyzed using Statistical Package for Social Science (SPSS). The data was presented in frequency tables & figures.

2.5 Ethical consideration

The research done in the way that no one can harm or suffer adverse consequences from research activities. A permission to access the surgery files were sought from the daynile hospital administrators & the medical record keeper. The research was conducted with respect to ethical values, confidentiality, & moral expectation. The Ethical approval was obtained from Ethical Review Committee of Jamhuriya University of Science & Technology (JUST). Informed consent was sought from the respondents who were invited for interview at the university.

2.6 Study Limitations

Security issues & poor transportation to Daynile hospital which is far from the city were challenges sometime, so we to hired a rent car to reach our destination. The data were extracted from medical records department of daynile hospital with variations in the level of completeness of documentation of the demographic and medical parameter described, however some of the surgery files were missing due to poor medical record keeping and insufficient human resource to keep all the records safe.

3.0 Results

3.1 Respondent based on time spend in labor during the occurrence of fistula

Time spent in labor	Frequency	Percent %
10 - 24 Hours	22	55
1 - 2 Days	10	25
> 2 Days	8	20

Table 3.1: Respondents based on time spent on labor during the occurrence of fistula in daynile hospital, fistula repair campaign held on December 2015.

From Table 3.1: Nearly 55% of the respondents had prolonged labor at the onset of fistula spending 10-24 hours on labor, followed by 25% of respondents had labor on 1-2 days while only 20% of the respondents had labor of more than 2 days.

3.2 Respondent based type of leakage

Type of incontinent	Frequency	Percent %
Urine	33	82.5
Stool	5	12.5
Both	2	5

Table 3.2: Respondents based on type of Incontinent in Daynile Hospital, fistula repair campaign held on December 2015

From Table 3.2: 83% of respondent were urine incontinent flowed by 13% were stool incontinent, while 5% were both urine and stool incontinent.

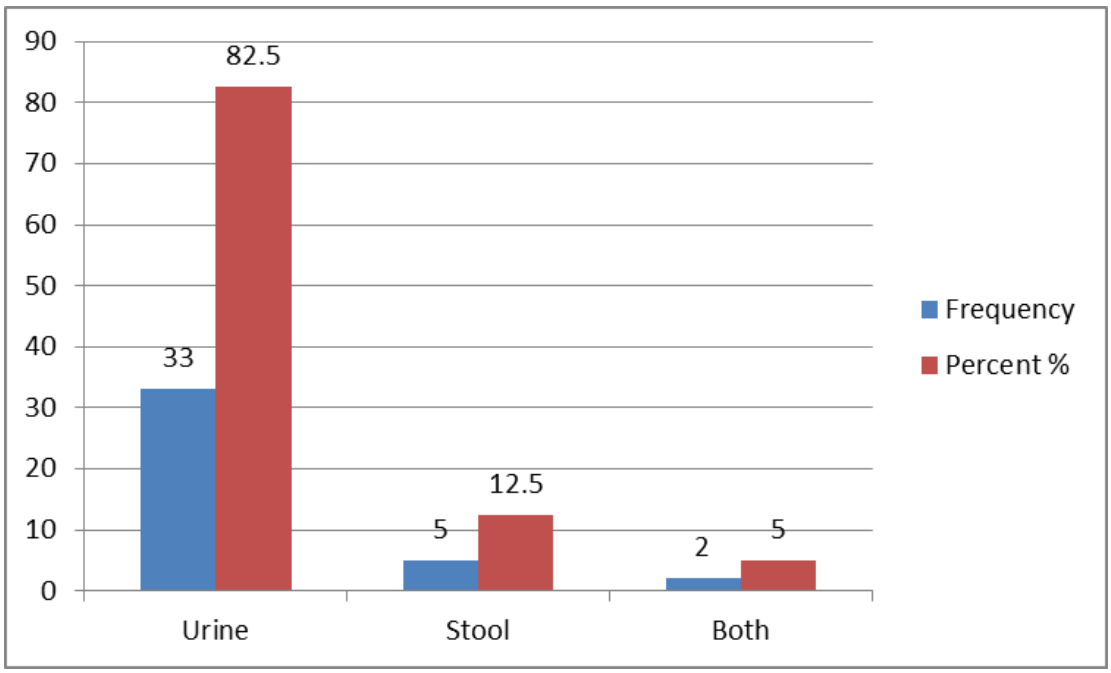

Figure 3.2: **Respondents based on type of Incontinent in Daynile Hospital, fistula repair campaign held on December 2015**

3.3 Respondent based on how long have been incontinent

Duration of incontinent	**Frequency**	**Percent %**
less than 1 Months	1	2.5
1 - 12 Months	14	35
1 - 2 Years	8	20
2 - 5 Years	9	22.5
> 5 Years	8	20

Table 3.3 Respondent based on how long have been incontinent, daynile hospital, fistula repair campaign held on December 2015

From Table 3.3*:* Nearly 35 % of the respondents had incontinent for almost one year, and 23% had incontinent of 2-5 years.

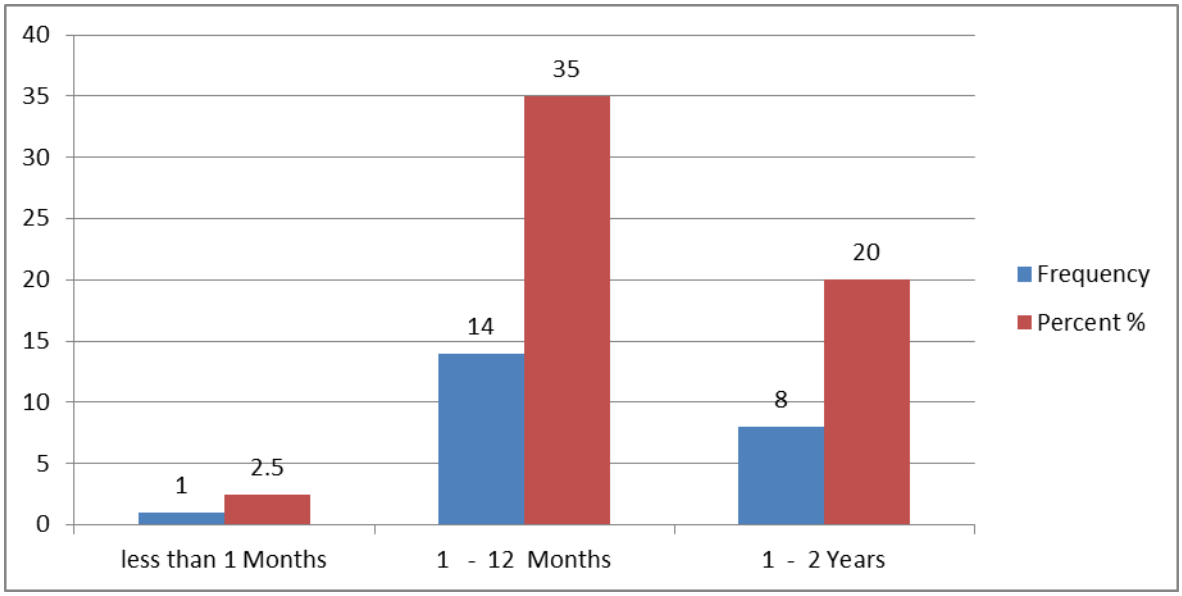

Figure 3.3 Respondent based on how long have you been incontinent, daynile hospital, fistula repair campaign held on December 2015

3.4 Respondent based on economic problem contributing incidence of obstetric fistula

Economic problem	Frequency	Percent %
lack of c/s money	20	50
Lack Transportation money	14	35
Other	6	15

Table 3.4 Respondent based on economic problem contributing incidence of obstetric fistula, Daynile Hospital, Fistula campaign held on December 2015

From Table 3.4: The Contributing factors to the incidence of Obstetric fistula were 50% lack of C/section money and 35 % lack of transportation money as the majority of the patients were from other regions of Somalia.

