



**EXPLORING TRADITIONAL BIRTH ATTENDANTS' PRACTICES TOWARD
PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HEPATITIS B IN
THE PRAMPAM, SUB-DISTRICT, ACCRA GHANA**

MPHIL MIDWIFERY

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DECLARATION

I, Veronica Martey, do hereby declare that except published papers that were used and duly acknowledged, this thesis is entirely a result of my own investigation under the supervision of Professor Charles Ampong Adjei and Dr. Josephine Kyei in the school of Nursing and Midwifery, University of Ghana-Legon. It is stated clearly that this work has not been presented whether in full or part to any other University for the award of another degree.

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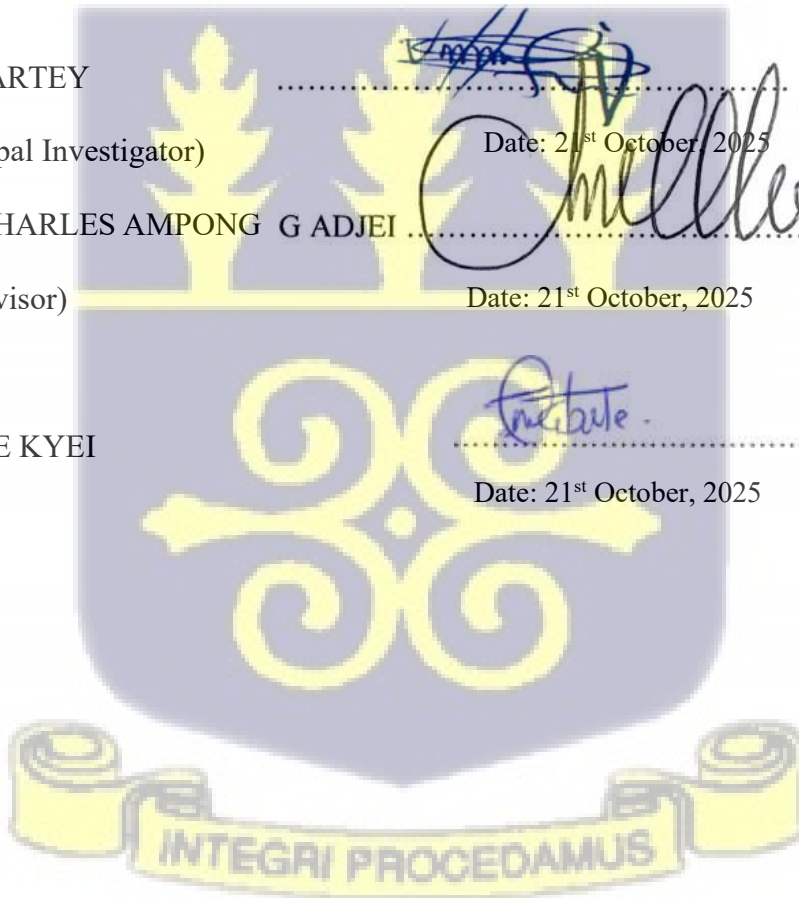


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ABSTRACT

Hepatitis B Viral infection (HBV) is a liver infection that remains a global burden, particularly in Africa. Known to be transmitted during child birth from mother to child, understanding maternity care practices of Traditional Birth Attendants (TBAs) is crucial. However, in Ghana, TBAs' prevention of mother-to-child transmission (PMTCT) practices for HBV infection-related problems have received little attention. Guided by the Theory of Planned Behaviour's model, this study explored TBAs' PMTCT practices towards HBV infection in the Prampram Sub-district of Ghana, a district known to patronize TBAs' services. The study employed an exploratory descriptive qualitative design. Eighteen TBAs were purposively sampled from the Prampram sub-district through a snow-balling approach. Data were collected by face-to-face interviews using a semi-structured interview guide, transcribed verbatim and analysed using a reflexive content analysis. The results showed that TBAs' attitudes towards PMTCT included referring pregnant women and new-borns to the hospital for HBV testing, insisting on vaccination of mothers and babies, and wearing protective gear such as gloves and polythene rubbers during and after delivery. Additionally, their practices were influenced by a number of internal and external factors such as knowledge on Hepatitis B, training, resources, acceptance and monitoring. The study therefore recommends that TBAs in Ghana receive PMTCT training on Hepatitis B. It further recommends more research into the practice needs of TBAs in order to identify key areas to tackle for improvement.



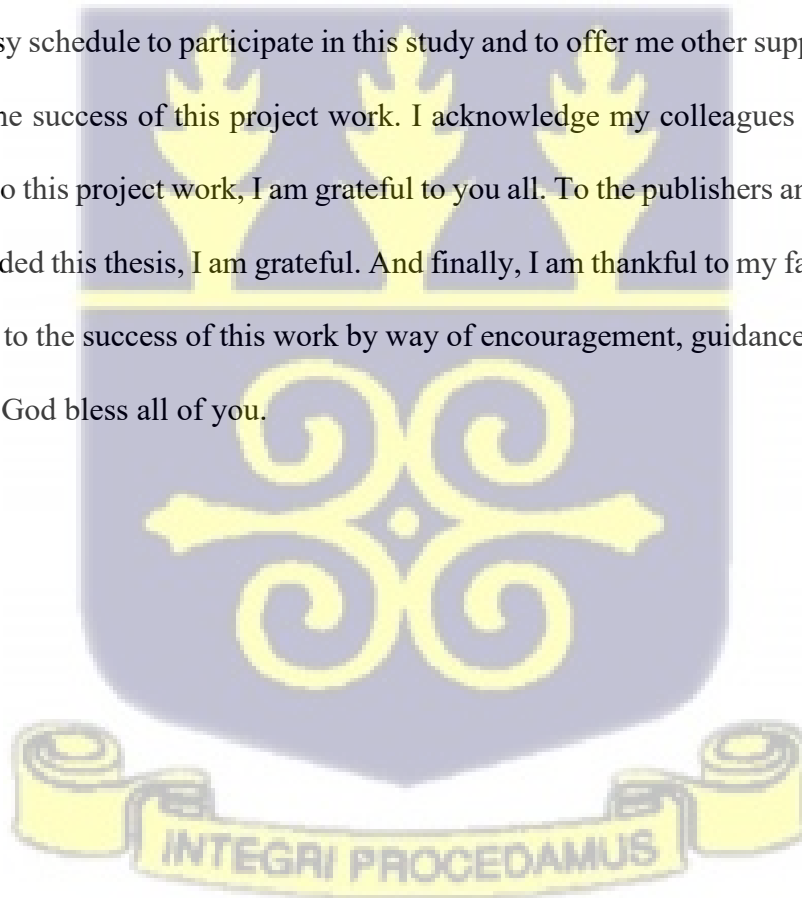
DEDICATION

I dedicate this work to my loving husband in appreciation of his unwavering support and encouragement during my academic pursuit. I appreciate his assistance in diverse forms and consign this work to his name. For their encouragement and support during this journey, I also dedicate this work to my children.



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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Since ancient times, Traditional Birth Attendants (TBAs) have cared for expectant mothers in many communities in low-income countries (Sawyer et al., 2024). Long before the formalisation and acknowledgement of midwifery as a distinct area of practice, TBAs played a crucial role in maternal health care such as assisting pregnant women to make decisions on their care plan, caring for women during pregnancy, childbirth, and puerperium and giving health education in their communities (Gurara, 2024; Shimpuku et al., 2021). They learn their skills by giving birth themselves or through apprenticeship from experienced TBAs (Ghosh, 2024).

Despite the advent of orthodox medicine and the thriving of its component skilled delivery services, coupled with several impactful initiatives implemented by governments all over the world, TBAs are still the most manageable choices for some pregnant women and their families (Gurara, 2024; Shimpuku et al., 2021). Over the past 20 years, Ghanaian governments have implemented several initiatives to improve access to skilled birth attendants (Adu & Owusu, 2023). These include the user fee exemption policy, implemented in 2005 to make maternal services provided in all public health institutions non-payable, increasing accessibility and utilisation of skilled birth assistance by women, particularly those from lower socioeconomic status (Rane et al., 2024). Other initiatives include the National Health Insurance Scheme (NHIS) and Maternal Health Care Program, which was implemented in 2008 to guarantee that women who were enrolled in the NHIS and were confirmed to be pregnant were exempted from paying for their healthcare (Alatinga, 2024). Despite these efforts, there is still a considerable difference between the number of pregnant women attending antenatal care and the number of skilled

deliveries especially in rural areas, and this difference is accounted for by the services of the TBAs (Lateef et al., 2024).

Several reasons have been identified as accounting for some pregnant women's preference for TBAs (Addeh & Bassey, 2024; Bassey et al., 2024). Research identified poor attitudes of health workers; perceived poor services and low experience of midwives; interpretation of skilled delivery for a caesarean section (Tabong et al., 2021); lack of access to health facilities; better care from TBAs; and financial constraint (Gurara et al., 2020) as some of the reasons women still patronise TBA services in Ghana and Nigeria (Adongo et al., 2024; Tabong et al., 2021).

Even though TBAs have been in existence for several years and have their services well patronised, with some health experts calling for training, support and supervision for them (Benediktsdóttir, 2022) and their integration into formal healthcare systems (Chizoba et al., 2020), they face challenges that hinder their ability to render the standard care of skilled midwives (Abredu et al., 2024). TBAs lack knowledge of standard practices in the field of maternity care (Esan et al., 2023), lack logistics, incentives and training (Kassie et al., 2022), and have been banned from conducting deliveries at home in some countries, including Ghana (Haruna et al., 2019).

Fobo et al. (2024) identified some inefficiencies in the works of TBAs. Researches revealed that as maternity healthcare changes, there is a growing focus on combining cutting-edge medical methods with time-honoured procedures to improve delivery results and safety; however, TBAs are left behind to practice based on their cultural and traditional ways with little or no supervision (Ekaeta, 2024). Another study revealed that TBAs were adamant about referring stigmatized and transferable diseased patients, such as HIV positive women, for appropriate care (Chizoba et al., 2020). A study conducted by Bustan et al. (2019) revealed that TBAs conduct deliveries without

any consideration for sterilising their equipment, leading to an avoidable spread of transferable diseases like the Hepatitis virus.

Ghana Demographic and Health Survey revealed that the majority of live births (76%) take place in public sector facilities including the Prampram Municipal Hospital, Tema General Hospital and 37 Military hospital, with 86% occurring in health facilities. Moreover, the report showed that over the past three decades, home deliveries have decreased from 57% to 13%, while deliveries in health facilities have climbed overall from 42% in 1993 to 86% (Ghana Statistical Service & ICF, 2024). Notwithstanding this great improvement at the national level, there are great regional and residential differences in these figures. For instance, regionally, the percentage of live births that take place in medical facilities varies from 67% in Oti Region to 97% in the Upper East Region (Klue et al., 2024).

Hepatitis B infection is a major global concern for public health (WHO, 2024). It is estimated that 90% of infants who contract the disease from their mothers or before turning five years old develop chronic infection (Duke, 2024; Terrault et al., 2018). Mother-to-child transmission and vertical transmission are therefore the primary modes of HBV transmission and are mainly associated with chronic HBV in Africa (Forna et al., 2024). In Sub-Saharan Africa, a comprehensive review estimated that 1% of neonates are prenatally infected with HBV each year, which is more than twice the number of paediatric HIV infections (Shimakawa et al., 2022).

The most crucial method of curbing the HBV epidemic is therefore to prevent viral infections from spreading from mother-to-child or throughout early childhood (Lu et al., 2023). To realize this, the WHO recommends, as a matter of policy, that all babies should be given Hepatitis B vaccine “as soon as possible after birth (within 24 hours)”, and this should be followed by two or three doses of Hepatitis B vaccines at four weeks intervals at least (WHO, 2024). This

recommendation has resulted in decline of 76.8% prevalence in children under five years old (EATG, 2022). Although there is no cure for Hepatitis B, it can be prevented with vaccination; since 1982, a potent and secure vaccine has been made accessible (WHO, 2019). These well tested approaches of preventing Hepatitis B are however largely not known by TBAs; and even when known, are not usually practiced by TBAs.

