WOMEN'S EXPERIENCES OF HOSPITAL DELIVERY AT CHIRADZULU DISTRICT HOSPITAL, MALAWI

Msc (Midwifery) Thesis

By

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Declaration

I, Colette Phiri Kabango, hereby declare that this study is a true reflection of my work, and has not been submitted for a degree at any other institution of higher learning. Acknowledgement has been done where other people's work has been used.

Colette Phiri Kabango

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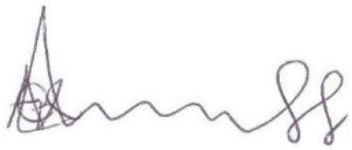
Legal full name



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Date

Certificate of Approval

We, hereby certify that this study is Colette Phiri Kabango's own work and effort, and has been submitted with our approval.

Signature ……. Date……

Lucy Ida Kululanga, PhD, RNM (Senior Lecturer)

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Dedication

This dissertation is dedicated to my husband, Owen Thoko, for his love, support and contributions. To my father Francis Simon, my late mother Vera and my sisters Priscilla and Lynn, for their encouragement and support throughout my academic journey.

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Abstract

The number of pregnant women who fall ill and die due to pregnancy related complications is rising each year. In response to this, skilled birth attendance was identified by the United Nations as an indicator for monitoring progress of Millennium Development Goal number five, that could be used to assist in lowering maternal and neonatal morbidity and mortality. However, evidence has shown that other women are giving birth away from Chiradzulu District Hospital where skilled birth attendants are available.

This study aimed to explore child birth experiences of women who delivered at the health facility in order to develop informed midwifery interventions that will motivate women to give birth at a health facility. A descriptive qualitative research method was used. The target group was postnatal women who had delivered normally and had stayed at the health facility for not more than 48 hours. A total of 20 participants were recruited for the study using purposive sampling method. Qualitative data was collected through in-depth interviews using a semi-structured interview guide and the interviews were audio recorded.

Data were analysed using thematic analysis. The following themes were identified; perceptions of health facility care, satisfaction with health facility care and expectations of health facility care. There is need to develop operational interventions that would address pregnant women's needs at the health facility in order to increase its utilization for maternity services.

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List of Acronyms and Abbreviations

ANC	Antenatal care
COMREC	College of Medicine Research and Ethics Committee
DHO	District Health Office
EmONC	Emergency Obstetric and Neonatal Care
FANC	Focused Antenatal Care
ICF	Intermediate Care Facility
NSO	National Statistics Office
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Operational Definitions

Skilled birth attendants – Accredited health professionals such as nurses, midwives or doctors equipped with the necessary knowledge and skills to manage both uncomplicated and complicated maternity cases ("WHO | Skilled birth attendants," 2017).

Experience – The process of getting knowledge that is obtained from doing, seeing or feeling things, or something that happens which has an effect on you ("Experience Definition in the Cambridge English Dictionary," 2017)

Chapter 1

Introduction and Background

Introduction

About 800 women die each day globally from pregnancy and child birth related causes and 99% of these deaths occur in developing countries with more than 50% occurring in Sub Saharan Africa (WHO, 2014). Maternal and neonatal mortalities as well as child birth complications could be lowered if women gave birth in health institutions (Hagos et al., 2014). Both mortalities have been reported lower in countries where skilled birth attendants are present at every birth, thereby supporting the significance of having women to give birth in health institutions. Maternal mortality in the industrialised world was reduced by half in the early 1900's through professional midwifery care provision and improvement in access to health facilities (Ronsmans, Graham, group, & others, 2006). Skilled birth attendance was identified as an indicator for monitoring progress of maternal health to achieve Millennium Development Goal (MDG) number five (UN, 2005). However, when the initiative of the MDGs came to an end and was reviewed in 2015, the global maternal mortality ratio in the developing regions of the world was still 14 times higher than that of the developed regions of the world. In September, 2015 a new set of broader goals called the Sustainable Development Goals (SDGs) which were built on the successes of the MDGs were agreed upon and came into effect in January, 2016 (UNDP, 2017). There are 17 SDGs in total where SDG 3.1's target is to reduce the

global maternal mortality ratio to less than 70 per 100,000 live births by 2030 (Nino, 2016).

In Malawi, the maternal mortality ratio is high at 675/100,000 live births, as compared to other countries in the developed regions of the world. The proportion of women who attend the antenatal clinic for at least one visit is at 97.6% (National Statistics Office [NSO] & Intermediate Care Facility [ICF] Macro, 2011). The proportion of these pregnant women who seek health facility delivery by skilled birth attendants has risen from 71.4% (NSO & ICF Macro, 2011) to 90 % in five years (NSO & ICF International, 2016). However, these figures show that a certain proportion of pregnant women still give birth away from health facilities. Furthermore, some of the reasons that women give for not seeking health facility delivery include onset of labour in the middle of the night, precipitated labour, community factors and poor health workers' attitudes (Kumbani, Bjune, Chirwa, Malata, & Odland, 2013). There is evidence that health care worker knowledge about labouring women's needs and values would lead to improvements in the provision of quality maternity care services at the health facility, consequently leading to positive child birth experiences (Iravani, Zarean, Janghorbani, & Bahrami, 2015). At Chiradzulu District Hospital, no study has been conducted to identify women's perspectives about health facility child birth. This study aimed to explore the experiences of women who chose Chiradzulu District Hospital as a health facility for their delivery; in order to learn from their experiences and improve midwifery care.

Background

Pregnant women have been attended to by female traditional midwives during labour and delivery since ancient times and by 1960, most births occurred in the health

facility (McKune, 2011). Increasing the number of skilled attendance at birth is one of the strategies aimed to reduce maternal and neonatal morbidity and mortality (Safer, 2004). Maternal and neonatal deaths have been a great challenge worldwide. In European countries such as the Netherlands, Norway and Sweden, low maternal mortality rates were reported in the early 20th century. This was a result of collaborative efforts between physicians and midwives in the provision of obstetric and midwifery care (Högberg, 2004). Similarly, in Asia, maternal mortality ratios for Malaysia, Sri Lanka and Thailand were reduced by half within 10 years due to the increase in number of midwifery and medical professionals, provision of free health care services and improvement in the referral system (Ronsmans et al., 2006). In 1987, the Safe Motherhood Initiative was launched by the WHO in order to reduce maternal morbidity and mortality by 50% by the year 2000. However, Mothers are still dying in large numbers in the developing world (Islam, 2007).

Globally about 286,000 maternal deaths occur every year in the developing countries and Sub-Saharan Africa accounts for 62% of these deaths (WHO, UNICEF, UNFPA, The World Bank, & United Nations Population Division, 2014). In Malawi, the maternal mortality ratio is 675/100,000 live births. One of the strategies for prevention of maternal mortality and morbidity is to increase the number of births attended by skilled birth attendants in Sub-Saharan Africa (WHO, 2005). In the health care facility, pregnant women are cared for by skilled birth attendants; midwives and doctors for example, who are specialised in taking care of them. Commonly, midwives are the primary providers of maternity services to most of the women in the child bearing age in Malawi (Kafulafula, Hami, & Chodzaza, 2005).

According to National Statistical Office (NSO) & ICF Macro, (2011), 28.6% of women do not use the health facility for child birth despite a high antenatal clinic attendance and there is evidence that as the number of children a woman has had increases, the utilisation of a health facility for delivery decreases. Additionally, Chirwa, Malata, & Maluwa, (2013), implemented a Focused Antenatal Care (FANC) intervention at Chiradzulu District Hospital. Of the 600 women who were recruited in the study in 2012 and completed their antenatal clinic visits, an average of 91.95% gave birth at the health facility, 0.4% at the traditional birth attendant, 5% on their way to the hospital and 3.7% in their homes. Sixty-three women were lost to follow up and their place of child birth was unknown. It is therefore evident that a proportion of women still gave birth outside the health facility despite the intervention that was put in place.

Studies conducted both internationally and nationally have reflected various reasons that prevent women from giving birth at a health facility. For example; in Malawi and in other developing countries lack of access to health facilities either due to long distance or unreliable transport facilities prevented women from reaching the health facility in time for delivery. (Alemayehu & Mekonnen, 2015; Chanza, Chirwa, Maluwa, Malata, & Masache, 2012; Essendi, Mills, & Fotso, 2010 & Montagu, Yamey, Visconti, Harding, & Yoong, 2011).Traveling to the health facility was more difficult or made worse during the rainy season since most of the roads were damaged and at times impassable (Kumbani, Bjune, Chirwa, Malata, & Odland, 2013). Timing of the onset of labour especially during the night prevented women from seeking health facility deliveries since they felt insecure to travel from their homes (Essendi et al., 2010 & Kumbani et al., 2013). In addition, if labour started during the day and it was a precipitate

one, women failed to make it to the health facility in time for delivery (Kumbani et al. 2013) .

Social cultural factors also played a role in preventing women from using the health facility for delivery (Kumbani et al. 2013). Women who did not have the opportunity to be assisted financially by their husbands and significant others during their hospital stay and those that perceived health services to be costly were less likely to opt for the health facility for delivery (Chanza et al., 2012; Essendi et al., 2010 & Montagu et al., 2011) as such they delivered at home. At times there were delays in health decision making by the pregnant woman or other influential decision makers in the family such as uncles and husbands because they were unable to recognise danger signs of pregnancy early so as to send the woman to the health facility in time (Essendi et al., 2010). Similarly, when a health facility delivery was seen to be unnecessary by a family decision maker, the woman would stay and deliver at home (Montagu et al., 2011). Furthermore, women who expected to undergo a smooth delivery did not think it was necessary to deliver at a health facility (Alemayehu & Mekonnen, 2015). Poor attitudes of health care workers towards labouring women prevented pregnant women from using the health facility for delivery. As a result they opted for the traditional birth attendant or the home for delivery (Chanza et al., 2012; Essendi et al., 2010 & Kumbani et al., 2013). Other women complained of poorly equipped health facilities in their locality which made it inappropriate for them to deliver at a health facility (Essendi et al., 2010).

A study to explore women's perceptions of child birth at a health facility was conducted in Tanzania by Shimpuku, Patil, Norr, & Hill, (2013) where twenty-five women underwent in-depth interviews and the main findings were that women preferred

the health facility from their home for child birth because it offered technological support in the event that a complication arose. Such support included medical equipment, personnel, surgery, injection to prevent bleeding and treatment of other obstetric complications. Furthermore, provision of care and support from family members was valued by most women who were included in the study. However, a few women did not have family support during labour and delivery such as escort to the health facility, that is, someone to cook or bring food for them during their stay at the health facility, while others complained of the lack of attention from health care providers that led to thoughts of changing a place of delivery in the next pregnancy. There is evidence that in Malawi in general and Chiradzulu in particular, there were a number of studies that looked at why women do not give birth at a health facility with the assistance of skilled birth attendants (Chanza, Chirwa, Maluwa, Malata, & Masache, 2012; Essendi, Mills, & Fotso, 2011 & Otis & Brett, 2008). However, in Malawi at Chiradzulu District Hospital no study has been conducted to explore women's experiences of child birth at a health facility, hence the need to conduct this study to learn from the mothers themselves, regarding their child birth experiences.

Problem Statement

The Malawi government advocates for health facility deliveries through the Safe Motherhood Initiative ("Information About Healthcare in Malawi, Africa," 2013). However, it was observed in practice, by the researcher that women in Chiradzulu District still gave birth away from the health care facility. For instance, between the months of July to December 2015, 2551 women attended ANC at Chiradzulu District

Hospital, 2030 women gave birth at the district hospital, 50 in transit to the health facility and 14 at their homes. These figures indicated that some women did not give birth in a health facility while others did. The researcher's interest is to have all women deliver at the health facility.

Significance of the Study

It is envisaged that results obtained from this study will highlight experiences that influence women to give birth at a health facility with the assistance of a skilled attendant. Narratives from the women will provide feedback on both the positive and negative sides of giving birth at a health facility. The results will inform midwifery interventions that will aim at promoting women to deliver at Chiradzulu District Hospital health facility and improve midwifery care; consequently reducing maternal and neonatal morbidity and mortality.

Objectives of the Study

Broad objective.

To explore child birth experiences of women who delivered at Chiradzulu District Hospital.

Specific objectives.

1 To describe postnatal women's perceptions of the care they received during the hospital delivery.

2 To describe postnatal women's satisfaction with the care they received during the hospital delivery.

3 To identify postnatal women's expectations of care during hospital delivery.

Summary

This chapter described the importance of health facility delivery under the assistance of skilled birth attendants. It has also stated the aim of the study, the problem statement, objectives and significance of the study.

Chapter 2

Literature Review

Introduction

This chapter presents a review of literature related to women's experiences of health facility child birth. The review was done in line with the study objectives. Information was obtained from the internet, journals and other relevant documents. Primary research articles were searched using HINARI, PubMed, Ebscohost databases, and Google scholar search engine. Back and forward chaining was also used to seek clarification from cited articles. The literature review focused on studies that were done between 2005 and 2016. This was done to capture relevant and recent literature that would determine relevance of the present study. Search terms used were skilled birth attendants, women's demographic characteristics AND health facility delivery OR child birth, women's perceptions AND health facility delivery OR hospital delivery OR child birth, women's satisfaction AND health facility child birth OR delivery OR hospital delivery and women's expectations AND health facility delivery OR hospital delivery OR child birth.