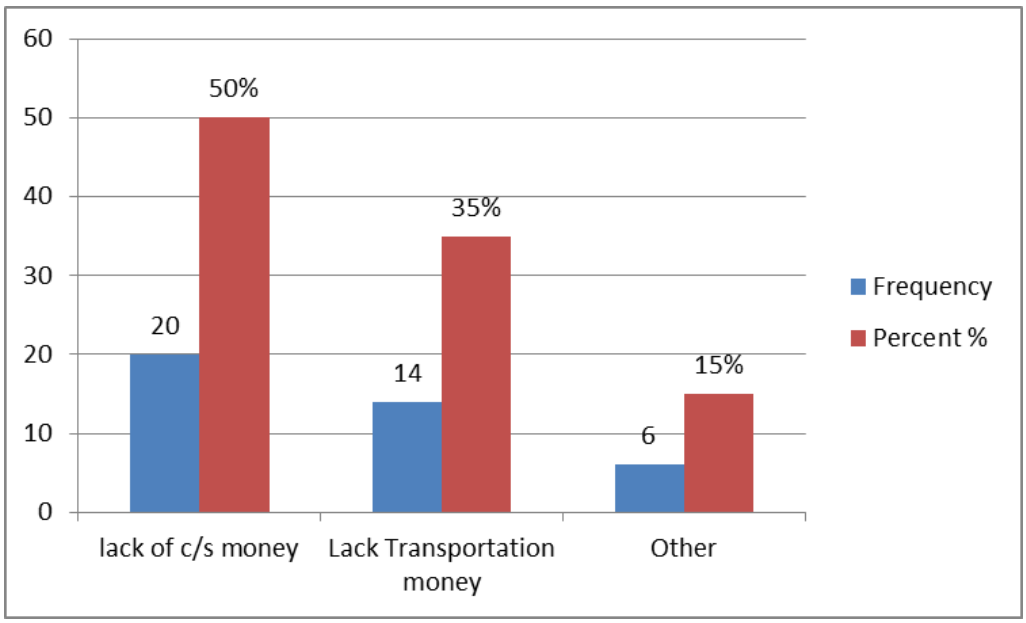

Figure 3.4 Respondent based on economic problem contributing incidence of obstetric fistula, Daynile Hospital, Fistula campaign held on December 2015

3.5 Respondent based on economical barrier to repair obstetric fistula

Economic barrier	Frequency	Percent %
Yes	22	55
No	18	45

Table 3.5 Respondents based on economical barrier to repair obstetric fistula, daynile hospital, fistula repair campaign, held on December 2015.

From Table 3.5: Nearly 55% of respondents have economical barrier, while 45% of respondents have no economical barrier to obstetric fistula.

4.0 Discussion

4.1 The factors influencing incidence of obstetric fistula

55% of the respondents were between 10-24 hours, followed 25% between 1-2 days of labor while only 20% of the respondents were above 2 days. were the major reasons that caused the obstetric fistula due to The soft tissues of the birth canal are compressed between the descending head of the fetus and the woman's pelvic bone. The lack of blood flow causes tissue to die, creating a whole (fistula) between the woman's vagina and bladder (vesico-vaginal fistula or VVF) or between the vagina and rectum (recto-vaginal fistula or RVF) or both. This

leaves the woman leaking urine and/or faces continuously from the vagina. . (Human Rights Watch. 2010*)*

35% of respondents delivered by TBA, flowed by 28% were doctor, while 13 % were nurses, midwifes and other of relatives 68% of respondents were delivered at home of TBA, flowed 25% of respondents were heath center, while only 8% delivered on the way. TBA practices, knowledge and beliefs showed high rates of dangerous vaginal cutting which can lead to fistula and lack of knowledge of when obstructed or dangerous labors should be referred to nearby health clinics, as well as low rates of referral in practice (Keri,2010)

4.2 Complications of obstetric fistula on women of childbearing age

83% of respondent were urine incontinent flowed by 13% were stool incontinent, while 5% were both urine and stool incontinent. As we mentioned before the physical effects of the bad smell were even worse for those who leaked feces in addition to urine. They felt the situation of bad smell would drive away any body they encountered. They often took a much time cleaning themselves to reduce on the smell. One woman who Leaked faces narrated her ordeal in delaying her husband every morning, as she would be in the toilet cleaning herself *(*Barageine *etal,*2015*).*

63% of respondent were stigmatized from society flowed by 27% were family stigma, while 10% have both society and family stigma. Obstetric fistula leads to sever socio cultural stigmatization for various reasons. For example, in Burkina Faso, most citizens do not believe obstetric fistula to be a medical condition but as divine punishment or a curse for disloyal or disrespectful behaviour (UNFPA, 2008).

4.3 Barriers preventing from accessing fistula repair

55% of respondents have economical delay, while 45% of respondents have no economical delay as we mentioned before About 80% to 90% of women with VVF can potentially be cured by simple vaginal surgery. However, transportation to surgical centers is physically tricky (what method of transportation would allow an incontinent woman in a vehicle?) and financially challenging. The cost of surgery for a poor woman or girl who has been abandoned by her village is nearly unattainable (Semere *etal,*2008).

5.0 Conclusion

Most of the women presented for fistula repair come from rural areas. Fistula was highly associated with low level of education and I increased duration of labor. The major issue of not

repairing fistula was economic barrier in addition with to lack of access to good obstetric care during pregnancy and labor as well as unavailability trained surgeons for obstetric fistula

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THE KNOWLEDGE OF THE RISK FACTORS OF CAESAREAN SECTION ON PREGNANT WOMAN IN BANADIR HOSPITAL

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Abstract

Cesarean section is one of the most increasing concerns here in Somalia during pregnancy especially at the late stage of the pregnancy, in Banadir hospital it has been recorded that 50% of the pregnant women came to the hospital with a complication which the mother and fetus are at an increased risk of death or organ damage.
The Specific objectives which guided the study were: To identify the risk factors of caesarean deliveries in Banadir hospital, to determine the complications of caesarean deliveries among pregnant women in Banadir hospital and to develop awareness in decreasing caesarean delivery for pregnant mothers in Banadir hospital. A cross sectional design was used, all the pregnant women who came in Banadir hospital during the period of study from 2nd July to 10th July, data were collected from women who were risk group of caesarean section using self-administered Questionnaire. The total sample were 60 using convenient method of sampling. Results presented the respondents by the cephalopelvic disproportion as indicated that the 88% of participants said cephalopelvic disproportion can increase the risk of caesarean section while 12% of the participants said cephalopelvic disproportion cannot increase the risk of caesarean section, this means the majority of the respondents were emphasis cephalopelvic disproportion can increase the risk factors of caesarean section on pregnant women.