1.2 Problem Statement

Around the world, the practice of TBAs are common, especially in deprived and rural communities with limited access to skilled health professionals (Onyiapat, 2024). Although TBAs are essential for the care of pregnant women and new-borns, their practices can also carry a high risk of infection transmission during labour (Arowosegbe et al., 2023).

TBAs' practices have been dented with inefficiencies, such as use of herbs and concoctions rather than standard drugs and intravenous fluid to manage postpartum haemorrhage in their clients (Esan et al., 2023), refusal to refer transferable ailments like the HIV positive women for appropriate care (Chizoba et al., 2020), and conduction of labour without any consideration for sterilising their equipment (Bustan et al., 2019), which, according to Bustan et al. (2019), have avoidable negative consequences for the health of perinatal women and their babies.

A key component of interventions to advance towards the elimination of viral hepatitis is the prevention of mother-to-child transmission (PMTCT) of the Hepatitis B virus (HBV) infection. It is recommended that prenatal testing, antiviral medication during the third trimester of high-risk pregnancies in some countries, a timely and universal HBV birth-dose vaccine, and post-exposure prophylaxis with Hepatitis B immunoglobulin (HBIG) for certain new-borns should all be done (Akter et al., 2020). The World Health Organization (2024) also recommends that all

babies are vaccinated against the Hepatitis B virus soon after birth. However, these recommendations are hardly practiced among Traditional Birth Attendants

Despite the shortcomings and inefficiencies associated with the practices of TBAs in Ghana, people in certain areas of the country still access their services. According to national demographic data, the majority (88%) of live births are conducted by a skilled provider. Over two-thirds (69%) were delivered by a nurse/midwife. By region, deliveries by skilled providers are low in Oti Region (70%) and highest is Upper East Region (98%) (Ghana Statistical Service & ICF, 2024)). In the Ningo-Prampram District, data obtained from the 2021 Maternal and Child Report indicated that out of 8,359 pregnant women who attended clinic, only 2,619 (31%) delivered at the health facility. In the year 2022, the figure shifted a little to 2,770 (33%) (Ningo-Prampram DHIMS, 2022). The two data points above indicate a disparity between what was happening in Prampram and the nation at large, pointing out that skilled delivery in Prampram is very low compared to the national demographic figures. Researcher observation, later supported by grassroots practitioners, suggested that if the number of women who delivered outside a health facility turned to TBAs in Prampram for assistance, then it is imperative to explore TBAs' practices in that area to understand their practices towards PMTCT of Hepatitis B.

Research has been conducted on the practice of TBAs in rural Ghana. Alatinga et al. (2024) and Tabong et al. (2021), for example, explored aspects of TBA practices such as the role they play in childbirth. However, there is dearth of literature on the exploration of preventive practices for Hepatitis B among TBAs. More so, there seems to be a dearth of literature on the practices of TBAs in the prevention of vertical transmission of Hepatitis B during and after the conduction of delivery. Little is currently known about how TBAs manage pregnant women's needs, and what in general, they are doing to prevent mother-child transmission of Hepatitis B.

It is against this identified gap in the literature and the need to eliminate mother-child transmission of Hepatitis B that this study seeks to explore traditional birth attendants' practices towards the prevention of mother-to-child transmission of Hepatitis B in the Ningo-Prampram District.

1.3 Purpose of the Study

The purpose of this study was to explore TBA's practices towards the prevention of mother-to-child transmission of Hepatitis B in the Prampram Sub-district.

1.4 Specific Objectives

The specific objectives of the study were to;

1. Identify the attitudes of TBAs towards the prevention of mother-to-child transmission of Hepatitis B.
2. Explore the beliefs and perceptions (subjective norms) of TBAs towards Hepatitis B infection.
3. Identify the factors that influence TBAs' practices towards the prevention of mother-to-child transmission of Hepatitis B (perceived behavioural control).

1.5 Research Questions

1. What are the attitudes of TBAs towards the prevention of mother-to-child transmission of Hepatitis B?
2. What are the beliefs and perceptions (subjective norms) of TBAs towards viral Hepatitis B infection?

3. What are the factors that influence TBAs in preventing mother-to-child transmission of Hepatitis B?

1.6 Significance of the Study

Although below the level of standard professional care, the role of TBAs in maternal and child health in Ghana cannot be underestimated as they are the preferred choice of some families (Tabong et al., 2021; Adatara et al., 2020; Ntoimo et al., 2022). Despite this fact, global efforts towards the prevention of communicable diseases have largely focused on equipping formal healthcare providers, with little attention given to TBAs (Esan et al., 2023; Kassie et al., 2022). Consequently, many TBAs remain untrained, relying on traditional methods that may be harmful to the health and safety of pregnant women and their foetuses (Chizoba et al., 2020; Bustan et al., 2019). Hence, it is needful to assess how safe TBA-conducted deliveries are from the Hepatitis B infection. This research is crucial for discovering TBAs' practices that will help reduce perinatal infection. Additionally, this study identifies practice gaps so that additional studies in this area can be conducted. Insights from the study can inform the development and implementation of health policies to complement efforts aimed at preventing mother-child transmission of Hepatitis B in the Ningo-Prampram District and elsewhere. It recommends guidelines for authorities to incorporate TBAs into formal healthcare systems, ensuring their practices align with established guidelines for preventing Hepatitis B transmission if necessary. Furthermore, the findings of the study may inform the design of awareness campaigns about the risks associated with mother-to-child transmission of Hepatitis B within the Prampram Township. Finally, this research adds to the few studies exploring TBAs' practices towards PMTCT of HBV and contributes to global efforts aimed at reducing the spread of HBV in rural areas. This can lead to informed decision-making among expectant mothers, promoting safer birthing practices.

1.7 Operational Definition of Terms

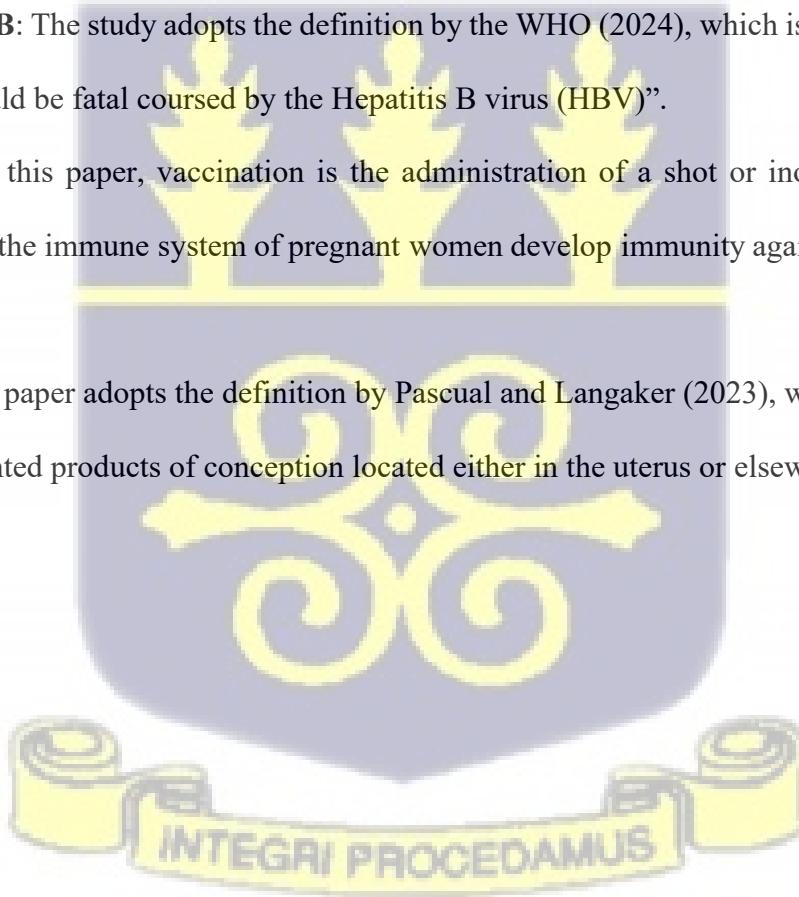
Prevention of mother-to-child transmission: The term “prevention of mother-to-child transmission” (PMTCT, also known as “vertical transmission prevention”) refers to measures taken to stop HBV from spreading from a mother who has the virus to her child during pregnancy, labour, delivery, or breastfeeding (WHO, n.d). The study adopts this as its operational definition for PMTCT.

Practice: The study defines practice as something that is usually or regularly done which has progressed from occasional activities to some kind of a habit, or in some cases have become a tradition, or custom.

Viral Hepatitis B: The study adopts the definition by the WHO (2024), which is “an infection of the liver that could be fatal caused by the Hepatitis B virus (HBV)”.

Vaccination: In this paper, vaccination is the administration of a shot or inoculation (called vaccine) to help the immune system of pregnant women develop immunity against a disease, in this case, HBV.

Pregnancy: The paper adopts the definition by Pascual and Langaker (2023), which is a state of having implanted products of conception located either in the uterus or elsewhere in the body.



CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.0 Introduction

This chapter presents the theoretical model that guides this study and the review of related empirical literature on TBA practices towards the prevention of mother-to-child transmission of Hepatitis B.

2.1 Selection of Theoretical Framework

Several models that address human behaviour were reviewed. The study considered three models in the beginning: The Health Beliefs Model, the Theory of Reasoned Action model, and the Theory of Planned Behaviour.

2.1.1 The Health Belief Model (Hochbaum, 1958)

The Health Belief Model is a popular theory used to predict individual's behavioural intentions. The theory suggests that an individual's impression of a disease's severity and vulnerability to it, along with their beliefs of the advantages and disadvantages of a protective behaviour, will determine how likely they are to engage in that particular behaviour (Green et al., 2020). The perception of the risk of illness and the advantages of the health activity must surpass the perceived obstacles for an individual to adopt the practice. The model also considers cues to action, personal characteristics, and a sense of self-efficacy. The main components are perceived severity, perceived susceptibility, perceived benefits, perceived barriers, cues to action, and self-efficacy (Boskey, 2024).

Perceived severity refers to how serious individuals think the consequences of disease or illness will be. Perceived susceptibility refers to how vulnerable they believe they are to a disease. Perceived benefits is concerned with the outcomes that individuals think they will get by taking

a particular course of action to avoid getting ill. Perceived barriers focuses on the hindrances that could make it difficult for individuals to engage in a said behaviour. Cues to action has to do with external factors that may trigger people to act in a healthy way, and self-efficacy refers to the confidence individuals have in themselves about taking a particular course of action (Alyaser & Easton-Carr, 2024). Thus, the theory suggests that individuals will engage in a particular behaviour to avoid getting ill, based on how vulnerable they think they are, how severe they think the illness is, what benefits they anticipate from the healthy behaviour, what barriers can or cannot be overcome, available cues that prompt them to act and how confident they are that they can take that course of action.

Despite its popular usage in guiding research and health interventions, the theory has been criticized for being weak and insufficient to account for behavioural change (Green et al., 2020). The theory also focuses largely on cognitive factors, neglecting the social, cultural and environmental influences that can significantly impact TBAs in resource-constrained settings.

2.1.2 Theory of Reasoned Action (Fishbein & Ajzen, 1975)

According to the Theory of Reasoned Action (TRA) (Fishbein & Ajzen, 1975), intention and volition govern behaviour. People have higher intentions (motivation) and are more likely to carry out an advised conduct if they view it favourably (attitude) and believe others want them to do so (subjective norm). Thus, TRA proposes two main factors that influence behavioural intentions – attitudes and subjective norms.