Demographic Characteristics of Women that give Birth at a Health Facility

Place of residence affects the pregnant woman's decision to seek health facility child birth under the care of a skilled birth attendant. Women who reside in the urban area and those whose homes are closer to a health facility are more likely to utilise it for delivery than their counterparts who reside in the rural area or stay further away (Agha &

Carton, 2011; Bedford, Gandhi, Admassu, & Girma, 2012; Gabrysch & Campbell, 2009; Tarekegn, Lieberman, & Giedraitis, 2014).

Higher maternal age and exposure to social media are also predictors of health facility delivery (Gabrysch & Campbell, 2009). Similarly, Fotso, Ezeh, & Essendi, (2009) found out that women who were aged twenty-five years and below utilised the health facility less. Consistently, Magadi, Agwanda, & Obare, (2007) found out that older women receive better maternal health services than their younger counterparts at the health facility, thus the discrepancies in utilization. Utilisation of a health facility for child birth is also associated with marital status of the pregnant women. Utilisation increases in unmarried women and first time mothers (Tarekegn et al., 2014 & Worku, Yalew, & Afework, 2013) and reduces with increasing parity especially after the delivery of the first child in a health facility (Agha & Carton, 2011; Fotso et al., 2009 & Worku et al., 2013). Women with a parity of less than four are more likely to give birth in the presence of a skilled birth attendant (Anyait, Mukanga, Oundo, & Nuwaha, 2012; Danforth, Kruk, Rockers, Mbaruku, & Galea, 2011; Gabrysch & Campbell, 2009 & Lubbock & Stephenson, 2008) and utilization decreases with increasing parity (Fotso et al., 2009). Unmarried women who are helped with household chores by their significant others are more likely to give birth at a health facility, but married women who receive this same support opt for the home as a place of delivery. However, married women who receive advice from their mothers-in-law and health care workers on the importance of health facility delivery are likely to use the health facility than their counterparts who do not receive such information (Ono, Matsuyama, Karama, & Honda, 2013).

Higher education of women and their husbands increases utilisation of the health facility for delivery (Bashour & Abdulsalam, 2005; Gabrysch & Campbell, 2009; Ono, Matsuyama, Karama, & Honda, 2013; Tarekegn et al., 2014) since they have the financial capacity to do so and others are able to afford health insurance (Ono et al., 2013a). On the contrary Spangler & Bloom (2010) found out that a husband's education did not affect health facility attendance for delivery services. Women with at least primary or secondary school education or those with higher education utilize the health facility more (Agha & Carton, 2011; Turan, Miller, Bukusi, Sande, & Cohen, 2008; Worku et al., 2013) than those that did not attend school (Mokdad et al., 2015). Maternal literacy is also associated with birth preparedness and seeking skilled birth attendance for antenatal services as well as for child birth (Agarwal, Sethi, Srivastava, Jha, & Baqui, 2010). Women who save money while pregnant are more likely to use a health facility for delivery or to seek skilled birth attendance (Moran et al., 2006).

Overall, socioeconomic status plays a vital role as a determinant of health facility delivery (Moyer et al., 2013). A high socioeconomic status predicts health facility delivery (Agha & Carton, 2011; Anyait et al., 2012; Gabrysch & Campbell, 2009 & Tarekegn et al., 2014). The use of a health care facility for maternity services increases with increasing house hold wealth (Gabrysch & Campbell, 2009). Women who come from families with more than one source of income such as a combination of farming and trading are more likely to use the health facility for delivery than their counterparts with only one source like farming, or no source at all (Turan et al., 2008 & Worku et al., 2013). Therefore, women with higher household income are more likely to deliver at the health facility with the assistance of a skilled birth attendant than those with less

household income (Mokdad et al., 2015). However, women of low socioeconomic status shun away from the health facility for maternity services because of fear of inhumane treatment by health care workers since they view health facility delivery as ideal for their counterparts of a higher social class (Spangler & Bloom, 2010).

Perceptions of Health Facility Delivery Care

Pregnant women and their significant others seek health facility delivery because the health facility is a place for complicated deliveries (Mwangome et al., 2012; Titaley, Hunter, Dibley, & Heywood, 2010 & Oyerinde et al., 2012). Women with a previous experience of obstetric complications are more likely to utilize the health facility for delivery since they have an increased fear and awareness of the risks involved in failing to seek care (Lubbock & Stephenson, 2008). Contrary, Lubbock & Stephenson found out that women with a past experience of obstetric complications at the health facility; caesarean sections for example, fear similar outcomes in future pregnancies and prefer the home instead for delivery while other women fear child birth altogether even after passage of a year since the occurrence of a negative birth experience (Nilsson, Lundgren, Karlström, & Hildingsson, 2012). For some women, the health facility offers a secure and safe environment where deaths are prevented during delivery, thus health facility delivery is facilitated (Bashour & Abdulsalam, 2005; Bhattacharyya et al., 2013; Ith, Dawson, & Homer, 2013; Izugbara et al., 2009; Lubbock & Stephenson, 2008 & Moyer et al., 2013). However, women's trust in the safety of a health facility is narrow where accounts of baby theft have been reported and thus home delivery is sought in such cases (Izugbara et al., 2009).

The health institution is viewed as a place where health care professionals and medical supplies are available in case of pregnancy related problems (Bhattacharyya, Srivastava, & Avan, 2013; Izugbara, Kabiru, & Zulu, 2009; Parkhurst, Rahman, & Ssengooba, 2006 & Spangler & Bloom, 2010) and women trust in the health care worker's competence in rendering maternity services to them (Bashour & Abdulsalam, 2005). Similarly, in their qualitative study conducted in Ethiopia, Bedford et al., (2012) found out that treatment at the health facility was perceived to be favourable and women had confidence in health care workers because they were able to provide injections to stop per vaginal bleeding and also that they were able to repair perineal tears since these interventions are not available to women who deliver in their home. Perception of danger signs of pregnancy also triggers health care seeking behaviours (Oyerinde et al., 2012). Examples of these danger signs are per vaginal bleeding, convulsions, excessive pain, vomiting, blurred vision, fever, obstructed labour, breech presentation and retained placenta (Bedford et al., 2012; Oyerinde et al., 2012 & Øxnevad, 2011). However, health seeking behaviours can be affected negatively if the pregnant women and their families view treatment for such complications as unnecessary or if the condition is viewed as not being serious (Bedford et al., 2012 & Koenig et al., 2007).

Decision making.

Culture and faith play very significant roles in perceptions of ill health, perceptions of care received and in predicting future use of health facilities (Oyerinde et al., 2012). Positive perceptions of health facility care and health care provider skills at individual, family and community levels are predictors of health facility deliveries (Danforth et al., 2011 & Kruk, Rockers, Mbaruku, Paczkowski, & Galea, 2010).

Similarly, Oyerinde et al., (2012) in their qualitative study which was conducted in Sierra Leone whose objectives were "to identify barriers to uptake of Emergency Obstetric and Neonatal Care (EmONC) and to recommend strategies for improvement in access, utilisation and client satisfaction with the services" found out that positive perceptions on the availability and quality of care in terms of effective management of emergencies and availability of experienced health care providers at all times were predictors of health facility delivery decision making. Negative perceptions of TBA skills by communities is also a predictor of health facility deliveries (Danforth et al., 2011& Kruk et al., 2010).

Women who are able to make their own decisions and have positive attitudes towards health facility delivery are more likely to deliver there than those who do not (Agha & Carton, 2011; Speizer, Story, & Singh, 2014 & Parkhurst et al., 2006). A pregnant woman's level of education does not affect her autonomous decision to deliver at the health facility (Fotso et al., 2009). In contrast, Moyer et al., (2013) found out that women who sought permission to deliver at the health facility were likely to be illiterate. In addition, Danforth et al., (2011) and Lubbock & Stephenson, (2008) found out that combined health decision making between the pregnant woman and her husband facilitated health facility use. However, maternal autonomy on access to health care is affected when third parties are involved in health facility decision making. Such decision makers are husbands, in-laws, pregnant woman's mother or her elder brother (Oyerinde et al., 2012 & Parkhurst et al., 2006). Mothers-in-law are responsible for decision making especially in the first pregnancy (Oyerinde et al., 2012). In other communities, male household heads are the ones who are responsible for making health facility attendance decisions (Bedford et al., 2012). Similarly, in Kenya among the Massai and Watemi

ethnic communities, husbands are responsible in deciding the place of delivery and labouring women only leave their homes upon their consent to do so or are justified to leave the home on their own when obstetric complications occur (Magoma, Requejo, Campbell, Cousens, & Filippi, 2010). Apart from development of obstetric complications, Parkhurst et al., (2006) in Bangladesh where institutional deliveries are registered low found out that women were sent on their way to the health facility to seek care when home labour was perceived to be progressing poorly.

Additionally, Bedford et al., (2012) found out that collaborative decision making was made between the husband, relatives and neighbours when labour was prolonged or when complications had developed. As a result of a chain in decision making, a labouring woman's plea to deliver at the health facility was sometimes ignored by family members leaving her powerless. Furthermore, Pembe, Urassa, Darj, Carlstedt, & Olsson, (2008) in their qualitative study on "maternal referrals in rural Tanzania", found out that the process of decision making at community level was based on the community perceptions of seriousness of the condition, difficult access to the health facility, transportation costs involved, living expenses at the health facility and perceived quality of care at the health facility. In contrast, Moyer et al., (2013) in their qualitative study whose aim was "to explore the impact of social factors on place of delivery in northern Ghana" found out that respondents disputed the fact that pregnant women needed a go ahead from other family members like the husband, mother-in-law or compound head to deliver at the health facility, but relied on their social networks for physical and psychological support throughout the journey to the health facility and back.

Health facility care and its influences on utilisation.

Good attitudes of health care workers and their good communication skills to women enhance health facility deliveries (Bashour & Abdulsalam, 2005 & Oyerinde et al., 2012). Pregnant women who base their trust on health care worker competence in their technical skills are likely to deliver at the health facility (Bashour & Abdulsalam, 2005). For other women, delivery of a healthy baby at a health facility is attributed to the reception of prenatal examinations, vaccinations and vitamins and thus future use is promoted (Lubbock & Stephenson, 2008). Gender of a health care provider plays a vital role on health facility decision making. In other parts of Kenya, male midwives are preferred because they are more respectful to their clients (Mwangome et al., 2012). Contrary to these findings, Bashour & Abdulsalam, (2005) in their study entitled "Syrian women's preferences for birth attendant and birth place" found out that more than 80% of the postnatal women who participated in the study preferred female skilled birth attendants because they provided better psychosocial support and some of the participants were shy to be assisted by male health care providers. Similarly, Bhattacharyya et al., (2013) in their study conducted in India found out that women were not comfortable to deliver in the presence of male skilled birth attendants at the health facility, thus they preferred not to deliver there.

However, poor attitudes such as skilled birth attendant harshness, rudeness to clients, poor interpersonal skills and perceived impatience with clients creates an environment of distrust and prevents health facility utilisation (Dzomeku, 2011; Izugbara et al., 2009: Lubbock & Stephenson, 2008 & Oyerinde et al., 2012). Similarly, Ith et al., (2013) found out that poor staff attitudes such as disrespect and physical abuse like slapping prevented women from seeking skilled birth attendance at the health facility but

they were willing to travel there for delivery upon the perception of comfort with health care providers. In addition, unavailability of health care providers at the health facility also affects health seeking behaviours negatively (Oyerinde et al., 2012). To other women, health care workers are viewed as strangers and those with a young age are perceived as having little knowledge and experience (Bedford et al., 2012; Øxnevad, 2011& Titaley et al., 2010). Restriction of women by health facility staff to explore upright birthing positions at the health facility is also a factor that prevents women to deliver there in other parts of Ethiopia (Bedford et al., 2012).

Furthermore, Øxnevad, (2011) and Lubbock & Stephenson, (2008) found out that procedures conducted at the health facility and embarrassing physical examinations such as performance of episiotomies and digital vaginal examinations affected women negatively on health facility delivery decisions. Similarly, Magoma et al., (2010) found out that digital vaginal examinations were perceived as painful, likely to damage the baby and those performed by male providers were viewed as dehumanising, where as perineal tears were viewed as normal such that no medical intervention was needed. Other husbands become jealous if their wives are examined by male health care providers at the health facility, as a result women do not report there for maternity services in fear of potential gender based violence (Lubbock & Stephenson, 2008).

A health facility is perceived as a delivery place for women with HIV infection such that women who deliver there risk being labeled by other people in their society as HIV infected (Turan et al., 2008). In addition, other women shun away from health facility deliveries due to fear of a positive HIV result that would lead to stigma and abandonment by the baby's father (Medema-Wijnveen et al., 2012; Mwangome et al.,

2012 &Turan et al., 2008). Other women's fears are on HIV testing and involuntary disclosure of a reactive HIV status to the husband and significant others, including fears of stigma and discrimination by health care workers at the health facility during the intrapartum period (Turan, Miller, Bukusi, Sande, & Cohen, 2008). Furthermore, Izugbara et al., (2009) found out that women avoided the health facility for delivery because they would be forced to undergo an HIV test, a procedure they were not psychologically prepared for.

Sources of information.

Women reported to have heard information about the importance of health facility delivery from community health workers and from health care workers at the health facility during antenatal care attendance (Lubbock & Stephenson, 2008 & Moyer et al., 2013). Similarly, Fotso et al., (2009) found out that women who were advised about health facility delivery at the antenatal clinic were more likely to deliver there than their counterparts who did not receive such information. Other women acknowledge past delivery experiences at the health facility and communication from elder women in their communities such as their mothers and mothers-in-law as their sources of knowledge about delivery at the health facility (Lubbock & Stephenson, 2008).