Keywords: *risk factors, placenta praevia, Cephalo pelvic disproportion, caesarean section,*

1.0 Background

Caesarean section may sometimes be the only means to save the life of the mother and foetus. (Althabe, 2006) Current estimates in Cameroon put the national caesarean section rate at about 2%, with the lowest rate of 0.4% being reported in the Far North Region. This is lower than the national rate of 5–15% of the estimated live births, currently recommended by the United Nations stillbirth rate of 7% to 12% was reported at the University Hospital, Cameroon. (Paxton, 2006) .

A recent study reported poor foetal outcome of fetus delivered through caesarean section in Far North Cameroon Region and revealed that one of three caesarean deliveries ended up in foetal death (Tebeu, 2008). A study in Nigeria revealed a high mortality of 34% in women who refused elective caesarean delivery compared to 5% for those who accepted the procedure

Refusal of caesarean delivery might be due to the lack of detailed information about the procedure. In order to perform caesarean section at right time for safety of the mother and her infant, counselling on caesarean delivery. The ultimate decision is based on the woman's obstetric history and the anticipated mode of delivery (Chigbu, 2007).

Placenta praevia occurs when the placenta lies low in the uterus and partially or completely covers the cervix. One in every 200 pregnant women was experience placenta praevia during the third trimester. Treatment involves bed rest and frequent monitoring. If a complete or partial placenta praevia has been diagnosed, a caesarean is usually necessary. If a marginal placenta prevue has been diagnosed, a vaginal delivery may be an option. Placental abruption separation of the placenta from the uterine lining that usually occurs in the third trimester. Approximately 1% of pregnant women was experience placental abruption. The mother was experience bleeding from the site of the separation and pain in the uterus. This separation can interfere with oxygen getting to the baby, and depending on the severity, an emergency caesarean may be performed

(illoabachia, 2007).

A caesarean delivery is a birth that occurs through an incision the abdominal wall and uterus rather than though the vagina. There has been in gradual increase in caesarean births over the past 30 years. In November 2005 the center for disease control and prevention (CDC) reported the national caesarean birth rate was the heights ever at 29.1%. this means more than 1 in 4 women are likely to experience a caesarean delivery . There are many reasons the health care provider might recommended a caesarean delivery. Same caesareans occur in critical situations, and some are elective. (American pregnency association, 2015)

Women who have a uterine caesarean scar have slightly higher long-term risks. These risks, which increase with each additional caesarean delivery, include Breaking open of the incision scar during a later pregnancy or labour (uterine rupture). For more information, see the topic Vaginal Birth after Caesarean (VBAC).Placenta praevia, the g growth of the placenta low in the uterus, blocking the cervix. Accretes, placenta, placenta percreta least to most severe (wise, 2014).

The risk for endometrities is significantly higher in Caesarean than vaginal delivery, and higher in Emergency Operations than in elective ones. Endometrities has decreased dramatically after introduction of prophylactic antibiotics as a common policy, but is still ten Times higher in Caesarean section than in women delivering vaginally. The total incidence of endometrities

related to Caesarean Section in US study was 6.9% CS (2.7% and 9.4%in elective and emergencyCaesareanSection respectively), 15 times higher than for Vaginal Delivery. Cephalopelvic disproportion (CPD**)** occurs when a baby's head or body is too large to fit through the mother's pelvis. It is believed that true CPD is rare, but many cases of "failure to progress" during labour are given a diagnosis of CPD. When an accurate diagnosis of CPD has been made, the safest type of delivery for mother and baby is a caesarean. (burrow, 2004).

Malpresentation Ideally, babies descend through the birth canal headfirst. Sometimes, however, they present in other positions. Positions other than head down are called malpresentation**.** The most common of these abnormal positions occurs when the baby's bottom or feet are toward the mother's birth canal. (Douglas 2012).

2.0 Methodology

2.1 Research Design

A cross sectional design was used in this study, data was collected once. A quantitative approach was used in order to find numerical based data about the risk factors of caesarean delivery on pregnant women in Banadir hospital.

2.2 Target population

The target population included all pregnant women who sought delivery care at Banadir hospital during the period of study from 2nd to 10th July, 2016; the study population were women who were risk group of caesarean section delivery in Banadir hospital (Cephalo pelvic disproportion, failure progressive labour, and cord prolepsis and placenta praevia).

2.3 Sample size and procedure

The sample size estimation was convenience sampling, and the sample size was 60 participants. During our stay the total number of pregnant women came in the Banadir hospital were 80 but 5 of them were sick and15 of them refused to answer our questionnaires. Hence the final sample size was 60 participants.

2.4 Data collection & Tools

Survey Questionnaires was employed by collecting the data and measurement scale of the questionnaires was be Liker scale rating of five point scale (SA=strongly agree, AG =agree, N=neutral, DA= disagree, SD= strongly disagree) and three point measurement scale (yes, no, and not sure). Here the interpretation of the measurement scale are strongly agree and agree

are grouped in to positively agree their percentage was shown as one respectively the other negatively agree and their percent was calculated as one.

2.5 Data analysis

Quantitative data analysis was used in this study. Analysis was carried out with the aid of the Graphs, Tables frequency and percentage and the data management packages that were employed include the following SPSS and EXCEL with which the researchers use after the collection of the data.

3.0 Results

3.1 Respondents by Can Placenta praevia increase C/Section

placenta praevia		
Variable	**Frequency**	**Percent (%)**
Agree	21	35
strongly agree	26	43
natural agree	6	10
Disagree	2	3
strongly disagree	5	8
Total	60	100

Table 3.1: Respondents by Can Placenta Praevia increase C/section

From Table 3.1: Nearly 43% of the respondents strongly agree placenta praevia can increase incidence of c/section delivery while 8% strongly disagree and 3% disagree that placenta praevia can increase incidence of C/section delivery.

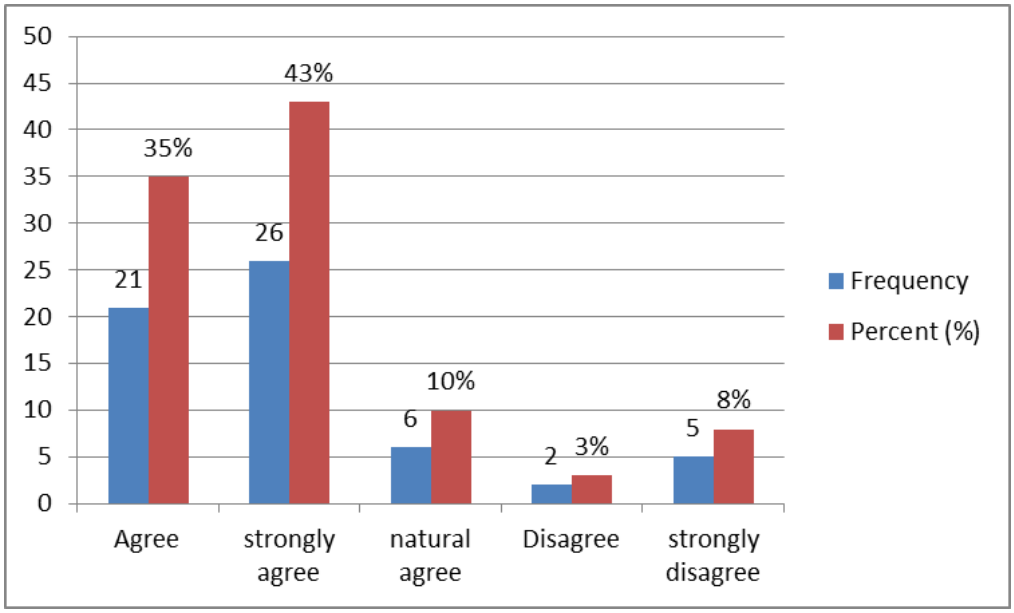

Figure 3.1: Respondents by Can Placenta Praevia increase C/section, Banadir hospital

3.2: Respondents can cord prolapse increase incidence of C/section delivery

cord prolepsis		
Variable	**Frequency**	**Percent (%)**
Agree	20	33
strongly agree	20	33
natural agree	10	17
Disagree	9	15
strongly disagree	1	2
Total	**60**	**100**

Table 3.2: Respondents can cord prolapse increase incidence of C/section delivery

From table 3.2: Majority of respondents (33%) agree or strongly agree cord prolapse can increase incidence of C/section delivery while 15% disagree and 17% were neutral agree cord prolapse can increase incidence of C/section delivery.