As such, TRA argues that Traditional Birth Attendants' motivation towards PMTCT will be influenced by how they view PMTCT practices and interpret societal norms surrounding it. If TBAs view PMTCT as important to the health of both mother and child, and believe that the

society celebrates PMTCT practices, they will be motivated to carry out such practices. On the other hand, if they have negative attitudes towards PMTCT practices or believe that the society disfavours such practices, their motivation will be weakened.

Despite its popular usage, the theory has been criticized for its risk of confounding between attitudes and norms, which can often be used interchangeably (Nickerson, 2023). Additionally, TRA has been criticized for not accounting for external factors, such as resource limitations, which hinder individuals from acting on their intentions (Nickerson, 2023). These limitations have been addressed by the Theory of Planned Behaviour (LaCaille, 2020).

2.1.3 Theory of Planned Behaviour (Ajzen, 1991)

According to the Theory of Planned Behaviour (Ajzen, 1991), attitudes, subjective norms, and perceived behavioural control all play a role in determining intents and influencing behaviours. Depending on the degree to which a behaviour is controlled by the individual and the degree to which perceived behavioural control is an accurate measure of actual behavioural control; external factors may also directly force or prevent behaviours, regardless of the intention. In this context, attitudes regarding the rendering of services by TBAs, in particular, are important. The expectations of others and how much an individual appreciates those expectations are subjective norms that can be seen as social pressures. There are pertinent subjective norms for all three categories since there are expectations from clients, the community, and society regarding how TBAs should render their services.

An individual's ability to carry out a certain behaviour in their environment is known as perceived behavioural control. Thus, it considers internal aspects like self-efficacy and external factors like knowledge, experience, time, and resources. The likelihood of the purpose and action occurring increases as the circumstances become more favourable. Purpose predicts behaviour more

accurately than attitudes alone (Ajzen & Fishbein, 2005).

According to the Theory of Planned Behaviour, people behave logically in accordance with their attitudes, arbitrary standards, and apparent behavioural control. Although not often actively or consciously considered, these elements serve as the framework for making decisions. In other words, even if a person does not express a certain attitude, it may still have an impact on their choices. This field of study seeks to expose these covert beliefs and values that affect decision-making. The presumption of reason is not universally accepted since people occasionally behave irrationally. Some researchers refer to this as “sense-making” instead of arguing that people act logically.

The target population’s discernible response in a particular situation is the behaviour, which is impacted by one’s desire and perceived behavioural control. The likelihood that the target population will engage in the desired behaviour increases with the strength of intentions and perceived behavioural control.

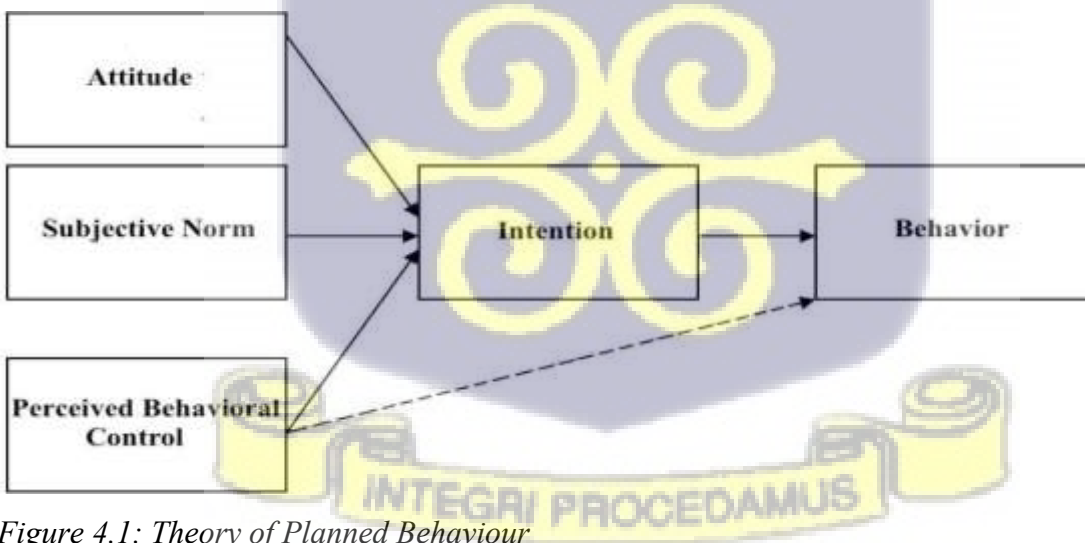


Figure 4.1: Theory of Planned Behaviour

Source: Ajzen (1991)

2.1.3.1 Application of the Theory of Planned Behaviour

The constructs in the TPB that was employed in this study reflects the contributions of TBAs to the prevention of viral Hepatitis B through PMTCT. Whether TBAs engage in behaviours that prevent MTCT of HBV will depend on their attitude towards HBV. The behaviour of the TBAs who feel like a part of the organisation and consequently must act as such may be influenced by subjective norms, such as beliefs and opinions of significant individuals, and the norms set by the organisation, Ghana's Ministry of Health, and the Ghana Health Service.

Additionally, perceived behavioural control shows that despite TBAs' best efforts and commitment to avoid all diseases knowingly and unknowingly, including preventing MTCT of HBV, there are instances in which TBAs may feel unable to complete the assigned responsibilities in accordance with the established norms of the society. This may be caused by a number of internal and external factors that may be out of their direct control, such as a lack of acceptance of TBAs in the community, resources, time, skill and knowledge. The perception of behavioural control can also directly or indirectly impact behaviour through behavioural intentions. Therefore, TBAs are more likely to take part in preventing MTCT transmission of HBV if they have all the necessary resources, can control internal and external circumstances, and have greater objectives.

2.2 Empirical Review

A literature search was done for the study on PMTCT of HBV in TBAs. The following databases were utilised to find pertinent literature: Google Scholar, EBSCOhost, CINAHL, PubMed, Science Direct and Tailor and Francis. The following search terms were included:

“Traditional Birth Attendants”, “PMTCT”, “Hepatitis B”, “HIV/AIDS”, “knowledge”, “attitudes” and “beliefs and perceptions”. The relevant publications for the study were found after a number of them were reviewed; these articles, with the exception of the definition and model, covered the years 2017 to 2024. The TPBs constructions and the study’s objectives guided the organization of the literature review.

2.2.1 Attitudes towards the Prevention of Mother-to-Child Transmission of Hepatitis B

In the northern part of Ghana, studies have revealed the various roles and practices that TBAs engage in when caring for pregnant women. Adatara et al. (2018) conducted a study exploring the roles of practicing TBAs from five communities within the Bongo District, sampling ten individuals for interviews. The study revealed six major roles of TBAs within the region. These included conducting deliveries, providing health education, counselling, psychological support and caregiving. These roles cut across physical, emotional and psychological health needs of pregnant women, demonstrating the breadth of Traditional Birth Attendants’ practice.

Additionally, Aziato and Omenyo (2018) conducted a study exploring the ways in which Traditional Birth Attendants are initiated into the practice, and the kind of practices they are engaged in. Sixteen Christian participants were sampled and interviewed in this study. The study revealed first that TBAs could be initiated through different means, including apprenticeship and spiritual revelations. Secondly, TBAs revealed that their work with pregnant women was guided by spiritual directions and traditional practices, such as hearing voices, having dreams or seeing visions, through which they are instructed on what to do, using herbs believed to have medicinal properties, combining artefacts such as blessed water, anointing oil, malt, milk, soda water,

and preparation of soap, among others, and conducting physical examinations to determine the stage of clients' pregnancies. Moreover, some unique practices include delaying cord cutting and burying the placenta of the new-born (Aziato & Omenyo, 2018). They believed that these actions were to ensure that the spirit of the child was preserved and its destiny secured, respectively.

The foregoing suggests that the roles and practices of TBAs in the northern parts of Ghana are multifaceted. This is demonstrated through the different ways TBAs are initiated, multiple roles they are involved in, and the several, non-conventional mediums that guide their work. However, the studies do not give attention to TBAs practices towards the prevention of mother-to-child transmission of HBV. These practices among TBAs remain underexplored in the Ghanaian setting, making it more difficult to address the growing prevalence of mother-to-child transmission of HBV (WHO, 2024). Hence, it limits the impact that these studies can have on designing PMTCT-promoting interventions in Ghana.

Some studies in Nigeria have shown how Traditional Birth Attendants are involved in prevention of mother-to-child transmission of infectious diseases. Because the current global literature lacks sufficient attention to Hepatitis B Virus and PMTCT among TBAs, attention is given to the PMTCT practices of TBAs towards HIV, which has a similar mode of transmission, or their general PMTCT practices.

In the work of Abazie and Eppie (2020), infection control practices of Traditional Birth Attendants in Lagos were examined. Using a descriptive method, 144 TBAs in the three local government areas, namely Ikorordu, Mushin and Surulere, were sampled for the study. The researchers used a questionnaire to examine the participants' knowledge, attitudes and practices towards infection control. Most of the TBAs were aware that they could be infected by their patients, and needles and sex were common means through which infections could spread.

However, around a third of them indicated that washing hands, wearing gloves and using new razor blades were safety measures for preventing the spread of infections. Nevertheless, while these practices may be useful, they are contrary to WHO's (2024) recommendation of vaccination after birth and do not prevent the transmission of HBV from mother to child. Other strategies utilised by the respondents of the study included disinfecting surroundings, cleaning tools, and referring clients for tetanus toxoid immunization, all of which have positive benefits and reflect TBAs positive attitudes towards prevention of infections.

Abazie and Eppie (2020) also found that TBAs in Nigeria demonstrated high levels of knowledge and safety precautions in preventing the spread of infections. Nearly all the participants indicated that they washed their hands before examining patients, before assisting with childbirth and after childbirth using various cleansing materials, and wore different gloves for different patients. Additionally, only a fifth of them were not aware of the Hepatitis B vaccine. But, the majority of them often referred their patients to the hospital for tetanus toxoid immunization and HIV testing. These positive practices towards prevention of infections for themselves, pregnant mothers and neonates emphasize that TBAs might be willing to perform PMTCT practices when trained to do so. Notably, only 2.8% of the sample for this study did not have formal education, while over two-thirds attained secondary level. This could explain the high levels of knowledge and precautionary measures within the sample, as other studies have shown that poor education contributes to negative PMTCT practices (Sarmiento, 2014; Orrego-Dunleavy, 2019).

Additionally, TBAs have demonstrated their willingness to contribute to PMTCT of infectious diseases. According to Olakunde et al. (2017), engaging and linking them with the formal healthcare sector can improve the reach of the PMTCT program in Nigeria. In the study, the researchers sampled and linked 640 TBAs to primary health centres within two states. They were

involved in capacity-building workshops on PMTCT and HIV, as well as standard precautionary measures and safe delivery. The researchers also determined TBAs' interest in and commitment to mobilizing pregnant women for HIV testing services. The results of the study showed that outreach contributed 20% to the overall number of pregnant women who received counselling, testing and results, and 12% to the total number of HIV-infected patients who were identified. Three specific ways that TBAs contributed to the program were awareness creation among pregnant women for HIV testing, promoting the uptake of PMTCT among pregnant women and referring pregnant women to health facilities for testing. Incentives were used to motivate TBAs to contribute effectively to the program. This demonstrates that TBAs are willing to contribute to PMTCT programs if they are integrated.

Similarly, Chizoba et al. (2020) conducted a review focusing on the roles and challenges of TBAs towards PMTCT of HIV in Nigeria. Twenty-one articles published between 2010 and 2020 were selected for this study based on the inclusion criteria. The study revealed that TBAs were receiving training from Non-Governmental Organizations, which improved their PMTCT knowledge and practices and enabled them to contribute significantly to HIV counselling and testing. The study however revealed that TBAs were reluctant to refer HIV positive patients unless they were incentivised, and they demonstrated poor reporting mechanisms and assessments. The recurring need for incentives could be due to low income earned by people who live in rural areas, particularly TBAs.