Satisfaction with Health Facility Delivery Care

Social support.

Physical, emotional and informational support from close family members is essential during pregnancy and health facility delivery (Bhattacharyya et al., 2013 & Story et al., 2012). Financial support from pregnant women's partners allows families to plan in advance for health facility delivery such that enough money is saved for the purchase of essential items like clothes for both the mother and the baby, for transportation to the health facility and for payment of hospital user fees (Lubbock & Stephenson, 2008; Parkhurst et al., 2006 & Story et al., 2012). Such male partners acknowledge the importance of health facility delivery (Lubbock & Stephenson, 2008 & Story et al., 2012) and take care of the home and children while their wives are at the health facility for delivery (Lubbock & Stephenson, 2008). However, Magoma et al., (2010) found out that lack of planning for delivery care is attributed to failure of health care professionals to provide information to all pregnant women about the importance of health facility delivery during antenatal care. Furthermore, failure to plan in advance for transportation to the health facility is a barrier to health facility delivery (Magoma et al., 2010).

The presence of other female family members like a pregnant woman's mother or mother-in-law at the health facility ensures that labouring women are satisfied with delivery care, medical advice and vaginal delivery in the unfamiliar hospital environment (Bhattacharyya et al., 2013 & Bruggemann, Parpinelli, Osis, Cecatti, & Neto, 2007). In addition, Bruggemann et al., in their study which was conducted in Brazil found out that the occurrence of meconium stained liquor was less likely in women who had a

companion present as compared to women who did not have a companion. Furthermore, women who are supported during labour and delivery experience shorter first and second stages of labour (Kashanian, Javadi, & Haghighi, 2010) and have fewer occurrences of caesarean sections and reception of pain relief during labour (McGrath & Kennell, 2008 & Kashanian et al., 2010).

However, the absence of a labour companion in an unfamiliar health facility environment creates feelings of distress such as loneliness and fear among labouring women, especially in primigravidas and women perceive the labour as difficult (Chadwick, Cooper, & Harries, 2014). Similarly, Ith et al., (2013) in their study conducted in Cambodia found out that women who delivered in the public health institutions and were not allowed to have a family member to accompany them during labour were not satisfied with delivery as compared to their counterparts who delivered at private health institutions where family members were allowed. Furthermore, Chadwick et al., found out that women who were left without being attended to until the very last minute by health care providers during labour were more distressed and they felt neglected. Other women reported that their call for assistance was unanswered since health care workers were either busy with other personal activities or were busy chatting with each other.

Interpersonal relationship with skilled birth attendant.

Pregnant women who experience a good relationship with their skilled birth attendants are likely to be satisfied with delivery (Cham, Sundby, & Vangen, 2009; Changole et al., 2010 & Dzomeku, 2011) and therefore have increased chances of using the health facility again for maternity services (Dzomeku, 2011). In a study conducted by

Changole et al., 2010 in Malawi on "patient's satisfaction with reproductive health services at Queen Elizabeth Central Hospital" majority (97.3%) of the women were satisfied with the care that they received in the maternity unit. Particularly they were satisfied with good interpersonal relationships with health care workers and described them as helpful, friendly and respectful. Similarly, Cham et al., found out that women acknowledged the care that they received at the health facility and were satisfied with greetings from health care workers, changing of soiled linen and provision of free drugs. Furthermore, women associate good health care worker attitudes with not being shouted at and paying attention to their needs while at the health facility (Dzomeku, 2011). Women who feel in control of their labour and delivery processes are likely to be satisfied with the care (Fair & Morrison, 2012). For example, women who are attended to by midwives, are nursed in a private environment, are encouraged in the second stage of labour and are given information about labour progress are more likely to experience more control over the labour and delivery processes leading to feelings of satisfaction with maternity services (Fair & Morrison, 2012 & Senarath, Fernando, & Rodrigo, 2006). Empathy of health care workers towards women who experience obstetric complications leads to their satisfaction with delivery care and such women praise the quality of care although foetal loss occurs in the process of that care (Bazant & Koenig, 2009 & Cham et al., 2009). Hastened maternal and child bonding and family planning counseling also lead to satisfaction with health facility delivery (Senarath et al., 2006).

Apart from health care worker attitudes, women are also satisfied with hygienic conditions of the health facility's maternity unit (Changole et al., 2010). In addition, timely assistance upon arrival at the health facility is essential in promoting maternal

satisfaction with delivery care (Bhattacharyya et al., 2013 & Senarath et al., 2006). Therefore women who live closer to the health facility benefit from the reduced waiting time on arrival and end up being satisfied with maternity services (Senarath et al., 2006).

Determinants of dissatisfaction with delivery care.

Women are dissatisfied with care where health care worker attitudes are poor (Avortri, Beke, & Abekah-Nkrumah, 2011; Chadwick et al., 2014; Cham et al., 2009 & D'Ambruoso, Abbey, & Hussein, 2005). Poor reception on admission at the health facility is a predictor of maternal dissatisfaction with delivery care (Cham et al., 2009). Women who perceive unfriendliness of health care workers on admission are 15 times likely to be dissatisfied with delivery care compared to their counterparts who viewed them as friendly (Avortri et al., 2011). Women's poor interaction with health care providers such as rudeness, shouting, lack of empathy, harsh treatment like midwife refusing to be touched by the labouring woman and neglect brings in feelings of distress among labouring women such that midwives are viewed as obstacles to the natural birthing process (Chadwick et al., 2014; D'Ambruoso et al., 2005 & Dzomeku, 2011). As a result, through this experience, future options on health facility delivery are either non attendance or late arrival (Dzomeku, 2011).

Women who lack knowledge on the channels of communication to lodge complaints are 50 times more likely to be dissatisfied with delivery care than their counterparts who were notified of the channels (Avortri et al., 2011). In addition, Dzomeku, (2011) found out that women were not satisfied with health care workers who did not give them information concerning their care. Women who are denied access to

medical information and information by health care providers like midwives on labour progress; cervical dilatation for example are more likely to be distressed during labour, have no sense of control over their labouring process and are demoralised leading to dissatisfaction with delivery care at the health facility (Chadwick et al., 2014). Such women are 9.4 times likely to be dissatisfied with delivery care as compared to women who feel that the information given was enough (Avortri et al. 2011). However, lack of knowledge by the labouring women in cases where health care workers expect them to know how to conduct themselves during all the stages of labour leads to punishment from the attending skilled birth attendants, actions that leave the labouring women to be dissatisfied with delivery care at the health facility (D'Ambruoso et al., 2005).

Other predictors of dissatisfaction with health facility delivery revolve around the health care delivery system. For example, poor quality of care in terms of overcrowding of babies in one crib, inadequate numbers of skilled birth attendants during labour and delivery, lack of local anesthesia for episiotomy repairs, difficulties in acquiring blood transfusions and high user fees (Cham et al., 2009 & D'Ambruoso et al., 2005). Overall, satisfaction with child birth is dependent on the fulfillment of maternal expectations about child birth (Christiaens & Bracke, 2007).

Expectations of Health Facility Delivery Care

Availability of human and material resources at the health facility.

The attitude of a health care provider is very crucial in meeting labouring women's needs at the health facility (D'Ambruoso et al., 2005). Women expect to be treated with respect by health care professionals (Iravani, Zarean, Janghorbani, &

Bahrami, 2015 & Kruk, Paczkowski, Mbaruku, de Pinho, & Galea, 2009). Women who feel that they are occasionally respected by health care workers are 3.6 times more likely to be dissatisfied with the care than those who feet respected at all times (Avortri et al., 2011). Women prefer midwives who are polite, patient and those who are always there by the labouring woman's side offering reassurance (D'Ambruoso et al., 2005). Women expect health care workers to be understanding to what they are going through during labour and also to be kind to them as this assists in boosting their self esteem and in turn promote their comfort (D'Ambruoso et al., 2005; Ghani, Mahmoud, & Berggren, 2011 & Iravani et al., 2015). Women expect health care workers to provide encouraging words to them during labour and delivery processes as women feel in control of the situation that they are in (Iravani et al., 2015). Good reception from health care workers at the health facility is expected by labouring women. Women expect a warm welcome at the health facility and also expect health care workers to be attentive to their conversations during admission and provide midwifery care in time (Iravani et al., 2015 & Ith et al., 2013). In addition, health care workers need to introduce themselves (Ith et al., 2013), they need to ensure privacy during labour and in all the procedures involved (Bhattacharyya et al., 2013; Ghani, Mahmoud, & Berggren, 2011 & Ith et al., 2013) and they need to maintain confidentiality at all times (Ith et al., 2013). Furthermore, D'Ambruoso et al., found out that women would recommend a health facility to their friends and family basing on their experience with good attitudes of health care workers at the health facility and would not do so if their attitudes were poor, but they would still recommend the health facility despite their experience with poor health care worker attitudes because it is safer to deliver there. Women expect to have their significant others present in the labour ward

for social support and to relieve boredom (Iravani et al., 2015). However, undesirable health care worker behaviour such as disrespect to women and physical abuse in terms of slapping at the health facility affects women's choice on health facility delivery (Ith et al., 2013). Similarly, D'Ambruoso et al., found out that women who anticipate poor treatment from health care providers are likely to change a future delivery place.

Women expect the fulfillment of their physical needs such as nutrition which is essential in boosting their strength, and would like to be nursed in a comfortable environment with minimal ward routines such as leaving the lights on for most hours of the day (Iravani et al., 2015). Physical needs also include a hygienic environment for example; changing of wet and dirty beddings and hand washing between patients (Ghani, Mahmoud, & Berggren, 2011 & Iravani et al., 2015). Women acknowledge a clean delivery place and also cleaning of both the mother and baby soon after delivery (Bhattacharyya et al., 2013). Other women prefer ambulation from lying down on the labouring bed as this brings comfort during labour (Iravani et al., 2015).

Women expect to find medical supplies like drugs and equipment readily available at the health facility (Kruk et al., 2009). Provision of pain killers during labour is preferred by other women (Ghani et al., 2011). Similarly, D'Ambruoso et al., (2005) found out that the presence of an ambulance at a health facility to ferry women from one health facility to another is vital in emergency cases. However, women expect that birth is a natural process such that the performance of other medical procedures such as routine insertion of urinary catheters to empty the bladder during labour, unnecessary vaginal examinations, routine episiotomies and routine enemas are a nuisance to other labouring women (Iravani et al., 2015). Most importantly, availability of respectful health care

workers and medical supplies at the health facility would increase pregnant women's preference for health facility delivery from 43 to 88% (Kruk et al., 2009).

Information giving.

Women expect health care providers to provide explanations and information on procedures being done to them while providing midwifery care such as labour progress, findings from examinations and provision of guidance and support throughout the labouring process. Women therefore develop confidence in themselves since they are equipped with the knowledge and skill to take care of themselves and their newborns (D'Ambruoso et al., 2005; Iravani et al., 2015; Bahrami, 2015 & Ith et al., 2013). Women's self esteem is boosted because they feel involved in their own care (Iravani et al., 2015). Health care workers need to orient women to the unfamiliar hospital environment and access areas like the toilet and bathrooms as this reduces stress in the women (Iravani et al., 2015). Furthermore, Ghani et al., (2011) found out that women also need information on care of themselves and their new born baby postpartum and also information on family planning.

Summary

Factors that facilitate health facility childbirth are pregnant women's belief in its safety, presence of skilled birth attendants and medical supplies for delivery care and for management of obstetric emergencies, good health care worker attitudes and fulfillment of their expectations on delivery care. Most of the studies included in this literature review for perceptions and expectations of delivery care at the health facility used qualitative study designs, while most studies for satisfaction with delivery care at the

health facility used quantitative study designs. Most of the existing literature on women's experiences of health facility delivery is largely drawn from developed and other developing countries whose findings may not necessarily apply in the Malawian context due to differences in culture and health care delivery systems. However, the literature reviewed is essential as it sheds light on practices that are there in other countries and will therefore form a foundation on which this study will build on and close the knowledge gap on this particular subject.

Chapter 3

Methodology

Introduction

This chapter presents the study design, study site, study population and sampling technique. It also describes the methods that were used for data collection and analysis.

Study Design

This was a descriptive study that utilized qualitative data collection and analysis methods. A qualitative study design was chosen for this study because it aimed to understand the problem of women delivering outside the health facility, from the women's perspectives, their experiences and how they viewed the health facility delivery.

Role of the Researcher

As a qualitative study researcher, my role was to become aware of my values and beliefs in order to minimize any personal biases. This made it possible for me to have an open mind throughout the research process in order to accommodate new ideas from the participants in an objective manner. The researcher worked as a civil service midwife in charge of a labour and delivery unit. She believes that her experience and skills in dealing with maternity women put her in a better position to explore the topic under study.

Study Site

The study was conducted in the postnatal ward at Chiradzulu District Hospital in the southern region of Malawi from the 27th of June 2016 to the 19th of July 2016. The hospital serves a catchment area that has a population of approximately 23,842 people and number of deliveries attended by skilled birth attendants in the 2014/2015 calendar was 4, 241. The study site was chosen because that was where the researcher would find women who had just given birth at a health facility and wanted to hear and document their experiences. The hospital also serves a large catchment population that would benefit from the findings of the study.