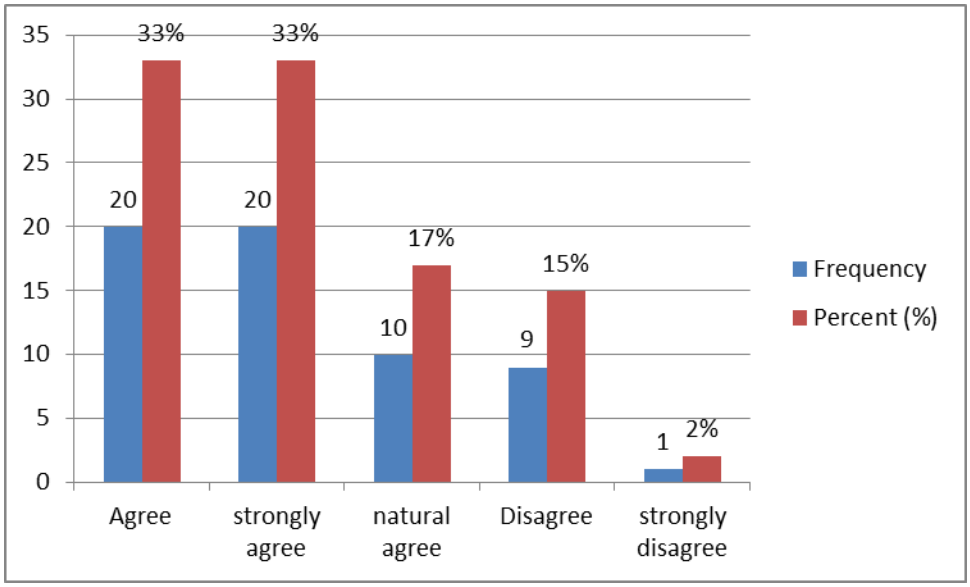

Figure 3.2: Respondents can cord prolapse increase incidence of C/section delivery

3.3 Respondents by Do you believe increasing the frequency of maternal visit to antenatal care decreases C/Section delivery

The frequency of maternal visit to antenatal care		
Variable	**Frequency**	**Percent (%)**
Yes	44	73
No	12	20
Not sure	4	7
Total	60	100

Table 3.3: Respondents by do you believe increasing frequency of maternal visits to antenatal care decreases C/Section deliveries, in Banadir hospital

From table 3.3: Majority of the respondents (73%) believed increasing frequency of maternal visits to antenatal care decreases C/section delivery while only 20% did not believe frequency of maternal visits to antenatal care can decrease C/section delivery.

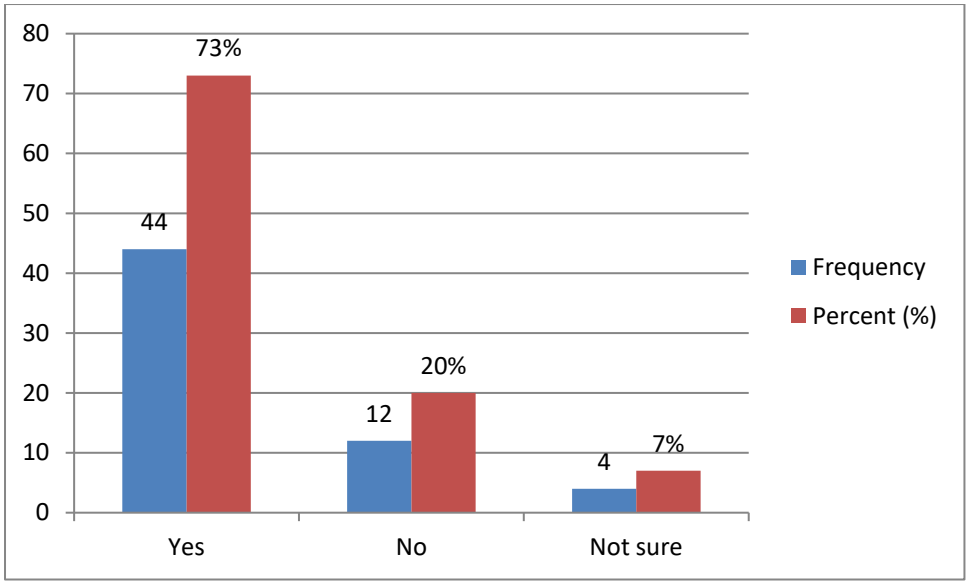

Figure 3.3: Respondents by do you believe increasing frequency of maternal visits to antenatal care decreases C/Section deliveries, in Banadir hospital

5.2 Discussion

The placenta praevia it occurs lies low in the uterus and partially or completely covers the cervix, If a complete or partial placenta praevia has been diagnosed, a caesarean is usually necessary. The placenta praevia as indicated that the 88% of participants have placenta praevia can increase the risk of caesarean section while 11% of the participants they told placenta praevia cannot increase the risk of caesarean section, this means the majority of the respondents were emphasis Placenta praevia can increase the risk factors of caesarean section on pregnant women .the placenta praevia is one of risk factor of caesarean section.

According to (wise, 2014) Women who have a uterine caesarean scar have slightly higher long-term risks. These risks, which increase with each additional caesarean delivery, include Breaking open of the incision scar during a later pregnancy or labour (uterine rupture). For more information, see the topic Vaginal Birth after Caesarean (VBAC). Placenta praevia, the growth of the placenta low in the uterus, blocking the cervix. Placenta accretes, placenta increate, placenta percreta least to most severe.

5.1 Conclusion

The finding of the study was concluded all of the following are Risk factor of caesarean section such as Cephalopelvic disproportion, Failure progressive labour, placenta praevia, cord prolepsis and uterine rupture.

The results we found based on the respondents by the Cephalopelvic disproportion as indicated that the 88% of participants told Cephalopelvic disproportion can increase the risk of caesarean section while 12% of the participants told Cephalopelvic disproportion cannot increase the risk of caesarean section, this means the majority of the respondents were emphasis Cephalopelvic disproportion can increase the risk factors of caesarean section on pregnant women.