Thus, TBAs have demonstrated that they are significant contributors to maternal health through traditional practices, and by leveraging training and collaboration opportunities with the formal healthcare system, are able to scale-up PMTCT services for HIV testing. In effect, they can be useful advocates and contributors to PMTCT for Hepatitis B Virus when engaged. Nevertheless,

the following challenges would have to be bypassed to support their work; need for training (Abazie & Eppie, 2020; Olakunde et al., 2017), poor reporting mechanisms and assessments (Chizoba et al., 2020), motivation (Chizoba et al., 2020; Olakunde et al., 2017) and traditions/cultural beliefs (Aziato & Omenyo, 2018).

2.2.2 Beliefs and Perceptions of TBAs towards PMTCT of Hepatitis B Virus

Due to the insufficient attention given to TBA's PMTCT beliefs and perceptions (subjective norms) towards HBV in the literature, insights have been drawn from studies that focused on TBA's PMTCT subjective norms towards HIV/AIDS. These insights have been grouped into four categories, namely, knowledge, causes, transmission and treatment of mother-to-child transmittable diseases, such as HIV.

The literature presents varied knowledge levels of TBAs towards transmittable diseases like HIV/AIDS. A study in Guatemala by Orrego-Dunleavy (2019) addressed knowledge and capacity limitations of TBAs towards prevention of HIV transmission. The sample for the study included 22 female adults aged between 56 and 70 years who had been practicing for 25 to 40 years. Locally referred to as Comadronas, the TBAs were engaged in a Focus Group Discussion and later observed in a practical session. It was revealed that TBAs were divided in their opinion of what exactly HIV was. The researcher noted that while some believed that HIV and AIDS were the same disease, others differentiated the two terms; others admitted that they did not know much about it. This was consistent with previous studies conducted in the other rural areas within the region (Orrego-Dunleavy et al., 2017; 2018). In contrast, the study by Abazie and Eppie (2020), which was conducted in Nigeria, revealed that TBAs were well-informed on HIV and Hepatitis B, with about two-thirds of the sample scoring a good level of knowledge. This variation could be due to several factors, including level of education, and availability of training

(Abazie & Eppie, 2020; Orrego-Dunleavy, 2019), among others. In effect, TBAs would likely demonstrate varied knowledge levels about Hepatitis B Virus, depending on these factors. Their knowledge about HIV/AIDS would also contribute to varied preventive practices.

TBAs demonstrate varied perceptions about the causes of these infections, and this has the potential of influencing prevention practices. A qualitative study conducted by Abdullah et al. (2021) examined perceptions and practices on new-born care from five communities in rural Bangladesh. The study revealed religious perspectives and how they influenced traditional care, including TBAs practices for new-borns. The community believed that complications in neonates, including infections, resulted from some mistakes caused by their parents, such as lack of care, past sins and disobedience to religious rules. Consequently, traditional practices included bathing the neonates and shaving their hair immediately after delivery. They believed that these practices would cleanse the neonates of dirty fluids. In Orrego-Dunleavy's (2019) study, TBAs in Guatemala believed that many people were infected by HIV due to their frequent intake of alcohol, use of brothels, early onset of sexual activity and engaging in sexual activities with multiple partners. This belief stemmed from their observation that these activities had increased significantly within the region. The foregoing suggests that TBAs hold beliefs and perceptions that are unscientific and may not accommodate primary health care strategies (Abdullah et al., 2021). These beliefs are also inconsistent with PMTCT practices; consequently, they might lead to unwillingness or hesitancy of TBAs to embrace PMTCT recommendations.

Thirdly, in the studies by Abdullah et al. (2021) and Orrego-Dunleavy (2019), TBAs that were sampled were not aware of how HIV/AIDS could be transmitted through delivery. However, in Nigeria, the study by Abazie and Eppie (2020) showed that TBAs were knowledgeable of the modes through which HIV/AIDS could be transmitted. They particularly highlighted multiple

means, such as healthcare giver to patient, used needles and sex. Moreover, they believed that transmission of infections could be prevented. Prevention mechanisms highlighted by the participants included washing hands, wearing gloves, vaccination for Hepatitis B, and immunization. Thus, the literature reveals knowledge gaps among TBAs in the modes through which infections such as HIV/AIDS and Hepatitis B Virus can be transmitted during delivery. Such knowledge gaps might be prevalent in rural areas where access to information is limited, and where much of what TBAs learn stem from the practices of former TBAs (Ghosh, 2024). By implication, TBA practices would be deeply entrenched in culture and traditions, making them more difficult to change.

Finally, most TBAs in the studies that have been reviewed for this research agree that testing for infections is necessary. However, their reactions to being involved in testing and treatment vary. While participants in the study by Abazie and Eppie (2020) were more willing to be trained in PMTCT and testing for HIV infection, those in the study by Orrego-Dunleavy (2019) were hesitant to the idea of testing their clients for HIV. Participants in the latter study considered HIV infection to be delicate, preferring that testing and treatment should be reserved for professional healthcare workers. Similar varied outcomes might be found among TBAs when considering PMTCT for Hepatitis B Virus.

There are several similarities and differences among TBAs when considering their beliefs and perceptions of PMTCT for infectious diseases. The differences observed in the studies, which have been reviewed above, could be influenced by several factors, including education level of the sample, availability of training opportunities and religion. Further evidence reveals that multiple factors influence Traditional Birth Attendants' PMTCT practices towards infectious diseases such as HIV/AIDS and Hepatitis B Virus. As such, varied beliefs and perceptions might

be associated with varied PMTCT practices. Where TBAs have a fair knowledge about HBV, understanding its causes, modes of transmission and treatments, they might be more willing to embrace PMTCT recommendations. On the other hand, poor knowledge about HBV might lead to a reluctance to practice PMTCT in managing HBV. This would necessitate further education of TBAs before integration into PMTCT practice.

2.2.3 Factors Influencing TBAs Practice towards PMTCT of Hepatitis B Virus

The studies reviewed above reveal multiple factors that may influence the practices of Traditional Birth Attendants towards prevention of mother-to-child-transmission of Hepatitis B Virus and other infections like HIV/AIDS. These factors can be grouped into two categories, namely, negative factors and positive factors. Negative factors are those that account for unsafe PMTCT practices of TBAs, while positive factors are those that enhance safe and healthy PMTCT practices of TBAs.

Major negative factors promoting unsafe PMTCT practices among TBAs include the cultural heritage of TBA practice (Sarmiento, 2014), religion and superstition (Aziato & Omenyo, 2018; Orrego-Dunleavy, 2019) and illiteracy and poor knowledge of infection control (Abazie & Eppie, 2019; Orrego-Dunleavy, 2019). Where these factors are predominant, TBAs are seen to perpetrate traditional healing methods such as herbalism and spiritism. Other factors that contribute to negative PMTCT practices include high cost of materials or equipment (Djaogol et al., 2019; Tabong et al., 2021) and inexperience of young TBAs (Abazie & Eppie, 2020; Orrego-Dunleavy, 2019).

On the other hand, major factors promoting safe and healthy PMTCT practices among TBAs include PMTCT training and collaboration with professional health workers (Olakunde et al., 2017; Abazie & Eppie, 2020; Chizoba et al., 2021). This is evidenced particular in studies that

have been conducted in Nigeria, where PMTCT programs have been significantly improved by TBAs. Moreover, these studies recommend that TBAs receive training and opportunities to collaborate with healthcare workers, particularly in regions where culture and religion are deeply ingrained in the lifestyles of the people. Other factors that contribute to positive PMTCT practices include availability of resources, such as test kits, gloves and disinfectants (Chizoba et al., 2020), education (Sarmiento, 2014) and incentives to motivate TBAs to refer HIV positive patients (Olakunde et al., 2017).



CHAPTER THREE

METHODOLOGY

3.0 Introduction

This section describes the methodology and approach utilized to accomplish the study's goals. This chapter covers the following areas: study design, research setting, target population, sample size, sampling procedure, data gathering tool, data analysis, data management, methodological rigor, and ethical considerations.

3.1 Research Design

To accomplish the goals of this study, a qualitative study design using an exploratory descriptive approach was employed. Qualitative study is used when little information is known about the study topic (Creswell & Creswell, 2017; Streefkerk, 2020). The choice of this paradigm was rooted in the belief that individuals and their experiences are complex and unique, and therefore, understanding these experiences requires an in-depth exploration and interpretation of meanings (Mohajan, 2018). In order to get a better knowledge of phenomena, exploratory descriptive qualitative design often seeks to provide a thorough and plain explanation of it (Doyle et al., 2020). Therefore, this design was employed to capture the depth and complexity of TBAs practices towards prevention of Hepatitis B (MTCT) in neonates since this study topic has not received much research. The focus of this study was on describing and understanding the data while respecting the perspectives and circumstances of the participants.

3.2 Philosophical Underpinning

Underpinning theory is the foundational framework for understanding or a guide to research across various disciplines (Abu Hassim et al., 2024). It provides the theoretical basis for explaining complex

phenomena and informs practical applications in research. Some philosophical underpinnings of research have been listed by Handema et al. (2023) to include pragmatism, ontology, post-positivism, interpretivism or constructivism paradigm, and symbolic interactionism; and Abbadia (2022) makes mention of epistemology and axiology as philosophical underpinnings of research.

This qualitative research attempted to understand the meanings and interpretations regarding the practices of TBAs towards PMTCT of Hepatitis B. Therefore, interpretivism paradigm was more ideal for this study as reality is constructed by the respondents through their experiences of it (Acharya, 2024). In other words, the research explored the subjective responses of TBAs. In Interpretivism, it operates on the assumption that knowledge is generated by exploring peoples view point. The interpretivism or constructivism paradigm approach is used in most qualitative research in the social sciences. It is based on the idea that there are multiple realities, rather than just one (Alele & Malau-Aduli, 2023).

TBAs in Prampram were engaged in interviews and asked open ended questions about their practices in relation to Hepatitis B. MTC transmission. The data was transcribed and analysed using a reflexive thematic analysis to identify recurring themes and pattern responses.

3.3 Research Settings

The study was conducted at the Prampram community in the Ningo Prampram District (Ghana Statistical Service, 2020) of the Greater Accra Region. Ningo Prampram District is one of 29 Districts in the Greater Accra Region (Ghana Statistical Service, 2020). Until the southern portion of the district was split off to create the Ningo-Prampram District on June 28, 2012, it was a part of the larger Dangme West District, formed in 1988 from the former Dangme District Council.

The remaining portion has since been renamed Shai-Osudoku District. The district's capital city is Prampram, which is 15-minute drive from Tema and a 45-minute drive from Accra, in the Greater Accra Region's east. The Gulf of Guinea, Ada West, Shai Osudoku, and Kpone Katamanso districts border the district to the north, east, south, and west. The entire land area of the district is 622.2 square kilometres. According to the 2010 Census (District Analytical Report - Ningo-Prampram, 2017), 70,923 people live there, with 33,514 males and 37,409 females. According to the Ghana Statistical Service, the most current population count was 87,393. There are about 22 actively practicing TBAs in the Prampram sub-district according to Prampram District Health Information Management System (DHIMS 2, 2022). Some of these TBAs collaborate with the hospital by referring cases to them. However, others have a clandestine practice.

3.4 Target Population

The population in research refers to the entire group of individuals from which a sample is drawn to make inferences or generalizations (Willie, 2023). All TBAs who provide open or covert maternity care to expectant mothers and their babies at Prampram made up the study's population.