Study Population

The study population comprised of women who had delivered at Chiradzulu District Hospital 48 hours post delivery and were in the post natal ward, aged 18 to 49 years. They were of any parity since studies have shown that higher parity predisposes women to low utilisation of a health facility for delivery (Kabakyenga et al., 2012; National Statistical Office (NSO) & ICF Macro, 2011). These women were targeted because they had gone through a health facility delivery and therefore, were capable of sharing the experiences they had.

Inclusion criteria.

Women who had a live child in the index pregnancy, born through spontaneous vaginal delivery and had stayed in the hospital for not more than 48 hours. Women who had a history of home deliveries were included so as to know why they had decided to

use the health facility for delivery in the index pregnancy. Women who gave consent to participate in the study.

Exclusion criteria.

Women with any previous obstetric complications, those who underwent caesarean section or instrumental deliveries. Since women with a history of obstetric complications are likely to use the health facility because they do not have any other choice. Women less than 18 years of age and those who did not give consent were also excluded from the study.

Sampling Method

Purposive sampling method was used in the study. This method was used to target people with rich information about the subject under study (Polit & Beck, 2010). In this study only women with experience of a delivery at a health facility were capable of giving adequate information on the care they received within the 48hours in the postnatal ward therefore, a relevant sample.

Sample Size

The sample size was set at 20 participants. A sample number of 20 participants ensured that meaningful data was collected by the researcher under experiences of the care received during delivery at Chiradzulu district hospital so as to address the study objectives in depth (Crouch & McKenzie, 2006). With the 20th participant there was saturation of data and no new information came out and data collection was stopped.

Data Collection Instrument

A semi-structured in- depth interview guide with open ended questions which was developed by the researcher and guided by literature and the study objectives was used to guide the interview process in order to collect the relevant information from the study participants after obtaining their informed consent (Appendix D). The use of a semi-structured interview guide with open ended questions allowed the researcher to encourage participants to talk more about their experiences and collected rich data as a result (Polit & Beck, 2010).

Data Collection Procedure

Women for the study were chosen with support from the postnatal ward midwives who generated a list of postnatal women who were in the ward within 48hours post delivery. The researcher then verified that the women met the criteria for being in the sample. The potential participants and their guardians were then approached at their bedside, were greeted and invited to another room for further discussions. A private room with a closed door situated at the postnatal ward was identified as a venue where the interviews were conducted. This was done in order to maintain privacy and confidentiality of the study participants. In that room, the researcher explained to both the potential participant and her guardian the study title, purpose, objectives and significance and that she would use a digital audio recorder to assist with data capturing. After they had said that information was clearly understood, an informed consent was signed by the participant and the guardian signed on the space provided for the witness that indicated willingness and voluntariness to participate (Appendix B- Information sheet and

informed consent) and (Appendix C- information sheet and informed consent Chichewa translation). All participants who were given an offer to participate in the study agreed to do so. The researcher then conducted the in-depth interviews on one- to- one basis for 20 participants (Appendix D & E). Each participant's field notes and recordings were assigned a code for anonymity and confidentiality during the data collection, entry and analysis processes.

The interviews were conducted in the local language (Chichewa), were audio recorded and took approximately 30-45 minutes. At the end of each interview termination was done and the participant was thanked for her participation. The same procedure was followed for each of the 20 participants. The data were kept under lock and key; accessed by the researcher and the supervisors only.

Pre-test Interviews

The researcher conducted pre-test interviews with the first two participants at Chiradzulu District Hospital. It is of importance to conduct a pretest that replicates exactly the processes that will be undertaken in the main study and also to ensure that all members to be involved in the main study take part in the exercise (Hurst et al., 2015). For this reason, the pre-test interviews were conducted at the same site as the one where the main study was conducted. Through the exercise, the researcher ensured that midwives at the postnatal ward knew their role to play in the main study, the questions on the interview guide were clear and that they elicited the intended responses. In addition, the researcher confirmed that the digital audio recorder was in good working condition and was user friendly. Through the pre-test experience, the researcher gained confidence

and improved on her communication skills during the rest of the interviews which improved the actual data collection process and quality of data.

Data Management and Analysis

The researcher analysed data concurrently with data collection and she sought clarification from the participants where not clear in order to collect ideal data in participant's own words. The responses were quoted directly and the grammar was not corrected by the researcher to prevent distorting the meaning of the given information. The interviews' data recorded on a digital audio recorder was downloaded into a computer that was password protected for safety at the end of each interview. Soft copies of interview data were kept in a flash disk for back up.

Data was analysed using thematic analysis. Thematic analysis as described by Braun & Clarke 2006, provides guidelines to qualitative research data analysis and this method identifies, analyses and reports themes within the data. In this study the data was analysed in six phases namely; familiarising with the data, generating initial codes, searching for themes, reviewing themes and producing a report.

Familiarising with the data.

In this phase, the researcher transcribed recorded data verbatim and translated it into English. The data set was actively read several times to ensure understanding of the meanings that were coming out from the data.

Generating initial codes.

In this phase, initial codes were given to sentences in the data set according to similar units. Codes were compared across the whole data set to identify any similarities, differences and linkages within them.

Searching for themes.

In this phase codes were combined to come up with themes and subthemes. The researcher drew a table that assisted in the organisation of the identified codes into themes and sub-themes.

Reviewing themes.

In this phase the researcher refined the themes to ensure that they were clear and they matched with the data that supported them. The researcher re-read the entire data set to make sure the themes matched the collected data.

Defining and naming themes.

In this phase the researcher identified the themes and subthemes and the meanings that each theme carried and determined what part of the data qualified what the participants said in their own words under each theme.

Producing the report.

In this phase the themes, subthemes and supporting narratives were fully polished in line with the study objectives which were to explore postnatal women's perceptions of the care they received during the hospital delivery, to examine postnatal women's

satisfaction with the care they received during the hospital delivery and to identify postnatal women's expectations of care during hospital delivery.

Trustworthiness of the Study

Credibility.

Polit & Beck, (2010) define credibility as the confidence that there is truth in the collected data and its interpretations and the congruency of the study findings with reality. In this study to enhance credibility, the researcher ensured that each participant gave consent to participate in the study and at the same time she was given the opportunity to withdraw at any time without providing an explanation and was assured of confidentiality and anonymity. Therefore this allowed the participants to say the truth without being coerced. This also ensured the collection of truthful data since the participants had a free mind in telling the researcher what they experienced during child bearing period in the labour ward at Chiradzulu District Hospital. In addition, the researcher asked probing questions to verify the truth of what was being said, observed participant behaviors and sought clarifications from participant responses during the interview up to the close of the interview. The researcher also clarified the questions that were asked to the participants during the interview to ensure that they understood them before responding such that they were able to answer truthfully on what happened to them in the labour ward exposing their feelings freely in a private comfortable environment.

Transferability.

Transferability is the extent to which the research findings can be transferred to other settings or similar groups of people. In this study to ensure transferability, the researcher chose the setting that was at Chiradzulu District Hospital which provides maternity services to mothers in its catchment area which has several health centers and the hospital also serves other women from other health centers in the neighbouring districts such as Zomba, Thyolo and Blantyre. Therefore, the findings of this study could be transferred to women in other neighbouring district hospital settings that have been listed.

Dependability.

Dependability refers to the stability of findings over time and conditions (Polit & Beck, 2010). Dependability was enhanced by making a detailed report of the research processes undertaken such as the research design, data collection and analysis. This would enable other readers of the research report to understand how the study was conducted and enable them to use the same methods and be able to come up with the same or similar results in their study settings. This will also ensure that if another researcher could use the findings of the study during another time and in other conditions could yield similar results.

Confirmability.

Confirmability refers to the objectivity of the study findings in terms of accuracy, relevance or meaning. The findings need to reflect the participant's words as they were spoken and recorded during the interview and this will prevent researcher biases (Polit & Beck, 2010). Confirmability in this study was enhanced by documenting of field notes

and recording of the interviewees coupled with development and reporting of findings with the guidance of supervisors. To ensure objectivity, the researcher presented the scientific study methods that were followed, presentation of the final study report to the supervisors, then internal and external examiners for review before the final report. To ensure accuracy, relevance or meaning, the researcher pre-tested the research instruments such as the in-depth interview questions and the digital audio recorder were pre-tested and improvements were made based on the gaps that were found during the pre-test which were addressed.

Ethical Considerations

Permission to conduct the study was sought from DHO of Chiradzulu District Hospital. The study proposal was submitted to COMREC for approval before data collection. The study ensured that human rights of all participants were respected. The right to privacy, confidentiality and protection from harm was employed. Information about the study topic and its objectives was made available to the participants for them to understand and therefore, to make an informed choice to participate. A consent form was signed before commencement of the interviews. To ensure confidentiality, names of participants were neither used on field notes nor on audio tape recordings; but codes were used to identify them. Furthermore, the interviews were conducted on one-to-one basis in a room with a closed door for privacy and confidentiality.

CHAPTER 4

Findings

Introduction

This chapter presents the findings of the study on women's experiences of child birth in a hospital delivery setting at Chiradzulu District Hospital (CDH). The aim of the study was to explore child birth experiences of women who delivered at a health facility at CDH. The study was conducted at CDH in the postnatal ward. Twenty postnatal women were interviewed. The findings are presented as; demographic characteristics of the participants and the categorisation of themes and subthemes that emerged from the qualitative data which were; women's perceptions of the health facility care, women's satisfaction with health facility care and women's expectations of health facility care at CDH guided by the study objectives. The findings are presented in narrative format with direct quotes from the participants written in italic to illustrate and support the themes and subthemes. Ellipses, which are a series of full stops with spaces in between them (. . .), are used in the direct quotes to indicate the omission of some unnecessary ideas from the narratives. At the end of a directly quoted sentence four dots are used (. . . .); three to indicate the omission and one to indicate a full stop at the end of that sentence. Participant pauses and physical gestures are presented in brackets within the quoted texts.

Demographic Characteristics of the Participants

The participant's characteristics were age, place of residence, marital status, education, occupation and parity. The women that resided in areas close to the hospital

were 70%, n=14 while 30%, n=6 lived far from the hospital and were referred from health centers attached to the hospital. Participant's age range was 18 to 35 years with a mean age of 25 years. Participant's parity ranged from 1 to 6 children with a mean of 2.6 children. A summary of the other demographic characteristics are presented in table 1.

Table 1: *Demographic Characteristics of Participants*

Variable	Frequency (n=20)	Percentage (%)
Age (Years)		

18-24	9	45
25-34	10	50
>/= 35	1	5
Marital Status		
Single	1	5
Married	17	85
Divorced	2	10
Educational level		
Primary	11	55
Secondary	8	40
Never been to school	1	5
Educational level of husband		
Primary	10	50
Secondary	5	25
Tertiary	1	5
Never been to school	1	5
Occupation		
Self employed	1	5
Employed	1	5
House wife	15	75
Farmer	1	5
Does nothing	2	10
Parity		
One	5	25
Two	5	25
Three	5	25
Four	3	15
Five	1	5
Six	1	5

Themes and Subthemes

The three main themes were predetermined and they were addressing the study objectives while the subthemes emerged from analysis of the transcribed data by looking at common narrations across participants. The subthemes that had similar meanings were merged together under their main themes in order to prevent any repetitions in the study findings. The objectives were to describe postnatal women's perceptions of the care they received during the hospital delivery, to describe postnatal women's satisfaction with the care they received during the hospital delivery and to identify postnatal women's expectations of care during hospital delivery. The themes and the subthemes have been presented in table 2.

Table 2: *Themes and Subthemes*

	Themes	Subthemes
Theme 1	Perceptions of health facility care	• Views about health facility delivery • Motivation to deliver at the health facility • Sources of information about health facility delivery • Health facility delivery care
Theme 2	Satisfaction with health facility care	• Positive child birth experiences • Negative child birth experiences • Social support during health facility delivery
Theme 3	Expectations of health facility care	• Interpersonal interaction with midwives

Perceptions of Health Facility Care

Five subthemes emerged under this theme namely; i) Views about health facility delivery, ii) Motivation to deliver at the health facility, iii) Sources of information about health facility delivery, iv) Health facility delivery care.

Views about health facility delivery.

The participants were asked to describe their views on delivering at a health facility. Findings revealed that delivering at the health facility was good because women were assisted in case there were problems such as malpositions, per vaginal bleeding,

draining liquor and retained products of conception. Assistance was also available in case babies were born with prematurity, were asphyxiated or had congenital abnormalities.

Some participants said:

"*I agree with the issue of delivering your baby at the health facility. It is good because one may deliver the first and second baby without any problems and could have problems during delivery in the third pregnancy. Because when you go to the health facility you learn more about the situation you are in. Because at times you may start losing blood and they assist you well at the health facility. Or if you drain liquor you will be assisted well at the health facility. They examine you and they are able to give you enough treatment for your problem". (Participant # 4)*

"It is good to deliver at the health facility. There health care workers are able to examine you, also a baby can be mal positioned in utero and health care workers know what to do to save the life of the baby. When a woman is losing blood they know what to do to save her life. Health care workers know what to do to save the lives of both the mother and her baby . . . For example today. . . When I was examined here they found that my baby was distressed in utero, but health care workers did their best to save the life of my baby. . . ." (Participant #9)

Other participants said that it is good to deliver at the health facility because midwives take care of the women from the time of admission to the labour ward, throughout labour and delivery and up to the post delivery ward.