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THE EFFECT OF NURSING ROLE IN THERAPEUTIC COMMUNICATION ON ADMITTED IN PATIENT SATISFACTION IN BANADIR HOSPITALOF MOGADISHU

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Abstract

The purpose of this study was to determine *the effect of nursing role in therapeutic communication on admitted in patient satisfaction Banadir Hospital****. This was guided by three research objectives meant to;*** *determining the level of patient satisfaction, and identifying the best strategies for patient satisfaction and factors which negatively effects on patient outcomes..****The theoretical and empirical literature was reviewed to ascertain and identify the research gaps which this sought to fill. The study was mainly underpinned by a mixed*** *To assess the cause of acute watery diarrhea under five children among care giver in Benadir hospital.*

*To decrease the complications related in acute watery diarrhea under five children among care giver in Benadir hospital. To develop recommendation in decreasing of acute watery diarrhea under five children among care giver in Benadir hospital****theoretical framework of*** *the appreciation therapeutic communication on patient. The study adopted the descriptive research design based on an integrated approach of the quantitative and qualitative methodologies. The sample population of study was 51 specifically included Doctors, \nurses, and patients. Data was collected by use of the questionnaire. It was analysed using the descriptive based on the SPSS programme and the interpretive method. The statistical methods were used for quantitative data while the interpretive technique was used for the qualitative data.*

Keywords group: *nursing role in therapeutic communication, and patient satisfaction in Banadir hospital muqdisho.*

1.0 Background

The concept of "therapeutic communication" refers to the process in which the nurse consciously influences a client or helps the client to a better understanding through verbal or nonverbal communication.

According to the study, under this section, the researchers found that there are some key indicators which influence patient satisfaction, enormously; Active listening, Silence reduces patient anger treats, Sharing empathy, Providing information, There is a relationship between therapeutic communication and patient satisfaction, Do you agree that therapeutic communication results in patient satisfaction, Patient self management, Adhered treatment, and Quick recovery. With regard of it, majority of the respondents from the area of study have agreed that the above mentioned list is key factors for patient satisfaction.

Phillip, (2012) stressed that Therapeutic Communication requires much Skills including; foremost, building relationships: listening, attending, responding, warmth, respect, empathy, genuiness. Secondly,self-awareness: self-disclosure, gender perception, personal and professional boundaries, confrontation, assertiveness, conflict, psychological and social factors. And lastly, understanding others: culture, defence mechanisms, end of life, electronic communication.

According to the responsiveness of the respondents, internal factors which influence the level of patient satisfaction. The results showed the confidence to the fact that the level of patient satisfaction.

2.0 Methodology

2.1 Study design

The study adapted descriptive design using quantitative approaches.

2.2 Data collection Instrument

During this study, the data was collected from 51 respondents from two different medical centers in wadajir district in Mogadishu - Somalia 2016.

The data was collected by hand and the researchers are responsible for data collection. Then, the researchers were tried to cooperate with the respondents to fill the questionnaires and also the researcher was translated the questionnaire to help the respondents understand the aim of the questionnaire and ease the completion of their task appropriately.

After the administration of the questionnaire the data collected was organized, summarized, statistically treated and drafted in Statistical Package for Social Sciences (SPSS 16.0).

2.3 Data Processing and Analysis

Data was analyzed by using statistical package of social science (SPSS.Version 16. 0) that was measured the relationship between therapeutic communication and interpersonal skills among patients aged 15-49 in warta nabadda district and the levels of therapeutic communication among patients aged

2.4 Ethical Consideration and Approval

The research was valid after when the researchers receive the permission letter from Jamhuriya University of science and technology and then the researchers were used individual and institutional data. Thus, the data collected was kept confidential and exclusively used for the purpose of Bachelor degree requirements in nursing.

A guarantee was given to the respondents that their names were not be revealed in the research report.

In addition, the team was request from the academic department, a certificate of confidentiality so as to get confidentiality and the researchers were provide

3.0 Analysis

4.3.1 The best therapeutic communication for patient satisfaction

Active listening	Frequency	Percent(%)
strongly Agree	34	67
Agree	6	12
neutral	6	12
Disagree	5	10
Total	51	100

Table4.3.1

According the table 4.3.1 above, the responds were asked to express their views about “active listening”. And 67% of the respondents denoted strongly agree, 12% of the respondents denoted agreement, while 12% of the respondents remained in neutral, although only 10% responded disagreement However, the presentation shows that almost more than half of the respondents agreed the idea of ‘solving active listening’. Whereas some few percentages (10%) of them disagreed.

4.4.2 Ineffective communication between the health care personnel

	Frequency	Percent(%)
Yes	28	55
No	23	45
Total	51	100

According to table 4.4.2 above, the responds were asked to express their views about "Ineffective communication between the health care personnel". And 55% of the respondents denoted 'Yes', 45% of the respondents denoted 'No'. However, the presentation shows that almost more than half of the respondents agreed the idea of 'Ineffective communication between the health care personnel'.

4.0 DISCUSSION

The findings show that the profile variable s of the respondents covered in the study include their gender, age, marital status, level of education, experience and current position as summarised in Concerning age, all the respondents were between 20-50+ years and thus mature enough to be in a position to contribute information about the effect of therapeutic communication on patient satisfaction. With regard to the technology, the researcher has considered gender balance so as to collect information from both male and female equally, to give consideration for each.

In case of level of education, almost, the respondents were formally educated enough and fairly competently respond to questions about the effect of therapeutic communication on patient satisfaction. Although majority of them had enough experience and were also currently in the field of business, that made them to give much information about the area of study.

Determination about the level of patient satisfaction

According to the responsiveness of the respondents, internal factors which influence the level of patient satisfaction. The results showed the confidence to the fact that the level of patient satisfaction.

Finally, researchers found out that the level of patient satisfaction has has been determined and influenced by many factors include educational level, health education, and family education. The implication of this finding is that health workers should meet the requirements of the patient satisfaction such as suitability of the place, better treatments, and active caring and so on.

Generally, the findings imply that there is some consistency in therapeutic communication and patient satisfaction but not reliably effective among some others that participated in this study. So, while this study was carried out in Mogadishu health agencies, it is not the case in equally many other hospitals.

In addition, there is evidence that some nurses stereotype patient groups Timmins,(2007). There are criticisms of teaching CIPS in nursing education that point to a lack of systematic evaluation of teaching and a difficulty in resolving the difference between the school way and the ward way Chant et al., (2002). There is a need to consider learning these skills in the clinical environment with greater involvement of clinical staff.

5.0 Conclusion

The study investigated the effect of nursing role in therapeutic communication on patient satisfaction from Al-Birri hospital in Mogadishu-Somalia. This section elaborated on the

conclusion of the research. Suitable communication, health talk, and supportive words today are highly recommended, while there are many factors which result in patient satisfaction including active listening, sharing empathy, adhered treatment, communicating with understandable language, encouraging patients that s/he will be recover as soon as possible, silence when patients treats with unhealthy words and acts badly, and so on. The findings suggested that therapeutic communication aids in continually satisfying with patients and lead to recovery. For this reason, the results suggest that such factors act as a driver of patient satisfaction, which at the end of day make them to win controlling them. Thus, when patients are satisfied with the communications offered by the doctors and nurses, they are likely to be releasing the ager, pain, and seemly being satisfied.