3.5 Sample Size and Sampling Technique

Purposive and snowball sampling methods were used in the study to recruit 18 TBAs. The purposive sampling technique was appropriate for this study because it afforded the researcher the opportunity to recruit only participants who had relevant knowledge and experience. In essence, they are the group that can freely give very useful information by coherently narrating their practices during delivery towards PMTCT as they were interviewed individually in their homes. Snowball sampling is a non-probability approach used to sample research participants where participants refer the research to identify other potential participants and recruit them for

the study (Nikolopoulou, 2022). It is used in circumstances where there is no official list of the population, members of the population are difficult to locate, or members of the population are not willing to be identified (Bhat, 2024). Therefore, the snowball sampling technique was adopted since there was no official list of TBAs at the disposal of the researcher; hence, making it difficult to locate them. This technique was applied by asking the first TBA who was accessed to lead the researcher to locate other TBAs who were subsequently recruited into the study and interviewed. Participants were interviewed one after the other to obtain relevant information until an in-depth understanding of their practices was obtained.

3.6 Data Collection Tool

A semi-structured interview guide was used to conduct in-depth face-to-face interviews with the participants. The interview guide had four sub-sections. Section A of the guide captured data on participants' demographic characteristics, i.e., their age, level of education, marital status, religious affiliation, duration of practice, and how they obtained their practical skills as TBAs. Section B of the interview guide was developed based on the constructs of the study's theoretical model (Theory of Planned Behaviour) and in tandem with the study objectives. This section of the interview guide consisted of open-ended questions exploring the participants' experiences with Hepatitis B. It assessed TBAs' beliefs and perceptions about hepatitis B and their attitude towards prevention of mother-to-child transmission of HBV. It also assessed subjective norms that affected TBAs practices towards PMTCT of Hepatitis B and factors that facilitated or hindered TBAs practices towards PMTCT of Hepatitis B. Appendix 1 presents the semi-structured interview guide used for the study.

3.7 Pre-testing/ Piloting of Interview Guide

The interview guide was pre-tested at New Takoradi a fishing/ urban community in Takoradi within the Western Region with three TBAs who met the inclusion criteria. This exercise was done to help ascertain the clarity of the questions in the interview guide and determined whether the questions answered the research questions. Also, this exercise helped test the data collection tool for efficacy. New Takoradi was appropriate for this piloting as it shares similar demographics with the study area.

3.8 Criteria

3.8.1 Inclusion Criteria

The inclusion criteria involved the following:

- All TBAs who gave their consent to participate in the study.
- Those TBAs who were involved in the conduction of delivery and have had at least one year of practical experience in the delivery.

3.8.2 Exclusion Criteria

These included TBAs who were retired or who provide other equally important services other than active delivery services. All TBAs who had been engaged or interviewed on a health related research in at least the past six (6) months were also excluded. This was necessary to avoid receiving expert responses from the selected respondents.

3.9 Data Collection and Management

Qualitative data management aims to organise and store data to enhance easy accessibility and interpretation of the data collected (Ritchie et al., 2013). Interviews conducted in Twi and Ga were translated and transcribed verbatim into English and cross-checked for accuracy by an expert in

the Twi language. Each interview was given a unique code to depict the traditional attendant who granted it for easy identification. Eighteen TBAs were interviewed face-to-face in the comfort of their homes and saturation was realised on the 15th participant. However, due to available interested participants, coupled with the researcher's curiosity for possible new information, the interviews continued to the 18th participant. Critical self-reflection and open-ended questions, transparency, meticulous record keeping, and a non-judgmental attitude were emphasized to mitigate biases.

Data cleaning and analysis were done concurrently with data collection as indicated by Vaismoradi et al. (2013). This approach helped to improve the depth and quality of the interview, as the initial analysis provided some direction in the subsequent interviews. A reflexive thematic analyses approach was used to analyse the data. Citing Braun and Clarke (2012), Byrne defined reflexive thematic analysis as “an easily accessible and theoretically flexible interpretative approach to qualitative data analysis that facilitates the identification and analysis of patterns or themes in a given data set” (Byrne, 2022, p.1392). Reflexive thematic analysis is conducted in six , namely familiarising with the data, generation of initial codes, generation of themes, review of potential themes, defining and naming of themes and report production (Braun & Clarke, 2012). Accordingly, the data for this research was analysed by first familiarising with the interviews by thoroughly reading through the transcript. Initial codes were generated, and with these codes sub-themes and themes were generated. These sub-themes and themes were reviewed to ensure that they were not just codes. The sub-themes and themes were defined and named, and the report was finally written on them. Field notes taken during the interviews were kept protected, and the transcribed data stored on Google Cloud to guarantee the safety of the data. Soft copies of the transcribed data are also saved on a password-protected computer and an external hard drive,

while the hard copies and the signed consent forms are kept separately under lock and key by the researcher.

3.10 Rigour of the Research

According to Gerrish and Lacey (2010), rigour in qualitative research refers to how strong a body of research is in confirming that all procedures have been followed judiciously and that the reader judges conclusions as dependable or trustworthy. Credibility, transferability, dependability, and confirmability have been identified as the major criteria to ensure trustworthiness in qualitative research by Lincoln and Guba (1985). To ensure the rigour of this study in Prampram, the researcher adhered to all laid down ethics of research on human population. The researcher also adhered to the approved methodology for the study to ensure that nothing was done outside what had been approved.

3.11 Credibility

Credibility in qualitative research explains the extent to which participants and readers identify the phenomena described in the research as reality or, in some instances, similar to their own experiences (Korstjen & Moser, 2018; Kornhaber et al., 2015). The interview guide was pre-tested on three traditional birth attendants (TBAs) who met the inclusion criteria to ensure credibility. This allowed the researcher to make necessary modifications to aspects of the interview guide that did not elicit relevant responses to the study. A purposive sampling technique was used to ensure that only participants who could vividly account for their practices were recruited. Probing and iterative questioning was used to elicit responses from participants; and in situations where there were ambiguities in the responses, clarifications were sought from the participants.

3.12 Transferability

Transferability refers to the extent to which the results of a study can be applied to other similar contexts or settings. To achieve this, the research process was described in detail so that others could evaluate the applicability of data to other contexts and settings.

3.13 Dependability

Dependability refers to the extent to which similar studies in the same context using the same method among the same participants yield similar results over some time (Shenton, 2004). To ensure dependability in this study, a detailed description of the study design, sampling method, data collection, and analyses were well documented.

3.14 Confirmability

Confirmability concerns the degree to which the findings of a study can be re-established or authenticated by others. It ensures that the researcher's beliefs and assumptions do not influence the interpretation of the data collected (Houghton et al., 2013). To ensure confirmability, the context of data collection was documented in a field note during the interview. This will enhance the validity and reliability of the findings.

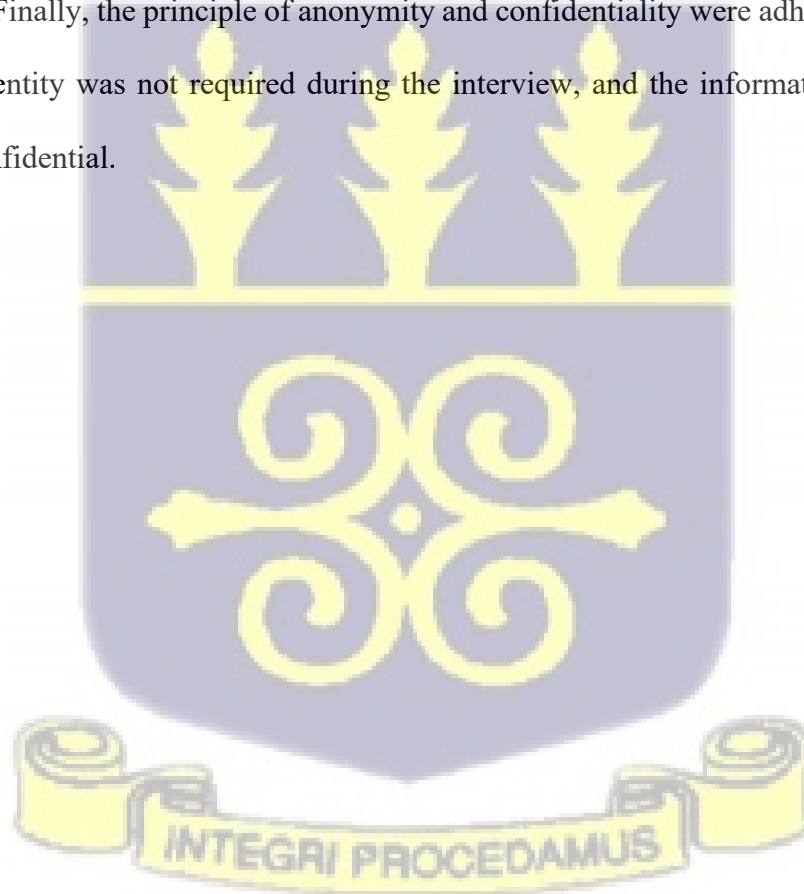
3.15 Ethical Considerations

Ethical considerations are very important aspects of the research process. The ethical principles underlying research are general and concern issues such as privacy, anonymity, confidentiality, honesty, and respect for fundamental human rights (E.S.I., 2021). Confidentiality and the provision of appropriate information about the research must also be safeguarded (Marianna, 2011). To ensure that this study is ethically certified, the research proposal was submitted to the Institutional Review Board of the Noguchi Memorial Institute for Medical Research to seek for ethical clearance before data collection. This was approved with the registration number NMIMR-

IRB CPN 070/23-24.

An introductory letter from the School of Nursing and Midwifery, University of Ghana, was also submitted together with the ethical clearance to the Director of the Ningo-Prampram District Health Directorate to seek permission to conduct the study in the Sub-districts: this was approved with a letter from the district director for health services. All participants' right to self-determination and autonomy were respected. Participation in the study was made voluntary, such that participants reserved the right to withdraw from the study at any time they wish.

TBAs who met the inclusion criteria and agreed to participate in the study were requested to sign consent forms. Finally, the principle of anonymity and confidentiality were adhered to; hence, the participant's identity was not required during the interview, and the information provided was kept strictly confidential.



CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the findings of the study. These results are shown in accordance with the study's objectives. The objectives of the study were to: (1) identify the attitudes of traditional birth attendants (TBAs) towards prevention of mother-to-child transmission (MTCT) of Hepatitis B (Hep. B); (2) explore the beliefs and perceptions (subjective norms) of TBAs towards Hep. B infection; and (3) identify factors that influence TBAs' practices towards the prevention of MTCT of Hep. B (perceived behavioural controls). The chapter first presents the profile of the respondents, which are mainly the socio-demographic characteristics of the respondents. With respect to the specific findings that answers the research questions of the study, three (3) themes and eleven (11) sub-themes were drawn from the responses. These are detailed and discussed under the appropriate research objectives.

4.1 Profile of Respondents

All the 18 study respondents were females (n=17) but one (1). They were aged 40-69 years old, Married (n=16) and Christians (n=18) with 6 to 30 years of practical experience as TBAs. Most of them schooled up to primary level (n= 9) and form four (n=5). They acquired their practices mainly through dreams and revelation (n= 8), training by relatives who were TBAs (n =8) and self-developed skills (n=2).

4.1 Socio-demographic Characteristics of Respondents

Respondents' socio-demographic details, such as their ages, marital status, religious affiliation, and work experience, were all examined and shown in Table 4.1.