Other participants expressed:

"It is good to deliver at the health facility because the midwives assist you well; they help you deliver well, they tell you a lot of things on the care of the baby. The midwives assist you in a timely manner. When labour starts they examine you, after that they give you a bed and you wait for the time of delivery". (Participant # 8)

"Delivering at the health facility is good because the midwives do a nice job in assisting you to deliver. (Laughs! Then pause). . . If you have a perineal tear they suture it, or if you deliver through an operation they also suture you well… sure . . . ." (Participant # 20)

When asked about the disadvantages of delivering at the health facility, participants pointed out that some midwives were cruel at the health facility.

Some participants had this to report:

"Disadvantages of delivering at the health facility? Because sometimes there are midwifes there whose behaviour, you get discouraged with and fail to go to the health facility for delivery yes. Like as for me, this time I have delivered at this health facility, but what happened at this health facility did hurt my feelings yes". (Participant # 4)

". . . Delivering at the health facility is difficult because there are other midwives and doctors who shout at you and send you back when you tell them that you are not feeling well . . . At times when you go to the labour ward at night you find that all the midwives are asleep. They are called to no avail and they do not provide the care so it is a difficult matter here. After going through the experience I have seen that midwives are

not providing good care . . . There is no advantage as far as delivering at a health facility is concerned and I have seen this during the time I have been here. . . I told my mother that had it been that they do not retrieve our files, I could have taken mine and gone home because there is no difference between delivering at home and at the health facility. (Participant # 13)

"There are other doctors who when you tell them your problem they respond rudely and ending up not assisting you. So you end up having worries asking yourself 'but are they really going to assist me'? During that time you are in pain and you wonder if you are going to be assisted well. Yes I met one, I told her that I felt pain in my heart and when I asked for her to come and see me she was just shouting at me and told me to stay where I was (pause)". (Participant # 14)

Motivation to deliver at the health facility.

Majority (n=17) of the participants made the decision to deliver at the health facility on their own. For others, the decision was made by the husband (n=1), relatives (n=1) and both the participant's husband and herself (n=1). Findings revealed that the decisions to deliver at the health facility revolved around importance of health facility delivery, timely assistance and good reception. Participant # 6 said: *"I saw that at the health facility is where one can receive appropriate care and not at home or at the TBA. The appropriate treatment in terms of examinations in case you are sick, they know what is wrong with you. I made the decision to deliver at the health facility on my own and I know that it was a good one".*

Other participants narrated:

"I have already said in the beginning that one is assisted well (Pause). I made the choice to deliver at the health facility on my own and that is why when labour started I asked my relatives to escort me here". (Participant # 14)

"I made the decision to deliver at this health facility on my own because I know that I receive the right care in the right manner. As I have already said that one may have retained products of conception and have no knowledge about it. But at the health facility this is noted in time and they know how to assist you. Maybe the baby may attain an improper position in utero; the doctors diagnose it early and know what to do for you to be well again". (Participant # 2)

Other participants decided on health facility delivery because of its closeness to their homes and others were afraid to honor fines that are put in place in their communities that are enacted if a woman delivers either at home or on her way to the health facility. Participant # 1 said: *"I made a choice to deliver at this health facility because it is the one closer to my home. I cannot go to Queens [Queen Elizabeth Central Hospital] when my home is close to this health facility (pause), there is no one who made the decision for me to deliver here, I made it on my own".*

Other participants added:

"This facility is closer to my home. If there was another health facility nearby I would also go there. My relatives are the ones who made the decision for me to deliver at the health facility. They said I should not deliver at home but at the health facility (pause)". (Participant # 16)

"I could have delivered at home but I could not do so because of the fines which have just started to be implemented. You think of the money you are supposed to pay if you deliver at home, maybe you cannot even afford to buy a packet of salt so for you to raise the K10,000 to give someone at this time of year it is very difficult. . . ."
(Participant # 13)

Sources of information about health facility delivery.

Most of the participants heard about health facility delivery from the chiefs in their communities, the antenatal clinic and on the radio. For a few women, the sources were their significant others and their school. The message that was contained in the information was on the importance of health facility delivery over home or Traditional Birth Attendant deliveries. Participant # 2 said:

"I heard it at this health facility when I came for antenatal clinic that we should deliver at the health facility and not in the home. Even the chiefs advocate for health facility delivery because health care workers are the ones who know how best to assist you (pause)".

Two other participants said:

"In our neighbourhood they advise us not to deliver at home but at the health facility yes. When you deliver at home chiefs charge you with a fine yes, to the chief a chicken, to the Traditional Authority a goat and to the midwives at the health facility you

pay money sure. So it is a difficult matter. I also heard on the radio that delivering at the health facility is good" (Participant # 4).

"I heard from my parents that it is good to deliver at the health facility. It is not good to deliver at home or on the way to the health facility because you may have retained products of conception and you will still need to go to the health facility. I heard from other people that it is good to deliver at the health facility because you get assisted in good time (pause)". (Participant # 6)

Intrapartum care.

Most (n=12) of the participants said that the care they received was good such that the interpersonal relationship with the midwives was good. However other participants disliked the care that they received and others preferred care from day duty midwives than that offered during the night. Majority (n=14) of the participants viewed male midwives as the ones who provide good care at the health facility as compared to female midwives. Others preferred care from students (both male and female), while others were neutral.

Some participants who had preferences in the gender of a health care provider had this to say:

"Male midwives are better because female midwives are rude. Male midwives assist you as if they are taking care of a fellow male. The ones I met yesterday evening were male midwives". (Participant # 16)

"It depends . . . because I found a female midwife and she assisted me well. In the morning a male midwife was also giving good care. I do not see any difference because when patients came they were waking each other up and came to attend to them". (Participant # 15)

"I am thankful for the trainees [students] yes? I did not take any mistake on them; they were doing good things throughout (pause) this is the truth. Maybe the qualified ones were there but the ones who were in large numbers were the trainees, they explain everything well without shouting at you. Both male and female [students], there is no difference between them". (Participant # 19)

Findings also revealed that women who were not given the right information by midwives on the procedures that were done attached their own explanations (misconceptions) to that care. Two participants misconceived the administration of oxytocin that is given before controlled cord traction in the third stage of labour as pain medication and as tetanus toxoide vaccine said:

". . . Then they came to me and removed the placenta and some clotted blood from my uterus. I was given an injection to prevent me from feeling pain the time the placenta was being removed . . . ." (Participant # 11)

". . . So today I was given another injection making them two. They did not explain what the injection was for but I am sure that they will record it in the health passport book as the second injection . . . I feel the injection I got today is the same as the first one and they will document that I have received two injections so far. The second

injection was given to me through the thigh as soon as the baby was born, but the first one was given through the arm (pause) . . . .” (Participant # 13)

Satisfaction with Health Facility Care

Participants described the care that they received as either satisfactory or unsatisfactory depending on their positive or negative child birth experiences respectively. Social support from their significant others also played a role in promoting their satisfaction.

Positive child birth experiences.

Most of the participants (n=12) were satisfied with the care that they were given in the four stages of labour. All participants who were satisfied had positive child birth experiences. Most of the participants (n=10) praised the interpersonal relationship that they had with the midwives who cared for them and others described the midwives as polite, kind, filled with love, good and honest. The presence of midwives on the delivery bed side and provision of information about labour progress from admission, through labour and delivery and discharge from the labour ward was liked by the satisfied participants. Other participants commended midwives who administered medication that gave them the strength to push and also those who encouraged them to push in the second stage of labour. Participants who had perineal tears rated the administration of local anesthesia before suturing highly. Eight participants shared that the reception on arrival was good, while (n=2) praised timely assistance on arrival. (n=6) participants were satisfied with the clean and good delivery place and (n=1) was satisfied with privacy

rendered during labour and delivery due to the presence of curtains which surrounded the delivery bed.

Participants who had good interpersonal relationships with the midwives said:

". . . But today they were there since admission, delivery and they escorted me here (postnatal ward) . . . on a wheel chair. . . So I have seen the advantage . . . I liked the care that I was given by the midwives, they were so kind . . ." (Participant # 10)

". . . I did not pick any mistake on the midwife I met yesterday because I feel he was good and honest . . . I am very thankful to the midwife I met yesterday, he was very good (pause). He received me well (pause)". (Participant #16)

Participants who were encouraged to push and those who were given medication to boost strength during pushing shared their experiences as follows:

". . . Because when I felt that the baby was about to come out, I called and they came there and then. Soon after delivery they commended me for a job well done because I was following what I was told (Pause). I liked this because they were encouraging me during the time I was giving birth (Pause)". (Participant #14)

"I was encouraged to work hard during the second stage of labour. I could try but the baby could go back in. when I pushed the baby was coming but it went back in when I stopped. He kept on encouraging me to push, there the baby is coming push (smiles) so I pushed hard and the baby was born. I am also thankful for the intravenous drip that I was given". (Participant # 16)

". . . Yes I was given an injection. I was given medication to boost my strength the time I was pushing. I was weak and they gave me an injection to boost my strength sure. I was on an intravenous drip so the medication was given through there. The care I received was very good and I would come here again but it is far from my home . . . ."

(Participant # 20)

Participants who were satisfied with the place of delivery shared:

". . . My place of delivery was alright and I was satisfied with it". (Participant # 15)

". . . The place of delivery was clean and the bed was surrounded by curtains which were drawn. As patients we could not see each other. It was very good because I was at a private place (laughs!). . . . " (Participant # 12)

Negative childbirth experiences.

A few participants (n=8) expressed their dissatisfaction with delivery care at the health facility. All of them went through negative child birth experiences. Mainly there were poor interpersonal relationships between the midwives and the labouring women. Participants reported delivering on their own because the midwives were asleep in the labour ward (n=4) and one of these four participants (participant # 5) a Para 5 had never been attended to by a skilled birth attendant all the five times she was delivering at the health facility. Other participants felt ignored by the midwives because they were denied obstetric examinations, they were not given information on the progress of labour, they were sent back from the labour ward to the antenatal ward while in pain and others said

that the midwives were busy chatting amongst themselves instead of attending to their needs. Participant # 4 expressed the need to expose one of the midwives with whom she had poor interactions with through letter writing and drop it in a suggestion box if the health facility had one. Poor reception on admission was also reported by the participants.

Some of the participants who complained of poor reception and delivered without the assistance from midwives had this to say:

". . . We got off the bike and arrived at the labour ward and found that all the nurses were asleep. My mother knocked at the door (pointing at her mother) and said that she had come with a patient and the midwives said 'tell her to go and lay her mackintosh on the bed and lie down there'. So I went and placed my mackintosh on the bed and lied down there. Then I felt that my time to deliver had come since it is easy to note that the time has come. Then I delivered my baby on my own, there was no midwife to assist me. . . ." (Participant # 1)

". . . (With tears in her eyes) when I went to the labour ward I found all the midwives sleeping, I delivered on the floor, I did not deliver on the bed and I gave birth on the floor not on the bed . . . I failed to climb on the bed so that I should deliver there. I laid my cloth on the floor and delivered my baby there; a midwife upon hearing the baby's cry came and took the baby . . . ." (Participant # 2)

Participants who were denied an examination and complained that the midwives were busy chatting instead of attending to them had this to say:

". . . I went to the labour ward and the midwife refused to examine me . . . I went back again 'she said I'm doing other things right now. If you want just go and lie down on one of the beds' I went there and made the bed, that was around 5pm and I lied down there. I tried to plead with the midwife, but she was chatting with her colleague who worked in the labour ward during the day, the one she exchanged shifts with. The other midwife she was chatting with left the labour ward at around 7pm. (Clears throat) they were just chatting and she left, they left together and left me like that. I was examined just after 2am . . . I was examined in a cruel manner and I was told that labour had not yet started I should go and wait outside . . . ." (Participant # 4)

"I went to the labour ward the first time to be examined and I was told that labour has not started. I went there the second time when I was feeling pain and I was shouted at 'I thought you came here already' so I did not respond and went back. I went there the third time when my water broke that is when I was received . . . When I went to the labour ward instead of them taking care of me they were busy chatting, but others took care of me knowing that I was in pain . . . ." (Participant # 6)

Apart from being denied examinations, one participant complained that she was treated sarcastically by the midwife and she said:

"I was not satisfied because I was not examined and I was not cared for while I was in pain. And when I said that without us patients the midwives will not have a job I was called a boss. 'Boss we are going to sleep'. This pained me in my heart".

(Participant # 4)

Most of the participants responded that they would deliver at the health facility in their next pregnancy. Although this was the case, one participant a primigravida who complained that an episiotomy was done on her without any explanations and that she was in pain as a result, gave conditions on health facility delivery depending on where she will be based in her next pregnancy.

She said:

". . . In the next pregnancy if I will come to deliver here following my parents who live here, I may deliver at this health facility since there [parent's village] they charge money if a woman delivers at home. If I will be where I live then I will not go to the health facility I will give birth at home . . . Yes but if I will have the money I will deliver at home [parent's village] and give the people their money (pause)". (Participant # 13)

Social support on health facility delivery.