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THE COLLABORATION OF TRAINED TRADITIONAL BIRTH ATTENDANTS AND THE HEALTH CENTER IN HAMAR WEYNE DISTIRCT OF MOGADISHO

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Abstract
The study is aimed to determine the integration of trained traditional birth attendants and the health center in Hamar Weyne district of Mogadishu, Somalia. According to the WHO, a traditional birth attendant (TBA) is "a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or by working with other TBAs". The study adopted a cross-sectional descriptive design using quantitative and qualitative approaches, the sample size includes 11 trained TBA linked to the health center, 3 qualified midwifes and 2 community midwifes working in Hamar Weyne health center. Key informant interview were performed to the head of the Hamar Weyne health center to gather further information. Data were collected using questionnaire after approval of informed consent. The data is compiled and then analysed by using SPSS version 17. Results found were: all trained traditional birth attendants were above the age of 35 years, none educated. The services offered by trained TBA included delivery care, the reason of using TTBA services were the TBAs are kind and care too much. TTBA refers pregnant women to the health center commonly when labor is not progressing. The study concludes that majority of the respondents were not satisfied the services offered by the TTBAs because 75 % of the respondents said complications could arise from TTBA services which include: 56 % prolonged labor, 25 % excessive bleeding and 19 % of infections, However most of the respondents agreed that trained TBA can be useful in linking the community to the health center. Proper collaboration between TTBAs and Health center can be fully implemented when appropriate training, regular supervision and Incentives are provided to TTBAs.

***Key words**:* Trained Traditional birth attendants, Hamar Weyne health center.

1.0 Background

According to the WHO, a traditional birth attendant (TBA) is "a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or by

working with other TBAs". In addition to attending deliveries, TBAs help with initiating breastfeeding; providing health education on sexually transmitted illnesses (STIs), reproductive health and nutrition; visiting mothers during and shortly following delivery to check for and educate them on the associated danger signs; and accompanying referrals to the health facilities for complicated deliveries (WHO, 2010)

The Sub-Saharan countries has the highest maternal mortality rates (510), At country level, Somalia is estimated to have high MMR at 850 per 100,000 live births in 2013 (WHO, UNFP & World Bank, 2014). This is mainly pregnant women are assisted by unskilled birth attendants during labor; hence if TBAs are trained they can be useful in linking the pregnant women and the district health center.

The trained traditional birth attendants have been the main health care providers for women during childbirth in Africa. They attend to the majority of deliveries in the rural areas of developing countries. TBAs are highly respected in African communities. They perform cultural rituals and provide essential social support to women during childbirth. Their clients trust them and share their secrets with them. TBAs are unable to recognize and respond appropriately to complications of pregnancy because they lack knowledge of danger signs and prober training. For this reason, deliveries attended by untrained TBAs are risky for women and their babies, leading to poor health outcomes and even death *(Homsy et al, 2004)*

TBAs are found in most communities of the world although their nature and function may vary based on the cultural differences, they remain, even today, an important asset for a majority of the world's rural as well as urban pregnant women. It is beyond doubt that their impact is significant when it comes to empathy, cultural competence, and psychosocial support at birth *(United Nations, 2000).*

It was also discovered according to the surveys carried out by Fortney (2001), in different sub-saharan African countries that the TBAs' contribution towards delivery care needs appreciation. Most women prefer to give birth at home. A health service provider in Dupti confirmed this when he said, "We serve about 15% of pregnant women during ANC, but only 3% of these will eventually deliver in our hospital." The TBAs were in agreement that during delivery, they would refer a woman to the health facility after abnormal presentation, prolonged labour, obstructed labour and excessive blood loss. Some TBAs refer after four hours of labour. They learned during the training to refer patients early, in order to have adequate time to

arrange for transportation and money. However most of referral cases during delivery were obstructed and prolonged labour

The role of a TBA during delivery was primarily described by TBAs as “receiving the baby” and comforting the mother by “holding her until she delivers”. Other women from the community may be present, but the TBA instructs them on what to do. TBAs traditionally feed laboring women oil or animal fat, then herbs, followed by porridge. Women are offered clean water or milk to drink for sustained energy. Abdominal palpation during delivery is practiced by most TBAs to hasten the birth process. Most trained TBAs allow any birthing position, and women typically express a preference for the squatting position *(Caulfield et al, 2016)*
One of the main reasons for seeking the services of the TBAs was the trust women had in the TBA. They explained that, in contrast with nurses who were perceived as being absent from the clinics, TBAs would rush to the woman’s home to assist as soon as they received the message, regardless of the time of the day or night.

The Specific Objectives which guided the study were:

1. To identify the services offered by trained traditional birth attendants (TTBAs) in Hamar Weyne District, Mogadishu.
2. To determine the factors influencing the collaboration of trained TBA and healthy center in Hamar Weyne district
3. To determine the collaboration of trained traditional birth attendants and healthy center in Hamar Weyne district of Mogadishu Somalia

Lewis (2004) asserts that the collaboration of stakeholders is an important factor in effective service delivery for TBAs. Access and utilization of reproductive health services are affected by the interaction between the formal and traditional health systems. The formal health system, as a result of its limited capability to reach all the communities, opted to train traditional health service providers. Moreover, given that many deliveries occur at home in Afar and the geographical distribution of pastoralist communities, the traditional service providers should be recognized

2.0 Methodology

2.1 Research Design

The study adopted a cross-sectional descriptive design approach in order to investigate the collaboration of trained Traditional Birth Attendants and the health center in Hamar Weyne district using both qualitative and quantitative approach.

2.2 Study Population and Study Site

The study was carried out in Hamar Weyne health at the maternity department. Hamar Weyne district is one of the oldest districts in Mogadishu, Somalia, bordered by Hamar jajab, Shangani, Bondhere, Warta nabadda and Indian Ocean. The reason we chose this site is because Hamar Weyne health center is one of the best health center in all seventeen districts of Mogadishu, secondly we found there were many trained TBAs linked to the Hamar Weyne health center, and in addition the health center administrators were helpful, welcoming and cooperative.

Our study population was the health professionals working at the maternity department of Hamar Weyne health center which included trained TBAs and Midwifes.

2.3 Sample Size and Data collection instruments

All the Eleven (11) trained traditional birth attendants (TTBAs) who were linked to Hamar Weyne health center, Three (3) Skilled Midwifes and Two (2) Community midwifes were all purposively selected after accepting written informed consent, hence the total sample size were 16 participants.

A key informant interview (KII) guide was used to the head of Hamar Weyne health center to elicit in-depth information

A questionnaire and Interview guide were used, the questions were prepared in English but the researchers interpreted in Somali language to make people participate fully in this research.

2.4 Data Processing and Analysis

Data collected were compiled then analyzed using the statistical package for social scientists (SPSS) version 17; data were presented in frequency tables and graphs.

2.5 Ethical Considerations

The research were done in the way that no one can harm or suffer adverse consequences from research activities, The research were conducted with respect to ethical values, confidentiality

3. Results

3.1 Respondents by Type of Attendants

Type of Attendant	Frequency	Percent %
TTBA	11	68.8
Midwife	3	18.8
Community midwife	2	12.5
Total	**16**	**100**

Table 3.1 Respondents by Type of attendants, Hamar Weyne health center

From Table 3.1: Majority of the respondents (69%) were trained TBA, while 19% were midwifes and 13% were community midwifes.