Table 4.1
Sociodemographic characteristics of respondents

Pseudonym	Age	Religion	Education	Marital status	Skill acquisition	Work Experience
TBA 1	40	Christian	JHS	Married	Training (from grandmother)	15 Yrs
TBA 2	42	Christian	Primary	Married	Self-practice	10
TBA 3	69	Christian	Form 4	Married	Training (from Aunt)	18
TBA 4	68	Christian	Form 4	Married	Training	35
TBA 5	42	Christian	Primary	Married	Training (from grandmother)	11
TBA 6	51	Christian	None	Married	Self-practice	6
TBA 7	40	Christian	JHS	Married	Training (from grandmother)	6
TBA 8	44	Christian	Primary	Married	Training (from mother)	4
TBA 9	57	Christian	Primary	Married	Spiritual (God's calling)	30
TBA 10	52	Christian	Primary	Married	Spiritual (God's calling)	22
TBA 11	45	Christian	Primary	Married	Training (from mother)	10
TBA 12	67	Christian	Primary	Married	Spiritual (revelation)	30

TBA 13	41	Christian	None	Married	Spiritual (in a dream)	25
TBA 14	52	Christian	Primary	widowed	Spiritual (gift)	30
TBA 15	57	Christian	Form 4	Widowed	Spiritual (in a dream)	25
TBA 16	53	Christian	Primary	Married	Training	13
TBA 17	65	Christian	Form 4	Married	Spiritual (revelation)	25
TBA 18	46	Christian	Form 4	Divorced	Spiritual (in a dream)	21

Source: Field Survey (2025)

Interviews were conducted with 18 Traditional Birth Attendants (TBAs). They were aged between forty to sixty-nine years old. In terms of religious affiliation, they were all Christians. Some were married and had worked as TBAs for six to thirty years. While the remaining TBAs, except for one, learned their craft by self-improvement and training, the other half claimed to have received their TBA skills spiritually through gifts, revelations, and dreams. Two (2) TBAs completed junior high school, five (5) completed form four education, nine (9) completed primary education, and two (2) did not attend any formal educational institution.

4.2 Organisation of Themes and Sub-themes

The data was analysed into themes and sub-themes using the Braun and Clarke (2020) reflexive thematic analysis approach. The themes that emerged from the data analysis were arranged in accordance with the Theory of Planned Behaviour (TPB) and the study's objectives. After the analysis, three (3) main themes and eleven sub-themes emerged. These themes are *TBA-level preventive practices and hospital referrals*, *Self-styled practice with passion to save life and please God and society* finally, *working with passion but full of internal and external challenges towards PMTCT/HB*. Table 4.2 presents the details of identified themes and sub-themes.

Table 4.2:
Themes and Sub-themes

	Theme	Sub-themes
Attitude towards prevention of MTCT of Hep. B	<i>Attitude of vaccination, referrals, protective equipment, and local remedies to prevent MTCT of Hep. B</i>	(a) Protection of babies from infected pregnant mothers with protective equipment
		(b) Vaccination against Hepatitis. B virus
		(c) Referral of suspected Hepatitis. B-infected pregnant mother and new-born babies to the hospital
		(d) Delayed initiation of breastfeeding of neonates to prevent MTCT of Hep. B
		(e) Administration of herbal concoctions to prevent MTCT of Hep. B
Subjective norms	<i>Perception and cultural beliefs of TBAs on Hepatitis B and PMTCT</i>	(a) Self-styled practice to please God and meet societal expectation.

		(b) To save life of the new-born and preserve their future from HBV
Perceived behavioural control	<i>Working with passion full of internal and external challenges for PMTCT of HB</i>	(a) Need for delivery equipment (b) Supervised Skill training (c) Some knowledge on Hepatitis B (d) Poor knowledge on Hepatitis B

Source: Field Survey (2025)

4.3 Attitude towards Prevention of Mother-to-Child-Transmission of Hepatitis B

The strategies used by TBAs in the course of their practice to prevent MTCT of Hepatitis B are encapsulated in their attitude towards prevention of MTCT of Hep. B. They go beyond their responsibilities as immediate caregivers for expectant mothers and their unborn children. There were four sub-themes that surfaced: (1) Recommendation of vaccination for themselves and the new-born, use of protective equipment; (2) Referral of suspected cases to the hospital; (3) Delay of initiation of breastfeeding; and (4) Administration of herbal concoctions.

4.3.1 Attitudes of Protective Equipment Usage, Vaccination, Referrals Cases, and Local Remedy to Prevent MTCT of Hepatitis B

4.3.1.1 Use of Protective Equipment

In order to prevent Hepatitis B infection in themselves, their clients, and the babies they care for, some traditional birth attendants (TBAs) in Prampram demonstrated the attitude of using protective equipment, such as gloves and polythene bags, during their pre-delivery exams and during the actual delivery and cord cutting. Some TBAs stated that they thought they could spread the Hepatitis B virus from mother to child if they did not wear protective gear.

Despite the fact that these methods do not prevent the spread of Hep. B MTCT, they partially aid in the fight against the virus by providing a protective shield against direct contact with the virus itself.

‘The likelihood of transferring Hep. B from the mother to the baby without wearing any glove is high. Due to this, I sometimes wear polythene bag on my hands during delivery and quickly change (put on another) to cut the umbilical cord or attend to the baby’.

(TBA 3)

“Okay so before the delivery, I get the bed ready, packed my gloves, spirit and errm errm when labour is due I put on my gloves and cover my hair ...after that I change glove before I cut the cord”. **(TBA 4)**

4.3.1.2 Vaccination against Hepatitis B virus

Some TBAs acknowledged that taking the Hepatitis B vaccine, and giving it to the babies can act as a barrier to prevent the Hepatitis B virus from spreading between them and the pregnant women and consequently to their babies. However, most TBAs in Prampram had not received any kind of vaccination when asked. A small percentage had some kind of vaccination but were unsure if it was against Hepatitis B.

“Oh, that injection, our leaders know best so anytime they announce about the

vaccination, we go for it, and I think it is good". (TBA 9)

"It is a protection mechanism for you the individual, pregnant woman and the new-born baby. So even me, when I hear about any vaccination or immunization exercise, I try to partake in order to protect myself and my patients. Even if it means waiting until the next day to receive the jab.....". (TBA 16)

"Because of the work that I do, I have taken all 3 jabs. Pregnant women must also take the vaccine to protect their unborn babies". (TBA 15)

4.3.1.3 Referral of suspected Hepatitis B-infected pregnant mothers and fresh mothers to the hospital

TBAs in Prampram focused on observable signs to identify people living with Hep. B. The disease (Hepatitis B) is typically referred to as "jaundice", "yellow fever", or "ebun". Additionally, they recognize it by its symptoms, which include yellowing of the palm, eyes, soles, lips, tongues, and generalised oedema. In an effort to prevent mother-to-child transmission, TBAs in Prampram demonstrated the attitude of referring pregnant women showing signs of Hepatitis B infection to the hospital. On some occasions, TBAs accompanied the pregnant women to see a midwife at the Prampram Polyclinic for further assistance.

They claimed that a small cord, greenish or yellowish skin colour, is an indicator of Hepatitis B infection, and these signs could be visible on new-borns. Two TBAs affirmed that they are able to recognize it by the red pen indication in their ANC maternal health record booklet. Pregnant women who have been tested and already knew about their status told the TBAs:

"Before the baby comes out, I do my inspection to make sure that Baby is not having any yellow colour of skin or cord before I allow mother to get closer to the baby. I sometimes escort the mother together with the baby to the hospital. There was a time I sent

a woman to the Hospital where I had to be with the mother and baby till they were discharged... Since then, any pregnant mother with such symptoms is quickly referred to the hospital by me.” (TBA 1).

“As I said when I was in Akosombo, that time there was no hospital so I boil herbs for them to drink them they will urinate all the jaundice from their body but here, we have hospital so the moment I see sign of jaundice I send you straight to hospital.” (TBA 13).

“...some clients who had the condition told me themselves that they have been diagnosed of Hepatitis B and been asked to deliver at the hospital and pay for vaccines for the baby but due to financial constraints, they fail to go. So, after delivery I send them to the hospital to be cared for”. (TBA 7)

4.3.1.4 Delayed initiation of breastfeeding of neonates to prevent MTCT of Hepatitis B

In order to prevent MTCT of Hepatitis B, TBAs in Prampram delayed initiation of breastfeeding to the infant. They prevent newly delivered mothers who had jaundice, symptoms of infection, or Hepatitis B, popularly known as yellow fever, from nursing their babies until they refer and accompany them to see a doctor. In some instances, TBAs have to keep the new-borns by themselves overnight if she suspects any infection or sees any sign of jaundice. In some cases, the colour of the breast milk is used to detect Hepatitis B infection. Some of the TBAs were aware of the fact that if infants born to mothers with HBV are vaccinated, the risk of HBV transmission through breastfeeding is minimal. Some of these respondents suggested that delaying breastfeeding until the baby has received all of the recommended vaccinations is necessary.

“you see every baby have something in the throat that I removed first after which I give the baby glucose and wait 24 hours for the breast to be full before breastfeeding, so I delay breastfeeding”. (TBA 17).

“So, when we deliver a mother with the Hepatitis B infection, we advise that she does not breastfeed the baby until she has been vaccinated and permitted by health professionals to begin breastfeeding”. (TBA 6).

4.3.1.5 Administration of herbal and indigenous therapies to prevent MTCT of Hepatitis B

According to the study’s respondents, spirituality is "caught" in practice rather than "taught". In essence, TBAs spiritual awareness develops naturally via exposure and experience. In their delivery, for instance, formal education and curriculum integration are not necessary. From their responses, TBAs attribute a lot of occurrences to deities and spirits including disease transmission. To prevent MTCT of Hepatitis B, several TBAs in Prampram prescribed a ‘concoction’ and other traditional treatments to their clients. Some of them believed that by providing their sick clients or those who show signs of jaundice herbal preparations, the Hepatitis B infection or jaundice would be flushed out of their system through urination. A small number of TBAs who also happened to be prophetesses claimed to have sought spiritual guidance and prayer in order to receive guidance over the kind of herbs to use.

“We give them some herbal preparations sometimes but greatly relies on the orthodox medications since the manufacturers have much knowledge about the condition”. (TBA 3)

“So for some TBAs, they send Hepatitis B clients to the hospital. But for me, I tackle every condition with my herbal preparation and spiritual guidance through prayers”. (TBA 11)

4.4 Subjective Norms that Influenced TBAs Practices towards Hepatitis B and Prevention of MTCT

The practices of TBAs in preventing MTCT of Hepatitis B is impacted by subjective norms. Pregnant women, families, the society at large, and significant others' opinions coupled with the confidence on TBAs' capacity to prevent MTCT of Hepatitis B were among these factors. The study revealed two sub-themes: (1) Self-styled practice to please God and society; and (2) Passion to save life and gain recognition.

4.4.1 Perception and Beliefs of Hepatitis B and MTCT Prevention

Some TBAs stated that their methods for preventing MTCT of Hepatitis B were unique to them and does not follow another person's procedures. Some of them believed that they were performing their duties in order to satisfy God, who had given them the skill and meet society expectation, protect the lives and future of the children, and eventually boost society's confidence in them.

They do all of those things because of the love for the babies and humanity as a whole. TBAs' motivation to prevent mother-to-child transmission is to show kindness to pregnant women and their babies, especially those that are financially challenged. Most importantly, to please God since the skill acquired is a God-given gift, and it was their duty to perform PMTCT Hep. B well in order to satisfy him. Other TBAs in Prampram saw themselves as a source of hope and confidence for society, thus they had no option than to fulfil their mandate with diligence in order to preserve the faith and confidence that society had placed in them. Some of them clarified that they practiced in their own way because, given that they were being watched by their society, they believed that performing well would increase the women's confidence in them as well. According to two TBAs, society's faith and trust in them had an impact on their MTCT practices:

“...but the fact that different people gifted with this TBA skill have different ways of going about their PMTCT things”. (TBA 11)

“That is what God called me to do. Mercy and kindness to the people, because if you turn them away, and something happens to them, you cannot forgive yourself and people will lose confidence in you. God will also not be happy because He gave you the gift to help mankind in PMTCT of Hepatitis B. Sometimes after you have suffered for them, they won't even pay you. But you did it for God and baby's future then get a good name”. (TBA 9)

4.4.2 Compassion for New-born PMTCT and Protection of their Future

TBAs in Prampram stated that their desire to preserve the lives of the baby served as the driving force behind their MTCT preventive measures for Hepatitis B. They understood that if nothing else, children are the world's future and should be protected in order to survive. The kind of compassion and zeal to save life is a whole motivation to some TBAs in Prampram. Seeking for protection and vaccination for all mothers and babies cannot be underemphasised according to them. They feel it is the core mandate as the future of the babies is unknown.