Married participants (n=16) were supported by their husbands both materially and psychologically. They provided them with money to be used for transportation to the health facility, they bought baby clothes and food, while others escorted their wives to the health facility. Some participants were advised by their husbands to use the health facility for delivery. Participant # 15 said: *"He escorts me to the health facility and he bought clothes for the baby (pause). Yes he supports health facility delivery because there assistance is given in good time".*

Other married participants said:

"Yes he supports health facility delivery. When labour starts at night he hires a vehicle, when it is my antenatal clinic appointment he provides money for transportation and he advises me to deliver at the health facility and not at home". (Participant # 11)

"Yes he supports health facility delivery . . . He brought me all the important things like food and wrappers. He said it is better to deliver at the health facility because if I were to deliver at home and lose a lot of blood no one will be able to assist me but at the health facility they can". (Participant # 17)

Guardians also played a supportive role in taking care of the participants during the time they were at the health facility. Most participants (n=19) were positive about the care that their relatives gave them, but only one participant had no guardian. The guardians prepared food, brought bath water and gave them spiritual and psychological care. Participant # 2 said: *". . . The care that I have received from my parents is very good. They have taken very good care of me, washed my clothes and are taking care of my baby until now. So I am thankful for this; parents are good. . . . "*

Other participants reported:

". . . The interaction with my mother was very good because she is the one who was encouraging me, at times she would come in and pray for me, she told me that women do not die from labour, I should bear the pain since this was my third time. When the time comes to deliver I should do my best to ensure the safety of my baby yes". (Participant # 4)

". . . All the time I have been here my guardian was encouraging me to take heart. And now that the baby is born she is still encouraging me that God makes a way where there is no way and it shall be well . . . ."(Participant # 6)

Expectations about Health Facility Care

Participants were asked on the care that they would like to receive at the health facility at the time of delivery. Findings revealed that participants valued interpersonal interaction with the midwives especially in the following areas i) good reception, ii) good birth attendant attitudes (they should be kind, they should not shout at labouring women, they should be attentive to labouring women's needs, they should not be rude and that the rude ones need to change their behaviour), iii) presence of a midwife at every delivery, iv) information giving in terms of explaining rationales for procedures being done on them, explaining the results of examinations, explaining about labour progress and providing instructions on what women need to do during labour and delivery and v) timely assistance.

Interpersonal interaction with midwives.

Some participants who valued good reception said:

"Good reception. When you come to the health facility the midwife should receive you well. Not that she should tell you to wait and not attend to you . . . ." (Participant # 18)

"When a woman arrives they should welcome her and show her in . . . You go and knock at the door and they welcome you, they make your labour bed, they carry your

belongings for you and you just go there on the bed and lie down. Then they will come and examine you . . . . " (Participant # 7)

Participants who valued good skilled birth attendant attitudes had this to share:

". . . I would be very happy to find a midwife in the labour ward who will treat me kindly during my delivery time. Not that I should feel labour pain and at the same time feel pain from cruel words spoken by the midwife . . . because they say rude things yes. It will be good if the rude behaviour is changed . . . . " (Participant # 1)

". . . The midwives should not shout at you . . . If you have a problem and you tell them they should be able to understand you, not to the extent of shouting at you . . . " (Participant # 3)

Participants who valued the presence of a midwife at every delivery said:

". . . Upon arrival a labouring woman should be welcomed in the right way, and she should be taken care of well until the time of delivery". (Participant # 16)

"My expectation is to be assisted by a midwife during delivery other than coming from home and deliver on your own in the health facility . . . " (Participant # 10)

"I would like to be assisted by a male midwife yes for me to be able to compare . . . " (Participant # 17)

Participants who valued information giving had this to say:

"I would be very happy that when I go to the health facility while in labour, they should ask me what time and when the labour pain started, then I should explain. When they examine me they should tell me the results . . . Labour has just started go and ambulate, come at such and such a time to be examined again . . . ." (Participant # 4)

". . . During labour you are in a lot of pain and they should listen to what you are telling them. If you call them they should come and examine you and tell you how long you should wait for the time of delivery . . . ." (Participant # 14)

On timely assistance some participants shared:

". . . When someone calls they should rush to assist, since you are in pain and you do not fail to scream. So when you call midwives are supposed to come according to the nature of their job. They should rush sure. They should see how things are going on with you (laughs! Smiles) . . . ." (Participant # 20)

"They need to take care of women depending on how their labour is presenting. If the cervix dilates fast they will assist you in good time. They should assist you in good time". (Participant # 8)

Summary

This chapter has presented findings of a study which was conducted at Chiradzulu District Hospital on women's experiences of hospital delivery. The study findings are presented in four sections namely; demographic characteristics of participants, women's perceptions of the health facility care, women's satisfaction with health facility care and

women's expectations of health facility care. Findings revealed that most participants who delivered at the health facility were aged between 26 and 35 years, resided close to the health facility, were married, attained primary or secondary education and had low parity. Participants perceived the health facility as a place where skilled birth attendants are available to take care of them in all the stages of labour and in case of the development of obstetric complications. However, participants pointed out cruel birth attendant behaviour as one of the disadvantages of health facility delivery. Additionally, participants who underwent a positive child birth experience were more satisfied with delivery care than those who went through negative child birth experiences. Satisfaction and dissatisfaction with delivery care was associated with good and poor interpersonal relationships with skilled birth attendants respectively. Furthermore, participant expectations were on good interpersonal interactions with the skilled birth attendants especially on good reception, good birth attendant attitudes, presence of a midwife at every delivery, information giving and timely assistance.

Chapter 5

Discussion

Introduction

This chapter presents a discussion of the study findings. The aim of the study was to explore child birth experiences of women who delivered their babies at Chiradzulu District Hospital. The research findings are organised and discussed following the study objectives. The study limitations and recommendations are also presented.

Demographic Characteristics

Place of residence was closer to the health facility for most of the study participants. The findings are consistent with the ones that were conducted in other developing countries like Ethiopia and Pakistan (Agha & Carton, 2011; Gabrysch & Campbell, 2009; Tarekegn et al., 2014). Proximity to the heath care facility could indicate that the physical terrain between their home and the health facility was conducive for travel either by foot or by public transport. The reason could also be that there was reduced cost of travel to the health facility at any time and thus utilisation of the health facility for delivery was likely.

Fifty-five percent of the study participants were aged between 26 and 35 years while forty-five percent were aged between 18 and 23 years. This finding shows that women who utilised the health facility had a higher maternal age. The findings are consistent with those by Gabrysch & Campbell, (2009) and Fotso, Ezeh, & Essendi, (2009), who found out that pregnant women with a higher age utilized the health facility

for delivery more and those aged 25 years and below utilised the health facility for delivery less respectively. In addition, Magadi et al., (2007) in their paper that used Demographic and Health Surveys data from 21 countries in sub-Saharan Africa to examine the use of maternal health services by teenagers, found out that older pregnant women utilised the health facility more because they received better maternal health services than their younger counterparts. The current study was conducted in Malawi which is one of the sub-Saharan countries thereby increasing the likelihood of it producing similar findings with other studies in the region.

Findings of the study revealed that utilisation of a health facility for delivery reduced with increasing parity. The findings are consistent with those from other studies (Agha & Carton, 2011&Worku et al., 2013). This could be due to the women's perception that the risk of obstetric complications is higher in persons with lower parity or that women after previous smooth deliveries at the health facility may plan to deliver away from the health facility or because women are no longer having more children after the fourth one.

Most of the study participants were married. The finding is contrary to the study by Tarekegn et al., (2014) which was conducted in Ethiopia whose findings indicated that health facility utilisation was mostly by unmarried pregnant mothers. However, Ono, Matsuyama, Karama, & Honda, (2013) whose study aim was to "explore determinants of association between social support and place of delivery" in Kenya found out that married women who received advice from their mothers-in-law and health care workers on the importance of health facility delivery were likely to use the health facility than their counterparts who did not receive such information. In addition, Lubbock &

Stephenson, (2008), Moyer et al., (2013) and Fotso et al., (2009) found out that women who were advised about health facility delivery at the antenatal clinic were more likely to deliver at the health facility than their counterparts who did not receive such information. In another study Gabrysch & Campbell, (2009) found out that exposure to social media was a predictor of health facility delivery. For instance, in this study, most participants' sources of information about the importance of health facility delivery was from the chiefs in their communities, skilled birth attendants at the antenatal clinic, the radio and significant others like mothers, mothers-in-law, sisters and friends just to mention a few. These findings are consistent with those of studies by Fotso et al., (2009), Gabrysch & Campbell, (2009), Lubbock & Stephenson, (2008), Moyer et al., (2013) and Ono et al., (2013). It can therefore be implied that most of the married participants is this study had prior information on the importance of health facility delivery, they had time to digest it and in turn made a decision to utilise the health facility for delivery.

Most of the study participants and their husbands attended primary and secondary school education while one participant and one of the participants husband did not attend school. The findings are consistent with the ones by Agha & Carton, (2011), Mokdad et al., (2015) and Worku et al., (2013), who found out that women with at least primary or secondary school education or those with higher education utilised the health facility more than those that did not attend school. On occupation, findings revealed that most participants were housewives, one was self employed, one was employed, one was a farmer and two did not do anything. The findings indicated that participants might have relied on other people like their husbands or their significant others for financial support. However, Gabrysch & Campbell, (2009) found out that the use of a health care facility

for maternity services increases with increasing house hold wealth and a high socioeconomic status predicts health facility delivery (Agha & Carton, 2011; Anyait et al., 2012; Gabrysch & Campbell, 2009 & Tarekegn et al., 2014). In addition, women who come from families with more than one source of income are likely to deliver at the health facility than their counterparts who only have one source or no source at all (Turan et al., 2008 & Worku et al., 2013). Information on other sources of income generation like the husband's occupation and that of participants' significant others was lacking in the current study to make a conclusion on the participants' social economic standing and link that to child birth service utilisation at the health facility.

Perceptions of Health Facility Delivery Care

Views about health facility delivery.

Findings of this study revealed that participants viewed the health facility as a place where skilled birth attendants and medical supplies were available for their care in case of the development of obstetric complications like malpositions, per vaginal bleeding, draining liquor and retained products of conception. Care is also available for neonatal complications such as prematurity, asphyxia or congenital abnormalities. This is consistent with findings from other studies (Mwangome et al., 2012; Oyerinde et al., 2012 & Parkhurst, Rahman, & Ssengooba, 2006). In their qualitative studies which were conducted in Sierra Leone and Ethiopia by Oyerinde et al., (2012) and Øxnevad, (2011) respectively found out that perception of danger signs such as per vaginal bleeding, convulsions, excessive pain, vomiting, blurred vision, fever, obstructed labour and retained products of conception were perceptions that led to health facility maternity service utilisation.

The findings also revealed that participants valued delivery care at the health facility since they trusted midwives who took care of them from the time of admission, through labour and delivery and later in the postnatal ward. This is consistent with study findings by Bashour & Abdulsalam, (2005), Bedford et al., (2012) and Oyerinde et al., (2012). As a result women have positive perceptions of health facility delivery because of its secure and safe environment that later leads to its utilisation (Bashour & Abdulsalam; Bhattacharyya et al., 2013; Ith et al., 2013; Izugbara et al., 2009; Lubbock & Stephenson, 2008; Moyer et al., 2013 & Oyerinde et al., 2012).

However, findings showed that one of the disadvantages of health facility delivery was meeting cruel midwives who shouted at some of the participants while receiving delivery care. This is consistent with findings from studies by Dzomeku, (2011), Izugbara et al., (2009), Lubbock & Stephenson, (2008) and Oyerinde et al.,(2012) whose findings described skilled birth attendants with poor attitudes as harsh and rude, actions that led to poor perceptions of health facility delivery that would consequently prevent future utilisation. In another study, Ith et al., (2013) described poor staff attitudes as disrespect and physical abuse such as slapping. This is contrary to the results of the current study since no physical abuse was reported.

Motivation to deliver at the health facility.

Most of the participants made the decision to deliver at the health facility on their own except for a few whose decisions were made by the husband and relatives. The findings revealed that most of the participants were autonomous in making a decision to deliver at the heath facility and thus consistent with studies by Agha & Carton, (2011), Parkhurst et al., (2006), and Speizer, Story, & Singh, (2014). In addition, this study found

out that one participant made a decision to deliver at the health facility together with her husband. Consistently, Danforth et al., (2011) and Lubbock & Stephenson, (2008) found out that combined health decision making between the pregnant woman and her husband facilitated health facility use. Furthermore, Bedford et al., (2012), Magoma, Requejo, Campbell, Cousens, & Filippi, (2010), Oyerinde et al., (2012) and Parkhurst et al., (2006), found out that maternal autonomy was affected where third parties like husbands and other relatives were involved in health facility delivery decision making. Such lengthy decision making processes may cause delays in seeking care and may create potential for development of obstetric complications. Although findings of the current study revealed that health facility decision making was made by some of the participant's husband and relatives, room for development of complications was not available since they reached the health facility in time and they did not develop any obstetric complications. Furthermore, findings from the above cited studies on health facility decision making by third parties, decisions were made either when home labour was progressing poorly or when there was development of obstetric complications. Therefore, the findings are contrary to the ones in this study. Findings from the study by Moyer et al., (2013) disputed that pregnant women needed third parties on health facility decision making but such parties should be relied on for physical and psychological support from home to the health facility and back.

Intrapartum care.

Findings of the study indicated that there were preferences among participants on skilled care received. For instance, preferences on gender of a skilled birth attendant leaned more towards male than female midwives. Male midwives were viewed by most

participants as the ones who provided good care as compared to their female counterparts. This is concurrent with findings of a study which was conducted by Mwangome et al., (2012) who found out that male midwives were preferred because they were more respectful to their clients. The gender preference in the current study could be because Chiradzulu District Hospital was mainly dominated by female midwives and thus their male counterparts were easy to spot in the way they provided midwifery care. On the other hand, Bashour & Abdulsalam, (2005) and Bhattacharyya et al., (2013) in their qualitative studies conducted in Syria and India respectively found out that female midwives were preferred more due to their provision of psychosocial support than their male counterparts, while others expressed shyness with male midwives as a reason for the gender preference. Furthermore, Magoma et al., (2010) found out that digital vaginal examinations performed by male providers were viewed by the participants as dehumanising. The difference in gender of skilled birth attendants might be because the countries in question; Syria, India and Malawi, belong to separate regions of the world and chances of having differences in religious and cultural beliefs are high.