3.2 Respondents by type of services offered by Trained TBAs

Type of TBA Services	Frequency	Percent %
Delivery care	11	68.75
Post natal care	2	12.5
Referral to health center	3	18.75
Total	**16**	**100**

Table 3.2: Type of Services offered by Trained TBAs in Hamar Weyne health center

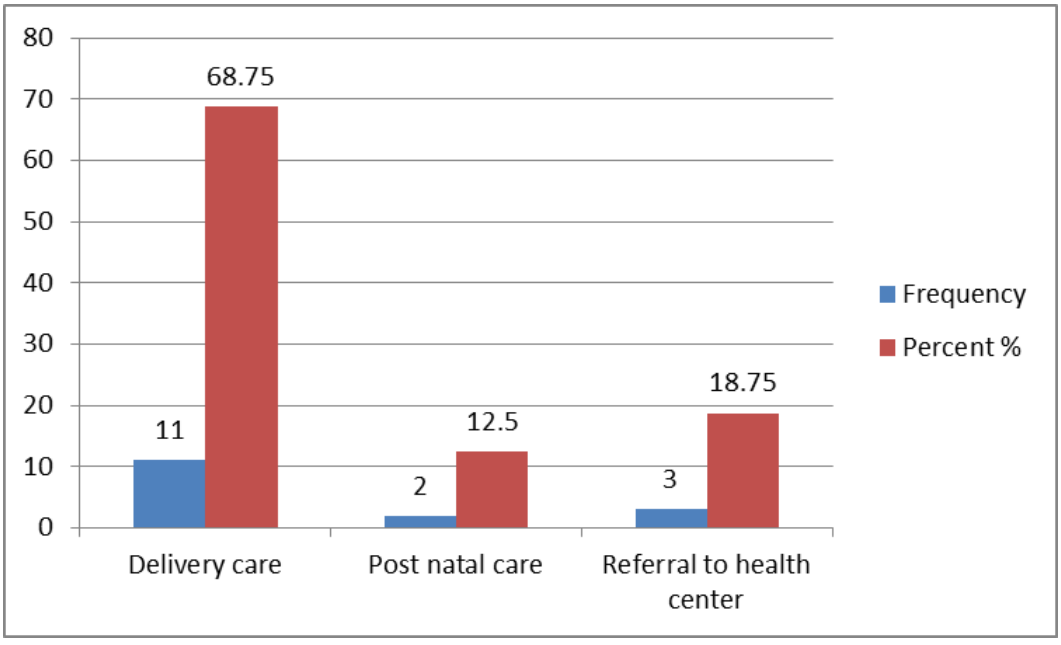

Figure 3.2: Type of Services offered by TTBAs in Hamar Weyne health center

3.3 Respondents by Reasons using TTBAs Services

Reasons of using TTBA Services	Frequency	Percent %
Customer to TBA	2	12.5
kind and care too much	12	75.0
Culturally acceptable	2	12.5
Total	**16**	**100.0**

Table 3.3: Respondents by Reasons using TTBAs Services, Hamar Weyne health center

From Table 3.3: 75% of the respondents said the reason of using TTBA services were TTBAs are kind and care too much.

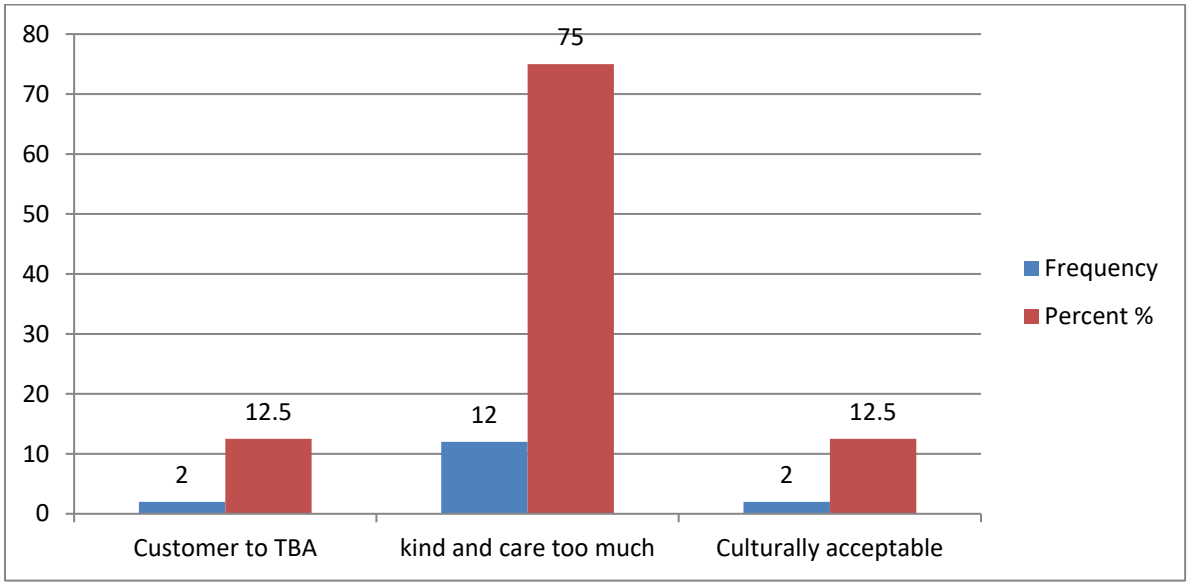

Figure 3.3: Respondents by Reasons using TTBAs Services, Hamar Weyne health center

3.4 Respondents by when TTBAs refer pregnant women to health center

When TTBAs Refer pregnant women to health Center	Frequency	Percent %
when labor is not progressing	8	50
Bleeding	5	31.25
had c/section in the past	3	18.75
Total	**16**	**100**

Table 3.4: Respondents by When TTBAs refer pregnant women to health center

From Table 3.4: when respondents asked when TTBAs refer pregnant women refer to health center. Nearly 50% of the respondents said TTBA pregnant women to health center mostly when labor is not progressing, while 31% said when pregnant women starts to bleed and only 19% said when pregnant women had C/section in the past.

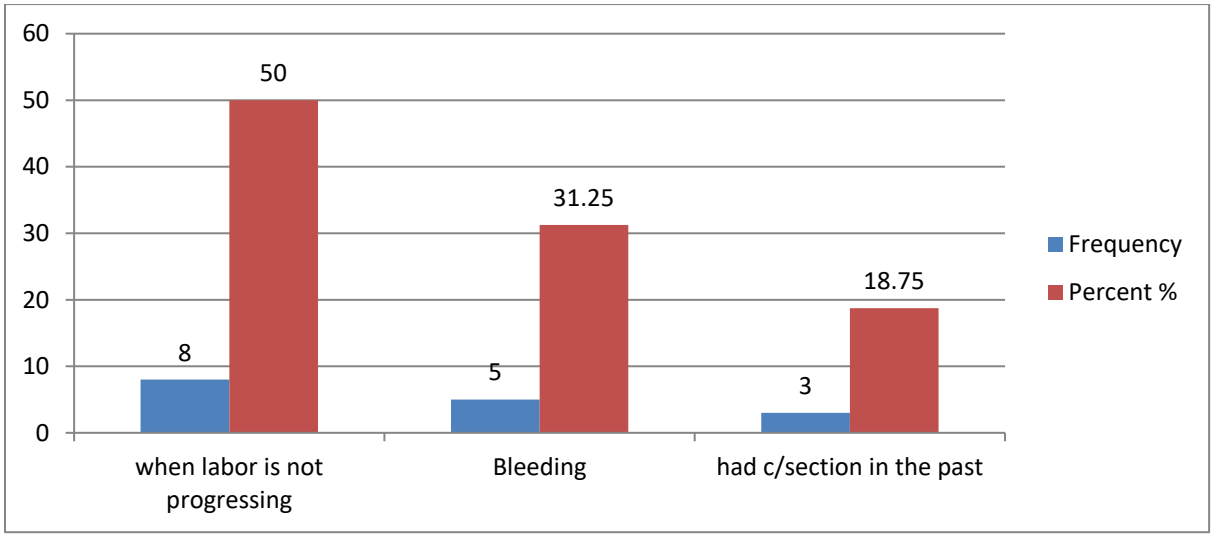

Figure 3.4: Respondents by When TTBAs refer pregnant women to health center

3.5 Respondents by how TTBAs and health center can collaborate

How TTBAs and health Center collaborate	Frequency	Percent %
Training TBAs	3	18.8
Providing incentive to TTBA	5	31.2
Good communication	8	50.0
Total	**16**	**100.0**

Table 3.5: Respondents by how TTBAs and health center can collaborate, Hamar Weyne health center

From Table 3.5: Majority of the respondents (50%) have agreed that if proper communication between the TTBAs and the health center is set up they can collaborate effectively, while 32% said providing incentives to TTBAs is the best way to collaborate and only 19% of the respondents said training TBA will improve collaboration.