“Okay, I do all of that delivery services in PMTCT as an act of kindness because the mother usually complain of lack of finances to foot hospital bills. Moreover, I find it fulfilling to save both mother as well as baby after delivery”. (TBA 7)

“Okay, thank you. The reason why I try to prevent MTCT of infection is that it will be waste of time to help deliver a baby and later hear that he / she died suddenly or had some chronic condition which could have been avoided”. (TBA 10)

4.5 Factors that Control TBAs' Preventive Practices (Perceived Behavioural Control) towards MTCT of Hepatitis B

Any factors that promote or hampered TBAs' MTCT of Hepatitis B practices is considered a perceived behavioural control. These factors fall into internal categories, such as willingness to prevent MTCT, skill, and knowledge of the TBA on Hepatitis B infection. Additionally, there are external factors, such as logistical accessibility, acknowledgement and acceptance of TBA's procedures, and Hepatitis B monitoring and training initiatives.

Four sub-themes emerged for this construct: (1) Need for delivery equipment; (2) Supervised skill training; (3) Some knowledge on Hepatitis B; and (4) Poor knowledge on Hepatitis B.

4.5.1 Need for Delivery Equipment

One of the most important concerns was the availability of personal protective equipment (PPE). TBAs in Prampram acknowledged that they would need assistance in various forms. It can be delivery equipment, financial support, and other supplies because they encountered numerous obstacles in their work, including rejection, witch hunts, and a shortage of money and equipment. Since some mothers do not pay for their services, some TBAs absolutely stated having difficulties in purchasing protective gear and basic logistics.

“Yes, I really need some equipment like bed, gloves, scissors, cord clump, rubber mackintosh, delivery mat, soap, towel and detergent”. (TBA 8)

“Oh, we face a lot of challenges because we buy a lot of the equipment we use with our own monies. For instance, gloves, face masks, soaps, detol, are being bought with our own monies. The clients sometimes don't even pay a dime”. (TBA 10)

4.5.2 Supervised Skills Training

Only one TBA attended MTCT HIV/AIDS with minimal Hepatitis B knowledge, but other TBAs

participated in supervised skill trainings to equip themselves with different preventive practices and delivery approaches. Few TBAs confirmed to have been receiving calls to attend these trainings not on Hepatitis B alone but many things. They sometimes prompt midwives occasionally to inform them on these kinds of available programs. However, some did not have the opportunity to attend trainings on MTCT of Hepatitis B. Most TBAs, however, were unable to attend any MTCT of Hepatitis B trainings. With the hope that they would also participate in some of these trainings, they lamented the dearth of skill training and monitoring on MTCT prevention of Hepatitis B.

“Yes, I believe I am capable. This is because, I have been trained that if you encounter an HIV positive client during delivery, the most important part is to protect the baby and myself as a TBA from coming into contact with the blood”. (TBA 7)

“I attended the training done at Effia Nkwanta. There was an elderly person from New Site who said the money we accumulate is what was going to be used to help out with the work”. (TBA 18)

“No, I have never had any training in that regard. Absolutely no training at all... I lack training and other working equipment like gloves to conduct the delivery. Usually when they call for training, it is my mother that goes. So I will say I haven't had any training about Hepatitis B before”. (TBA 6)

4.5.3 Some Knowledge on Hepatitis B

A few TBAs in Prampram showed some knowledge on Hepatitis B, but they were unable to recognize it by its name; instead, they used terms like "fever", "jaundice", "yellow fever", or "Ebun". Their MTCT preventive methods for Hep. B may have been impacted by their thorough explanation of its presentation, causes and risk factors, mode of transmission, and effects on

humans.

TBAs were aware that this disease is blood-borne and would not risk it or take it for granted. They further stated that the adverse effect of Hepatitis B infection included damage to the organs in the body especially liver causing the swollen of feet, shiny abdomen, etc.

“What I know about the disease is that when someone contracts it, the liver will be damaged and yellowing of the eye.... Sometime ago, we were told that Hepatitis B can be likened to HIV/AIDS. Hence, it can be transmitted through sexual intercourse, through direct contact with sweats from an infected person, sharing clothes that are wet with sweat from an infected person, engaging in French kiss and through blood and fluids from sharing sharps with an infected person”. (TBA 7)

“Hepatitis B is not a spiritual disease, but a disease that can be transmitted through blood and bodily fluids. So, when we find someone with that disease, we must allow the doctors to take care of them and prescribe the right medications so that the life of the baby will be preserved”. (TBA 10)

4.5.4 Poor Knowledge on Hepatitis B

The majority of TBAs in Prampram showed a lack of knowledge on Hepatitis B, which would have influenced how they handled MTCT for Hep. B. Hepatitis B was described to be caused differently by some TBAs, while others saw it as a spiritual illness that they managed spiritually via fasting and prayer. Some TBAs related Hepatitis B for presentations and unrelated reasons. They defined Hepatitis B as an airborne illness, poor eating habits, filthy surroundings, and vectors like mosquitoes and worms as its cause.

“Firstly, when you are not kept clean. Secondly, eating in public may cause stale air to contaminate the food. Thirdly, leaving your bowl of food on the floor. You will start experiencing some signs like abdominal pains and sometimes a greenish vaginal discharge” (TBA 2).

“It is an air born disease, the wind that blows carry a lot of germs, mosquitoes can also cause, this jaundice... even the small, small worms can transmit it. I also believe that evil eye can also plague as well as it can be sprinkled on you and you can be cursed with it, but it all goes into your blood” (TBA 5)

Some TBAs in Prampram linked Hepatitis B to spiritual attacks like witchcraft transactions and curses and spells ("Ábonsan yare3). Some TBAs stated that they did not believe in the Hepatitis B vaccine since, to them, it is spiritual and should be treated as such. Some also related it to curses from family or other people.

It is also known as ‘Abosam yare3’. Meaning that it’s demonic sickness” if someone does not like you, he or she can plague you with it. And when you are about to die, your feet, lips, palm and eyes become yellow and pale. (TBA 9)

“It is a deadly and scary spiritual and physical disease; it can kill you in no time. They can plant it in meat, oily foods, some sugars and many more, when they are looking for you to kill you and they get chance they plague you with it but the doctors have to help us TBAs at home because we don’t know much and we are vulnerable but we are practicing with some form of ignorance that is why it is important to involve us to manage it to help us learn”. (TBA 14)

4.6 Summary

The study revealed varied practices of TBAs in Prampram on preventing MTCT of Hepatitis B. This included appropriate use of protective gear, referral of pregnant women and their babies to hospital for proper management, administration of herbal preparations, postponing breastfeeding, and additional care. TBAs' practices in preventing MTCT of Hepatitis in Prampram are influenced by their personal beliefs, confidence, and expectations, which are influenced by their inner satisfaction with their strategies. TBA's MTCT practices on Hepatitis B were effective due to their understanding of prevention and actions. However, limitations included inadequate knowledge, logistical issues, and lack of acceptance, training and monitoring.



CHAPTER FIVE

DISCUSSION

This study explored Traditional Birth Attendants (TBAs) practices towards prevention of mother to child transmission (MTCT) of Hepatitis B (Hep. B) in Prampram sub-district. The study assessed TBAs attitudes and beliefs towards Hep. B MTCT prevention, subjective norms that influence TBAs practices towards MTCT prevention and practices adopted by TBAs towards prevention of MTCT of Hep. B. A reflective thematic analysis approach was adopted to analyse the data. The TBAs in Prampram applied different measures towards the prevention of MTCT of Hepatitis B: these measures were influenced by different factors, both internal and external.

Traditional birth attendants displayed the attitude of using protective equipment and Hepatitis B vaccines to protect themselves and their clients; while referring Hepatitis B infected pregnant women and their new-born babies to the hospital towards prevention of mother-to-child transmission. This attitude of referring Hep. B infected pregnant women or puerperal women to the hospital for further management is a good attitude and can help prevent MTCT of Hep. B. This attitude has the potential of enabling healthcare professionals at respective hospital to implement MTCT Hep. B prevention protocols for neonates (WHO, 2024) only if referrals are initiated and received within 24 hours after delivery. This attitude differs from what was reported in earlier research (Chizoba et al., 2020; Onyiapat, 2024) where TBAs had the attitude of not referring perinatal women with infections such as HIV for medical care.

Traditional birth attendants delayed initiation of breastfeeding and gave concoctions to prevent MTCT of Hepatitis B. These practices are not well-documented preventative practices for MTCT of Hepatitis B, and could therefore endanger the life of the new-born. According to current

recommendations, prenatal testing, antiviral medication during the third trimester of high-risk pregnancies, a timely and universal HBV birth-dose vaccine, and post-exposure prophylaxis with Hepatitis B immunoglobulin (HBIG) for certain new-borns should all be done (Veronese et al., 2021). The WHO recommends, as a matter of policy, that all babies should be given Hepatitis B vaccine as soon as possible within 24 hours after birth (WHO, 2024; Adjei, 2024), and should be followed by two or three doses of Hep. B vaccines at four weeks' interval at least (WHO, 2024). In instances where these recommendations cannot be met, two alternatives, namely delivery by a caesarean session and “avoidance of breastfeeding”, have been suggested for mothers with a high viral load (Pan, Jia, Wu, Lv & Jiang, 2022; Sintusek et al., 2023). However, it is cautioned that despite the effectiveness of these alternatives, the safety of the new-born and the cost of the strategy must be considered when choosing them (Sintusek, Wanlapakon & Poovorawan, 2022) so that the safety of the new-born is not negatively affected.

Traditional birth attendants in Prampram used protective equipment such as gloves and polythene bags when conducting delivery. This attitude of using protective equipment is a highly recommended practice towards infection prevention (Centers for Disease Prevention and Control, 2024; UK Health Security Agency, 2024). However, it is not one of the recommended approaches for the prevention of MTCT of Hepatitis B that have been outlined in literature (WHO, 2024; Adjei, 2024), and is therefore not likely to achieve the goal of preventing MTCT of Hepatitis B.

The administration of concoctions and use of protective equipment, although it may be useful for other purposes, implies that generally, the TBAs in Prampram did not have any good practice towards prevention of MTCT of Hep. B. This finding is similar to an earlier study and aligns with typical practice of TBAs, which research has established to be associated with the use of

concoctions to treat medical conditions in perinatal women (Esan et al., 2023).

According to the Theory of Planned Behaviour's model, subjective norms in the society might have a significant influence on TBAs' attitudes towards PMTCT of HBV. The study revealed that their practices were influenced by the desire to please God, meet society's expectation, gain society's trust and a general compassion to save children's lives. This suggests that TBAs' practices are largely influenced by religious and traditional or cultural factors of the society. This explains why their practices, such as delayed initiation of breastfeeding and use of concoctions, do not align with PMTCT of HBV recommendations. It also clarifies why TBAs' practices are dented with inefficiencies, as their beliefs about their practices are not rooted in science.

The traditional birth attendants (TBAs) in Prampram acknowledged that their work was full of challenges, and therefore called for support. They acknowledge challenges such as lack of protective equipment and other logistics and lack of training on Hepatitis B, among others. This finding of TBAs facing challenges with their work is not in isolation from other findings that established that the work of TBAs was faced with many challenges such as inadequacy of logistics (Kassie et al., 2022), discrimination from mainstream healthcare professionals and governments (Gurara et al., 2020; Musie et al., 2022; Esan et al., 2023). These challenges could negatively affect their practices towards prevention of MTCT of Hepatitis B, therefore, requiring appropriate interventions to protect babies of infected mothers. The challenges might also explain why TBAs rely on religion and traditional methods when providing services to pregnant women.