Satisfaction with Delivery Care

Positive child birth experiences.

Findings of the study revealed that most participants who underwent positive child birth experiences were satisfied with health facility delivery care. In addition, majority of the satisfied participants were positive about their interpersonal interactions with skilled birth attendants such that they were described by the participants as polite, kind, filled with love, good and honest. Concurrently, Cham, Sundby, & Vangen, (2009),

Changole et al., (2010) and Dzomeku, (2011) found out that women who experience good interpersonal relationships with skilled birth attendants were satisfied with the delivery care they received at the health facility and they were likely to utilise the maternity services again in future. For instance, women were satisfied with being greeted by health care workers, a change of soiled beddings, provision of free drugs and the health care workers were described as helpful and friendly (Cham et al., 2009 & Changole et al., 2010). Furthermore, Fair & Morrison, (2012) found out that women who felt in control of their labour and delivery processes were likely to be satisfied with the care. The good interpersonal relationships might have created feelings of self worth in the participants since they were attended to and they felt important in the unfamiliar health facility environment. Therefore, feelings of satisfaction with maternity care were more likely to be achieved.

Additionally, findings of the study also revealed that satisfaction with delivery care was associated with the availability of a skilled birth attendant from admission and throughout labour and delivery, information giving in all the stages of labour, administration of pain medication before suturing of perineal tears and episiotomies, provision of privacy and encouragement to push in the second stage of labour. The findings are concurrent with the ones found by Fair & Morrison, (2012) and Senarath, Fernando, & Rodrigo, (2006) in the United States of America and Sri Lanka respectively. In the two studies, maternal satisfaction with delivery care was associated with skilled birth attendance, being nursed in a private environment and provision of information about labour progress which led to feelings of control over labour and delivery. Although the studies were conducted in different regions of the world from the current study, it is

important to note that labour and delivery processes are the same in every woman no matter the geographic position. This being the reason, women may have similar feelings of satisfaction basing on the care received at the health facility. Furthermore, findings of the study revealed that good reception, timely assistance and being nursed in a clean environment at the health facility were aspects that led to satisfaction in the participants. The findings are concurrent to the ones conducted by other researchers (Bhattacharyya et al.,2013; Senarath et al., 2006; & Changole et al., 2010).

Negative childbirth experiences.

The current study's findings revealed that a few of the participants who were not satisfied with health facility delivery care went though negative childbirth experiences, specifically on poor interpersonal interactions with skilled birth attendants. Avortri, Beke, & Abekah-Nkrumah, (2011), Chadwick et al., (2014), Cham et al., (2009**)** and D'Ambruoso, Abbey, & Hussein, (2005) found out that women were not satisfied with delivery care where health care attitudes were poor and thus, they concur with the findings of this study. For instance, poor attitudes of health care workers that were found by Chadwick et al., (2014), D'Ambruoso et al., (2005) and Dzomeku, (2011) were rudeness, shouting, lack of empathy and harsh treatment. For this reason, pregnant women explored other options for future deliveries such as non attendance or late arrival at the health facility (Dzomeku, 2011).

Additionally, findings of this study revealed that some participants felt neglected to the extent that they delivered without the assistance of a skilled birth attendant at the health facility and others expressed that their needs were not attended to because other midwives were busy chatting among themselves. This concurs with findings from a study

by Chadwick et al., (2014) which was conducted in South Africa where participants who were attended in the very last minute by skilled birth attendants were more distressed and felt neglected. In the same study, the call for assistance was neglected by attending health care workers because they were either busy with other personal things or they were busy chatting with each other.

Participants who were not given enough information on labour progress were not satisfied with delivery care. This concurs with findings from studies by Dzomeku, (2011) and Chadwick et al., (2014) where women who were denied information on labour progress such as; cervical dilatation, were dissatisfied with delivery care at the health facility due to lack of control in their own care. Women who are not given enough information on delivery care are 9.4 times likely to be dissatisfied with delivery care (Avortri et al., 2011). In addition, in the study, findings revealed that there was lack of knowledge on the procedures of lodging complaints about poor care at the health facility, the presence of a suggestion box at the health facility for example. Avortri et al., found out that lack of knowledge of such channels of communication among women who attend the health facility for delivery leads to dissatisfaction with delivery care. The findings of both studies therefore concur. Furthermore, the study revealed that poor reception on admission at the health facility led to dissatisfaction with delivery care. Cham et al., (2009) found similar findings and Avortri et al., found out that women who perceived unfriendliness on health care workers on admission were 15 times likely to be dissatisfied with delivery care as compared to their counterparts who perceived them as friendly.

Social support on health facility delivery.

In this study, most of the married participants were supported by their husbands both materially and psychologically. For example, money for transportation to the health facility, for buying baby clothes and for buying food while at the health facility was provided to the participants. Other husbands escorted their wives to the health facility. The findings are consistent to the ones found out by Lubbock & Stephenson, (2008), Parkhurst et al., (2006) and Story et al., (2012) where the saved money for health facility delivery was not only used for transportation and purchase of clothes for the wife and the new born baby but also for payment of service user fees at the health facility. In addition, husbands took care of the home and children while their wives were at the health facility. The participants might have been encouraged to deliver at the heath facility because of the support they received from their partners. Also they might have been at ease while receiving care at the health facility because they knew that their home was taken care of well in their absence thereby reducing feelings of stress.

The presence of other female members in the company of labouring women is vital in promoting feelings of self esteem in labouring women. For instance, in this study, most participants were positive about the care that was given to them by their relatives while they were at the health facility seeking delivery care. The care ranged from preparation of food, provision of bath water, offering of prayers and other forms of psychological care just to mention a few. This is consistent to the findings from other studies where participants were satisfied with delivery care at the health facility because of the presence of a familiar birth companion (Bhattacharyya et al., 2013 & Bruggemann et al., 2007). In addition, in other studies, women who had a companion present experienced reduced occurrences of meconium stained liquor, had shorter first and

second stages of labour and had fewer occurrences of caesarean sections and reception of pain relief during labour than their counterparts who did not have a companion (Bruggemann et al., 2007; Kashanian et al., 2010; McGrath & Kennell, 2008 & Kashanian et al., 2010). However these parameters were not measured in the current study and therefore difficult to relate. Absence of a companion at the health facility creates feelings of distress among labouring women (Chadwick, Cooper, & Harries, 2014 & Ith et al., 2013). In this study, such feelings of distress were not reported although one participant had no companion.

Expectations towards Health Facility Delivery Care

Good interpersonal relationships among pregnant women and skilled birth attendants were expected by the participants. Firstly, good reception on arrival at the health facility was found to be one of the expectations of health facility delivery. This is concurrent with findings by other researchers like Bhattacharyya et al., (2013), Ghani, Mahmoud, & Berggren, (2011), Iravani et al., (2015) and Ith et al., (2013) who found out that women expected a warm welcome, expected to be greeted, expected privacy and expected confidentiality at all times while receiving maternity services at the health facility.

Secondly, findings revealed that good birth attendant attitudes were expected at the health facility. For instance, health care providers were expected to be kind, attentive, polite and not to shout at labouring women. Concurrently, D'Ambruoso et al., (2005), Ghani, Mahmoud, & Berggren, (2011) Iravani, Zarean, Janghorbani, & Bahrami, (2015) & Kruk, Paczkowski, Mbaruku, de Pinho, & Galea, (2009) found out that women expected health care workers to be respectful, polite, empathetic and to provide

reassurance during their stay at the health facility. As a result of such actions from skilled birth attendants, labouring women could have a boosted self esteem and they could put more efforts in involving themselves in their care at the health facility. However, poor health care worker attitudes prevented women from utilising the health facility for delivery (D'Ambruoso et al., 2005 & Ith et al., 2013). Poor health care worker attitudes in a country like Malawi could facilitate women to deliver without the assistance of a skilled birth attendant since professional care could not be sought. As a result, maternal and neonatal indicators could not improve.

Thirdly, findings of the study revealed that participants expected skilled birth attendants who would take care of their needs during labour and delivery at the health facility. For example, participants valued to be assisted with child birth other than them delivering on their own while at the health facility. Although findings showed that participants were not specific on their needs during labour, such expectations were revealed in studies conducted elsewhere and would therefore be applied while caring for any labouring woman. For instance, women expect their nutritional needs to be fulfilled during labour as this would assist in maintaining their strength (Iravani et al., 2015). In addition, a comfortable and clean delivery place were expectations from studies conducted by Bhattacharyya et al., (2013), Ghani, Mahmoud, & Berggren, (2011) and Iravani et al. Furthermore, women expected skilled birth attendants to clean both them and their babies soon after delivery so as to leave them comfortable (Bhattacharyya et al., 2013), while others expected to be encouraged to ambulate during labour since the exercise brought comfort as compared to lying on the labour bed (Iravani et al., 2015). Apart from midwives providing comfort during labour and delivery, women also

expected them to provide pain medication (Ghani et al., 2011) and for them to avoid performance of procedures that were a nuisance to them such as; routine insertion of urinary catheters to empty the bladder during labour, unnecessary vaginal examinations, routine episiotomies and routine enemas (Iravani et al., 2015).

Lastly, findings revealed that participants expected skilled birth attendants to provide them with information and explanations about labour progress. Expectations were also on provision of instructions on the role of participants during labour and delivery. Concurrently, D'Ambruoso et al., (2005), Ghani et al., (2011), Iravani et al., (2015), and Ith et al., (2013) found out that provision of information and explanations about labour progress and family planning counseling to maternal women instilled them with knowledge, skill and boosted their self esteem such that they were confident to take care of themselves and their newborns in the postpartum period. Furthermore, Iravani et al., found out that women expected an orientation to the unfamiliar health facility environment such as the toilet and bathrooms as this reduced their stress during their stay there.

Constrains and Limitations

The study was conducted at one health facility only, thus the findings may not be generalised to the whole population. However, the issues that come out from this study may be applied in other similar settings.

Dissemination of Findings

The findings of the study will be disseminated to Chiradzulu District Health Office through a meeting. A report of the findings of the study will also be submitted to Kamuzu College of Nursing and College of Medicine libraries. The study findings will

also be disseminated through publications in referred journals and presentations at national and international research conferences.

Recommendations

- Skilled birth attendants need to be aware of how to provide age specific maternity care, in order to provide age appropriate maternity services that would encourage future utilisation of the health facility for delivery for all reproductive ages.
- Midwives have to be trained on customer care and client focus to create awareness on how to treat pregnant women at the health facility. Monitoring and evaluation procedures following the trainings need to be put in place so as to measure skilled birth attendant attitudes at the health facility.
- A suggestion box needs to be put in an open place at health facilities and pregnant women and their significant others need to be informed of its whereabouts and use. Items in the suggestion box will need to be periodically reviewed by a responsible team for purposes of maternity care delivery improvements at the health facility.
- Exit interviews need to be conducted on postnatal mothers following discharge from the health facility for purposes of maternity service improvements.
- Male partners as breadwinners need to be encouraged to attend the antenatal clinic with their pregnant partners since they will receive information on birth preparedness together and plan appropriately for health facility utilisation for delivery.

- Strategies to empower men on their supportive role need to be put in place at district level in order to promote institutional deliveries.

Areas for Further Research

The following areas for further research were identified basing on gaps that were identified following the results of this study;

- Socioeconomic status of husbands and significant others of pregnant women was not fully explored in this study. Therefore the researcher suggests for a study to be conducted to explore the influences of occupation of pregnant women's husbands and/or significant others on health facility utilisation for child birth services.
- Measure the relationship between demographic characteristics and the motivating factors for health facility delivery.

Summary

In summary, this study aimed to explore child birth experiences of women who gave birth at Chiradzulu District Hospital. Results revealed that perceptions of women on the health facility were mostly on the trust of skilled birth attendants on the management of obstetric complications and that the disadvantage of health facility delivery was to be attended by a cruel midwife. Additionally, satisfaction with health facility care was as a result of good interpersonal relationships with the attending midwife. Similarly, results indicated that women's expectation on health facility delivery also revolved around good interpersonal relationships with the attending skilled midwives. Therefore, meeting women's expectations on delivery care would cause women to be satisfied with the care

leading positive perception of health facility delivery and future utilisation of maternity services at the health facility.

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Appendices

Appendix A. Time frame

Activity	June - November 2015	December 2015 to March 2016	April 2016	June 2016	July 2016	August 2016
Identification of topic and literature review						
Proposal writing						
Proposal submission to COMREC						
Pretest and Data collection						
Data analysis and report writing						
Report submission						

Appendix B: Information Sheet and Informed Consent

Informed consent for postnatal women who gave birth at a health facility who are being invited to participate in a study entitled "Women's experiences of hospital delivery at Chiradzulu District hospital.

Name of Principal Investigator- Colette A.K. Phiri

Name of Organisation- Kamuzu College of Nursing

Name of sponsor- USAID

This informed consent has two parts:

- Information sheet (which will explain information about the study).
- Certificate of consent (where you will sign if you choose to participate).

A copy of the full consent form will be given to you.