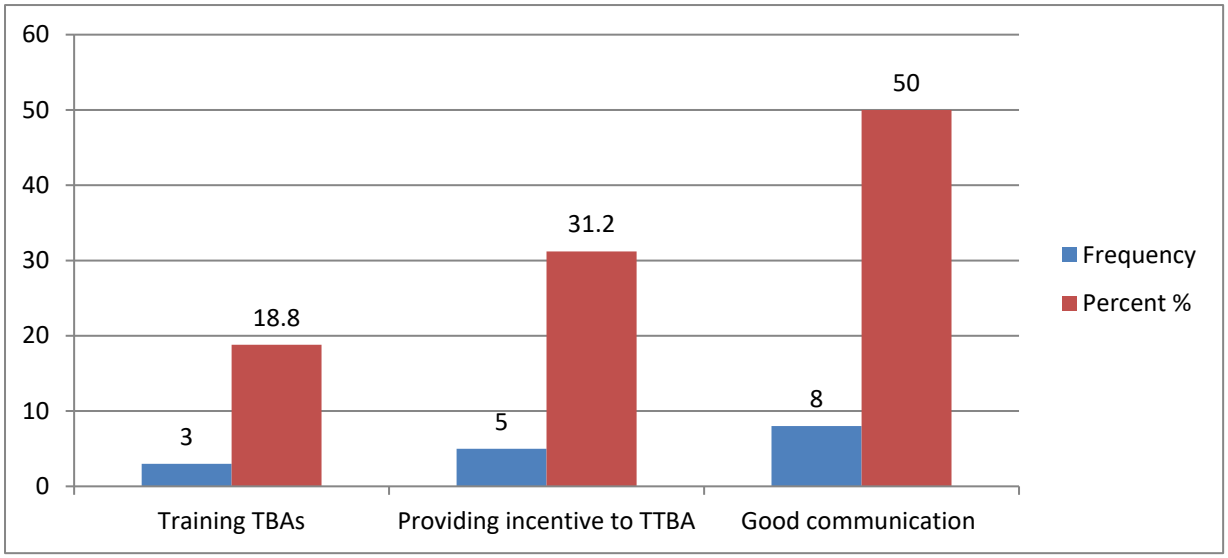

Table 3.5: Respondents by how TTBAs and health center can collaborate, Hamar Weyne health center

4.0 Discussion

5.1 Discussions

Most of the respondents were above the age of 35 years (56%), none educated (69%) and 81% had experience of more than 5 years.

Types of Services offered by TBAs

69 % of the respondents said TTBA provides delivery care and the reason of using TBA services were TBAs are kind and care too much (75%). However 75 % of the respondents were not satisfied the services offered by the TTBAs because 75 % of the respondents said complications could arise from TTBA services which include: 56 % prolonged labor, 25 % excessive bleeding and 19 % of infections.

Similar study by Fortney J. (2001) from different sub- Saharan countries found that TBAs' contribution towards delivery cares needs appreciation. Most women prefer to give birth at home. The role of a TBA during delivery was primarily described by TBAs as "receiving the baby" and comforting the mother by "holding her until she delivers"

Similar study indicated that trained TBAs provide postnatal care by cleaning the newborn after delivery; they encourage the mothers to breastfeed when the baby is awake. The study confirms

when TBAs are trained they improved child care *(Yusuf et.al 2012-2015)*. TBA ensures that the placenta is removed following delivery of the placenta, the TBA boils water and bathes the mother, changes her clothing, cooks tea and/or porridge that fed to the woman, and holds the baby so the mother can rest (*Caulfield et al, 2016).*

Factors influencing the collaboration of TTBA and the health center

Even the services available at the health center were free and accessible (69%), still 44 % of the respondents believe the reasons for home delivery with TBAs is that they are easily accessible and available, 36 % lack preparation before the onset of labor or transportation to the health center and 19 % pressure from family or husband. Nearly 38% of the respondents said relatives had the major influence of the pregnant women to choose the birth place.

Similar study done by Fortney J. (2001), asserts that, another factor that influenced the use of traditional birth attendants was being told by other family members such as the older sister, parents, or husbands to use their services. One of the main reasons for seeking the services of the TBAs was the trust women had in the TBA. This result has been consistent with many other studies done by Telfer M, *et.al*, (2002), that in rural areas there was better access to the traditional birth attendants compared to the village midwife.

The collaboration of Trained TBA and the health center

All of the respondents had confidence the services provided by the health center, however TBA services could be improved if given to appropriate training related to the care needed by the pregnant women.

While majority of the respondents agreed TBA can't deliver complicated labor, they refer pregnant women to health center if such complications arise; the most common reasons of referring pregnant women to the health center by TBAs were 50% when labor is not progressing, 31% during excessive bleeding and only 19% when the pregnant women had C/section in the past.

When pregnant women is referred to the health center, access to health facility is immediate as said by 63% of the respondents because TBAs and the health center has strong collaboration and their patients are served immediately and given respect.

This confirmed similar study done by Telfer M, et. al., (2002) that beyond the advice they provide during the prenatal and post-natal period, and during home delivery, TBAs are also central in referring women to the health facilities.

Even though large number of pregnant women is still delivered at home, the skilled birth attendants such as midwifes, nurses and community midwifes view TBAs as tradition which can't be ignored and close to the community (56%) while 38% believed TBA and health center work together.

Regarding TBA, 56 % of TBAs itself view health center as the best place to deliver providing good care to pregnant women (36%) about 81% of the respondents believed TBAs can play major role in linking the community to the health center.

Proper collaboration between TBA and Health center is possible only if communication channels are used such as referral and regular reporting system (50%), if appropriate training and supervision (19%) is provided to TBAs as well as incentives to TBAs can encourage them not to deliver pregnant women at home (31%).

From our literature Lewis G (2004) asserts that the collaboration of stakeholders is an important factor in effective service delivery for TBAs. Access and utilization of reproductive health services are affected by the interaction between the formal and traditional health systems. Having both a midwife and a traditional birth attendant present at a delivery was perceived important so that the tasks and responsibilities could be shared together (Titaly *et el, 2010)*

Conclusion

Majority of the respondents were not satisfied the services offered by the TBAs because 75 % of the respondents said complications could arise from TBA services which include: 56 % prolonged labor, 25 % excessive bleeding and 19 % of infections

The study recommends appropriate training and supervision to TBAs, and Joint-Collaboration between TTBA and skilled midwifes where to be should be allowed to bring their patients at the health center and deliver with the assistance of midwifes.

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