Some TBAs displayed good knowledge on Hepatitis B with few having good knowledge about Hepatitis B infection. The respondents acknowledged that it is a physical, blood-borne disease,

and identified some of its risk factors, signs and symptoms, and effects. This good knowledge displayed by the TBAs is likely to influence them to elicit good approach towards the prevention of MTCT of Hepatitis B as was revealed by earlier studies. Some studies revealed that good knowledge on Hepatitis B influences attitudes towards Hepatitis B prevention such as testing or screening for Hepatitis B among certain populations (Adjei et al., 2022; Dwiartama et al., 2022; Larebo et al., 2024; Statiri et al., 2024).



CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Summary

The findings of this study are summarised as follows:

1. The majority of traditional birth attendants at Prampram displayed the attitude of referring pregnant women and new-born mothers with Hepatitis B to the health facilities for further management, and delaying initiation of breastfeeding of the new-born towards prevention of MTCT of Hepatitis B. However, some of them displayed the attitude of rather giving concoctions towards prevention of MTCT of Hepatitis B.
2. TBAs MTCT prevention practices were influenced by their passion to save lives of new-born and their mothers to please God and society and to gain recognition.
3. TBAs' MTCT prevention practices were controlled by challenges such as lack of protective equipment and other logistics, knowledge on Hepatitis B. and supervised training on Hepatitis B.

6.2 Conclusion

The study concludes that TBAs generally displayed a good attitude towards MTCT prevention of Hepatitis B, such that the majority of them referred Hepatitis B suspected cases to recognised health facilities for management, and prevented infected mothers from breastfeeding their new-born while they had not yet gone to the hospital. However, several factors make their practices towards prevention of mother-to-child transmission ineffective. This therefore calls for more research into the practice needs of TBAs to identify key areas to tackle for improvement.

6.3 Recommendations

The study's conclusions lead to the following suggestions being given to Ghana's Ministry of Health, Ghana Health Services, and the Ningo-Prampram District.

6.3.1 Ministry of Health, Ghana

The Ministry of Health should;

1. Increase Hepatitis B education for Traditional Birth Attendance by working with other Ghanaian organizations to raise awareness of the endemic
2. Ensuring Hepatitis B vaccination before practice should be made a mandatory policy for TBAs before they are allowed to care for pregnant women.
3. Provide Hepatitis B vaccine and testing subsidies by working with pharmaceutical companies and other health agencies.
4. Create a tracking mechanism that enables the Ministry of Health to check the services of TBAs
5. Fund and assist research pertaining to Hepatitis B and the work of TBAs.
6. Establish national guidelines, standards and protocols for becoming a TBA to ensure proper monitoring of their activities particularly on the prevention of Hepatitis B-infection and mother to child transmission.
7. Units should be assigned to handle Hepatitis B activities.

6.3.2 Ghana Health Services (GHS)

The Ghana Health Service should;

1. Offer TBAs a skill development program that focuses on PMTCT and HBV.
2. As with HIV, empower TBAs to screen for HBV as part of their prenatal care.

3. TBAs should be guided on how to identify and keep records of Hepatitis B infected persons.
4. TBAs should be directed to create data on Hepatitis B immunization doses at birth.
5. Ensure that TBAs compile and submit a report to the Prampram polyclinics after each delivery.

This will make it possible to track the district's and Ghana's HBV prevalence.

6. Ensure that HBV protocols are accessible to TBAs.

6.3.3 Ningo-Prampram Health Directorate of the Sub-District

The Prampram Health Directorate should;

1. Keep proper records of TBAs in the Prampram sub-district;
2. Provide training on viral Hepatitis B to all TBAs;
3. Enrol all TBAs in a skill development course targeted towards HBV PMTCT;
4. Verify that all TBAs have had the HBV vaccine free of charge to prevent them from infecting clients;
5. Communicate with the relevant centres to guarantee that the HBV vaccine is always available in the health facilities where referrals are made by TBAs;
6. Make sure that the clinic's public health unit helps TBAs learn about Hepatitis B to practice MTCT prevention effectively;
7. Create a structured outreach campaign to vaccinate infants born outside the facilities in coordination with the public health unit;
8. Ensure that resources like test kits are always available;
9. Ensure that TBAs in Prampram have adequate protective resources to enhance their PMTCT practices.

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APPENDIX I: CONSENT FORM

NMIMR-IRB CONSENT FORM TEMPLATE

Title: EXPLORING TRADITIONAL BIRTH ATTENDANTS' PRACTICES TOWARDS PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HEPATITIS B IN THE PRAMPARAM SUB-DISTRICT

Principal Investigator: Veronica Martey

Address: University of Ghana, School of Nursing and Midwifery, Department of Public Health Nursing, SONM P. O. Box 16 UG, 0542434180,
vmartey002@st.ug.edu.gh

General Information about Research

This study aims to explore and understand traditional birth attendants' practices towards prevention of mother-to-child transmission of hepatitis B. Your consent is being sought for this important study and your response is very important in helping us understand those factors in Prampram sub- district of Ghana. By responding honestly to this interview guide, this research will help healthcare workers as well as policy makers to provide the needed help in the district to improve the care rendered by you with regards to hepatitis B transmission. Your identity and responses including your personal hepatitis B status will be kept hidden from all other people. The exercise will take away about 30 to 45 minutes of your time. You can decide to take part in this research or not without your decision affecting maternity care anyway in this community. Your precious understandings will help improve on the prevention of mother-to- child transmission of hepatitis B. Please cooperate with me during the data collection process. Lastly, you will be required to sign or thumbprint on the consent form to show that you have fully consented to your participation. Thank you.

Possible Risks and Discomforts

The study procedure will not involve any physical, social, and psychological risks to participants. However, there may be inconveniences due to work schedule of the respondents, for this reason, the researcher intends to make the data collection time per respondent at their own convenience and as brief as possible.



Possible Benefits

There will be no direct benefits to participants from this study. However, their participation will help in exploring traditional birth attendants' practices towards prevention of mother-to-child transmission of hepatitis B. Again, it will also inform policies on health care by the government and non-governmental organization to put measures in place to prevent mother-to-child transmission of hepatitis B.

Confidentiality

The researcher will protect all information about you at all costs. The researcher will hold in strict confidence, any information he collects from you. Your name will not appear or be mentioned in any reports. Only appropriate codes or codes will be used to represent you for identification purpose; this will help to protect your identity more. Privacy will be provided for you during the data collection. The researcher assures you that any information given out during the study will be utilized only for the research. Only 2 members (who are my supervisor) may sometimes look at the data.

Compensation

Each participant will be compensated with a bar of key soap valued at GHC 20.00. A person qualifies for this package after signing the consent form and answering all questions on the interview guide. The compensation will be given immediately after data has been collection from the participant.

Additional Cost

There will be no cost incurred by participants in this study since participants will be studied at their own homes.

Voluntary Participation and Right to Leave the Research

Participation in this study is voluntary and participants can withdraw from the study at any point in time without any consequences to the participants.

Notification of Significant New Findings

The findings of this study will not be shared directly with participants, but it will be shared with the selected health sectors, published in the ug space and peer review journal

Contacts for Additional Information



You can contact the researcher, Veronica Martey on the contacts (0244960423) or through the email voseimart@gmail.com if you want to know more or have any concerns about the research.

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant, you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses:

nirb@noguchi.ug.edu.gh

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title exploring traditional birth attendants' practices towards prevention of mother-to-child transmission of hepatitis B in the Prampram sub-district has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name and signature of person who obtained consent



APPENDIX II: INTERVIEW GUIDE

Participant Code _____

Date and time of Interview _____

Interview Number _____ (1st or 2nd Round) _____

Duration _____

DEMOGRAPHIC DATA

Please can you tell me about yourself?

Probes: Name, age, educational level, category of TBA, years of experience, mode of training, religious affiliation, marital status.

Attitudes and Beliefs about Hep B

1. How do you care for pregnant women until they deliver?

Probe (ANC, labour, postnatal, relationship, services)

2. Can you describe the very first time you came into contact with a hepatitis B patient?

Probe (e.g., What did you do for her: counselled, referred, treated?)

3. How do you and your colleague TBAs treat Hepatitis B patients?

Probe (e.g., give herbal preparation, prayer, and incantations, change delivery position)

4. What is your experience in working with women who have hepatitis B?

Probes (How do you determine if they have the infection? How do you care for them during ANC, labour, care after delivery?)

5. Describe the number of times you engage in practices that prevent mother-to-child transmission of Hepatitis B.

5. In your work as a TBA you are exposed to lots of blood and body fluid, what measures do you employ to prevent spreading infections

Probes: (Self-protection, protection of mother, protection of baby, immunization)



Subjective norms towards prevention of mother-to-child transmission of HBV

1. Tell me what you know about Hepatitis B?

Probes (What is hepatitis B, what causes, how is it transmitted, how can it be prevented, how is it managed, what happens if it is not treated? (e.g., perceived transmission, perceived severity because of the norm of punishment from gods, curses, or a particular food intake).

2. What are your concerns as a TBA on Hepatitis B?

Probe (e.g. risk factors or predisposing factors)

3. Can you describe your thoughts about Hepatitis B immunisations?

Probe: (Is safe, effective, costly, harmful)

4. Please tell me about the measures you in place to prevent mother-to-child transmission of Hepatitis B.

5. What makes you do those things that you do?

Probe: (belief to please gods and society, they are what other people say or do, they are standards)

6. Do you see yourself as more skilful personnel in terms of knowledge and ability to ensure PMTCT of Hepatitis B? Please give more examples

Perceived Behavioral Control

1. As a practising TBA, have you had any training on the PMTCT of Hep. B? If yes, what does it comprise?

2. Why is it important for TBAs to prevent mother-to-child transmission of Hepatitis B?

3. As a TBA, do you have any challenges when managing Hepatitis B-positive women and their babies?

Probes (Training, Equipment, and access to the maternity ward)

4. Tell me about your HBV status.

5. What do you know about HBV vaccination?



6. How many doses of HBV vaccine have you taken?

7. If no, why?_

Probe (e.g., cost, no times, no reason, no knowledge of vaccine available





**UNIVERSITY
OF GHANA**

**NOGUCHI MEMORIAL INSTITUTE
FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES
INSTITUTIONAL REVIEW BOARD**

13th March 2024

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 00001276

NMIMR-IRB CPN 070/23-24

IORG 0000908

On 13th March 2024, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) conducted a full board meeting review and approved your protocol titled:

TITLE OF PROTOCOL : Exploring Traditional Birth Attendants Practices Towards Prevention Of Mother Child Transmission Of Hepatitis B In the Prampram Sub- District

PRINCIPAL INVESTIGATOR : Veronica Martey

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 12th March 2025. You are to submit annual reports for continuing review.

Signature of Chair:

Dr. Abraham Hodgson
(NMIMR – IRB CHAIR)



**UNIVERSITY
OF GHANA**

**NOGUCHI MEMORIAL INSTITUTE
FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES
INSTITUTIONAL REVIEW BOARD**

My Reference: DF 22

08/07/2024

Veronica Martey

**RE: Cur Study # 070-23-24
RESEARCH-IRB**

At: NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL

Dear Martey:

**Meeting Date: March 13, 2024
RESEARCH-IRB**

At: NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL

Protocol Title:

Traditional Birth Attendants' practices toward prevention of Mother-to-Child transmission of Hepatitis B in the Prampram Sub-District

This is to advise you that the above referenced Study has been presented to the Institutional Review Board, and the following action taken subject to the conditions and explanation provided below.

Internal #: New Appl
Expiration Date: March 12, 2025
On Agenda For: Initial Submission
Reason 1:
Date Received - 02/27/2024
IRB ACTION: Approved
Condition 1:
Action

Reason 2:

The protocol is duly approved.

Yours Sincerely,

NMIMR-IRB Administrator