Part I: Information sheet

Introduction

I am Colette Phiri, pursuing a Master of Science in Midwifery degree at Kamuzu College of Nursing. I am doing research on experiences of women who deliver their babies at this institution. I am going to give you information and invite you to take part in this research. You do not have to decide today on whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. This consent form may contain information that you may not understand. Please feel free

to ask for any clarification and I will take my time to explain in ways that will help you understand further.

Purpose of the research

The Malawi government advocates for health facility delivery but records show that some women in Chiradzulu District Hospital catchment area do not use the health facility for child birth. We therefore would like to know more from the women who choose the health facility for delivery with the aim of identifying our strengths and challenges to help us improve care in the health facility so as to increase the number of women who deliver at a health facility.

Type of research intervention

This research will involve your participation in an in-depth interview that will take between 30 to 45 minutes.

Participant selection

You are being invited to participate in the research because we feel your child birth experience at a health facility can create an understanding of the experience and contribute to the interventions that will promote use of the health facility for delivery in future.

Voluntary participation

Your decision to take part in the study is entirely voluntary. It is your choice whether to participate or not. In the event that you choose not to participate, be ensured that you will

receive all the necessary health care services and nothing will change. You may choose to withdraw your participation at any time even if you agreed earlier without giving any explanation.

Procedures

We are asking you to help us learn more about your child birth experience at a health facility. You are being invited to take part in this research. You will be asked to undergo an in-depth interview with myself if you accept. During the interview I will sit down with you in a comfortable place. You may choose to sit in a chair or lie on a bed or you may choose any other position that will ensure your comfort. If you do not wish to answer any of the interview questions, you may say so and the interviewer will move on to the next question. You and the interviewer will be the only persons present in the interview unless you would like someone else of your choice to be present.

The recorded information provided during the interview will be confidential and no one else but the interviewer and her two research supervisors will access the information recorded during the interview. The entire interview will be tape recorded, but no one will be identified by name on the tape. The tape will be kept in a locked cupboard where access will only be limited to the researcher and her two research supervisors. The tapes will be destroyed after 5 years.

Duration

Data collection for the research will take place over a period of four weeks.

Risks

There is a minor risk that is associated with your participation in the research. For instance, the interviews will be audio recorded. In that regard, a number that will be

known by the study team only will be used in place of your name for privacy and confidentiality purposes.

Benefits

There will not be a direct benefit to you, but your participation is likely to help us find out more about your child birth experience and how we can put in place interventions that will promote health facility delivery

Reimbursements

You will not be provided with any incentive to take part in this research.

Confidentiality

We will not share information about you to anyone outside the research team. All information that will be collected will be kept private. Any information about you will not have your name on it, but a number that will be known only by the research team. The interview information will be kept under lock and key and will only be shared among the researcher and her two research supervisors.

Sharing the results

Nothing that you will tell us today will be shared with anybody outside the research team and nothing will have your name on it. The knowledge that will be gained from this research will be shared with you and the members of staff at Chiradzulu District Hospital before public knowledge. Following meetings with Chiradzulu District hospital staff**,** the

research results will be published so that other interested people may learn from the research.

Right to refuse or withdraw

Participation in this research is entirely voluntary and you do not have to take part if you wish to do so. Deciding to participate will not interfere with the care that you are supposed to receive at this hospital. You may choose to withdraw from the interview at any time and this will also not affect your care. You will be given an opportunity at the end of the interview to review your remarks so that they can be modified, removed and clarifications made before closure.

Who to contact

If you have any questions you can ask them now. If you wish to ask them later you can contact me; Colette A.K. Phiri, Kamuzu College of Nursing, P.O. Box 415, Blantyre, Cell- 0888901777

This proposal was reviewed and approved by College of Medicine Research and Ethics Committee (COMREC) whose task is to ensure that research participants are protected from harm. If you wish to find out more about COMREC contact; COMREC Secretariat, P/Bag 360, Chichiri Blantyre 3, Tel- 01989766

Part II: Certificate of consent

I have been invited to participate in the research about "Women's experiences of hospital delivery at Chiradzulu District Hospital". I have read the information about the research,

or it has been read to me. I have had the opportunity to ask questions and they were answered to my satisfaction. I hereby consent to participate in this study voluntarily.

Print name of participant…….

Signature of participant……

Date……Day/month/year

If illiterate

I have witnessed the reading of the consent form to the potential participant. The participant was given the opportunity to ask questions about the research. I confirm that she has given consent to participate without being coerced.

Print name of witness……. Thumb print of

Signature of witness…….. Participant

Date……..(Day/Month/Year)

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant. I conform that the participant was given the opportunity to ask questions concerning the research and I have answered them accurately to the best of my ability. I confirm that consent from the individual to participate in the research has been given freely and voluntarily and that she was not in any way coerced to do so.

A copy of this information and consent form has been provided to the participant.

Print name of researcher/person taking consent……

Signature of researcher/person taking consent……..

Date…….. (Day/Month/Year)

Appendix C: Information Sheet and consent form Chichewa Translation

Kalata yofotokoza za ndondomeko ya kafukufuku kwa amayi omwe achilira ana awo ku chipatala

Kalata iyi iri ndi magawo awiri:

- Kalata yofotokoza ndondomeko ya kafukufuku
- Kalata yovomeleza kutenga nawo mbali mu kafukufuku

Mupatsidwa kalata imodzi yovomeleza kutenga nawo mbali mu kafukufukuyu

Gawo Loyamba: Kalata Yofotokoza Ndondomeko ya Kafukufuku

Malonje

Ine dzina langa ndi Colette A.K. Phiri, ophunzira za uzamba pa sukulu ya ukachenjede ya Kamuzu. Ndikupanga kafukufuku ofuna kudziwa zomwe amayi omwe amachilira ana awo pa chipatala pano amakumana nazo. Ndikufotokozerani ndondomeko ya kafukufukuyu ndipo ndikupemphani kuti mutenge nawo mbali. Musanapange chiganizo chotenga nawo mbali ndiinu ololedwa kufotokozera aliyense wa kumtima kwanu za

kafukufukuyu. Kalatayi itha kupezeka ndi nkhani zina zoti simukuzimvetsetsa. Metero khalani omasuka kufunsa pomwe simunamvetsetse kuti ndikufotokozereni bwino lino.

Cholinga cha kafukufuku

Dziko la Malawi limalimbikitsa amayi oyembekezera kuti azichilira ana awo ku chipatala koma kafukufuku akuwonetsa kuti amayi ena ozungulira chipatala chachikulu cha Chiradzulu sakuchilira ku chipatala. Pa chifukwa ichi, tikufuna kudziwa kuti amayi omwe amachilira ku chipatalawo amakumana ndi zotani pa nthawi imene akuchilira ku chipatala kuti tidziwe mbali imene tikuchita bwino komanso yomwe tikufowoka. Izi zizatithandiza kukonza zofowokazo ndi cholinga choti chiwerengero cha amayi ochilira ana awo ku chipatala chichuluke.

Mtundu wa kafukufuku

Kafukufukuyu afunika inu kutenga nawo mbali ndipo ndizakufunsani mafunso. Zokambirana zathu zizatitengera pakati pa mphindi makumi atatu (30) ndi makumi anayi ndi mphambu zisanu (45).

Kasankhidwe ka otenga nawo mbali

Mukuyitanidwa kutenga nawo mbali mu kafukufukuyu chifukwa tili ndi chiyembekezo kuti zomwe munadutsamo pa nthawi yomwe munachilira ku chipatala zitha kuthandizira amayi ochuluka kuti azichilira ku chipatala mtsogolomu.

Kutenga nawo mbali mu kafukufuku mosakakamizidwa

Simukukakamizidwa kupanga chiganizo chitenga nawo mbali mu kafukufukuyu. Zili kwa inu kutenga nawo mbali kapena ayi. Ngati mungasankhe kutenga nawo mbali, dziwani kuti mulandira chithandizo chomwe mukuyenera kulandira popanda kusintha kulikonse. Muthanso kusankha kusintha maganizo otenga nawo mbali mu kafukufukuyu ngakhale mutavomera kale kutero ndipo simukuyenera kupereka chifukwa chirichonse.

Ndondomeko ya kafukufuku

Ndidzakufunsani mafunso kuti ndimvetsetse zambiri za zomwe munadutsamo pamene mumachilira mwana wanu ku chipatala. Mukuyitanidwa kutenga nawo mbali mu kafukufukuyu. Ngati mungavomere kutenga nawo mbali mu kafukufukuyu tikhala limodzi mu zokambilana pa malo omwe inu mukhale omasuka nawo. Mu zokambilanazo, mutha kusankha kukhala pa mpando kapena kugona pa bedi kuti mukhale momasuka. Ngati simungakhale omasuka kuyankha mafunso ena munene, ndipo ndizakufunsani mafunso a patsogolo. Inu ndi ine ndi omwe tizakhalemo mu zokambilana za kafukufukuyu pokhapokha inuyo mutafuna kuti pa zokambilanazo pakhale munthu wina wa kumtima kwanu.

Zokambilana zonse zizakhala za chinsinsi ndipo omwe azaloredwe kuwerenga kapena kumvetsela zomwe titakambilane ndi ine ndi aziphunzitsi anga awiri. Ngakhale zokambilana zathu zizakhale pa kaseti, dzina lanu silizapezeka mu zokambilanazo.

Kasetiyo idzasungidwa mu kabati yomwe izizatsekedwa ndi kiyi ndipo omwe adzaloredwe kumvetsera kaseti imeneyo ndi ine ndi aziphunzitsi anga awiri. Kaseti yomwe izakhale ndi zokambilana zathuyi izawotchedwa pakazatha zaka zisanu malingana ndi malamulo a kafukufuku.

Nthawi yopangira kafukufuku

Kafukufukuyu adzatitengera mwezi umodzi.

Zovuta zomwe zingadze chifukwa chotenga nawo mbali mu kafukufuku

Pali zovuta zochepa zomwe zingadze kwa inu kamba kotenga nawo mbali mu kafukufukuyu. Mwa chitsanzo, zokambilana zathu zidabidwa pa kaseti. Ndikukutsimikizilani kuti dzina lanu silidzagwiritsidwa ntchito mu zokambilana zathu koma tidzagwiritsa ntchito nambala ya chinsinsi imene tidzadziwe ife amene tikupanga kafukufukuyu pofuna kukusungirani chinsinsi inuyo.

Ubwino otenga nawo mbali mu kafukufuku

Ubwino wotenga nawo mbali mu kafukufukuyu siukhudza inuyo pa nthawi ino. Koma zimene inuyo mwadutsamo pa nthawi imene mumachilira mwana wanu ku chipatala zizatithandiza ifeyo kudziwa zomwe tingapange kuti tipititse patsogolo ntchito ya uchembere wabwino ndi cholinga choti amayi ochuluka adzichilira ku chipatala.

Chithandizo chokupatsani chifukwa chotenga nawo mbali mu kafukufuku

Simudzapatsidwa china chilichinse chifukwa choti mwatenga nawo mbali mu kafukufukuyu

Kuwonetsetsa kuti pali chinsinsi kwa otenga nawo mbali

Palibe munthu yemwe azadziwe zokhudzana ndi zokambilana zathu kupatulapo ine ndi aziphunzitsi anga awiri. Zokambilana zathu zidzasungidwa malo a chinsinsi. Mbiri yanu komanso zokambirana zathu zonse sizidzakhala ndi dzina lanu koma nambala yomwe tizadziwe ine ndi aziphunzitsi anga awiri basi.

Kugawana zotsatira za kafukufuku ndi anthu ena

Zotsatira za kafukufukuyu tizakudziwitsani komanso tizawadziwitsa ogwila ntchito a pa chipatala chachikulu cha Chiradzulu asanadziwe anthu ena. Kuchoka apo, zotsatilazi zidzalembedwa mmabuku kuti anthu ena amene adzakhale ndi chidwi ndi kafukufukuyu azadziwe zomwe tinapeza.

Ufulu okana kutenga nawo mbali mu kafukufuku

Kutenga nawo mbali mu kafukufukuyu ndi kosakakamiza. Kutenga nawo mbali sikusokoneza chithandizo chomwe mudzalandile pa chipatala pano. Muthanso kusankha kusiya kutenga nawo mbali mu zokambilana pa nthawi iliyonse ndipo chisamaliro chomwe mukuyenera kulandira sichidzasintha. Pa mapeto pa zokambilana pazakhala mwayi obweleranso mmbuyo ndi kuwunika zomwe tidzakambilane kuti tidzathe kukonza pomwe sitinamvetsetsane kapena kuchotsa pena ndi pena posafunikira

Omwe mungalumikizane nawo zokhudzana ndi kafukufuku

Ngati mungakhale ndi mafunso, mutha kufunsa panopa. Koma ngati mungafune kudziwa zambiri nthawi ina mutha kudzandilembera kalata pa keyala iyi; Colette A.K. Phiri, Kamuzu college of nursing, P.O. Box 415, Blantyre, kapena kundiyimbila pa foni ya mmanja pa 0888901777.

Kafukufukuyu anavomerezedwa ndi bungwe lowona za kafukufuku wa za umoyo ku Malawi kuno la pa sukulu ya ukachenjede ya medicine lotchedwa College of Medicine Research and Ethics Committee (COMREC) omwe udindo wawo ndi kuwonetsetsa kuti onse otenga nawo mbali mu kafukufuku ndi otetezedwa. Ngati mungafune kumva zambiri za COMREC mutha kulemba kalata ku keyala iyi; COMREC Secretariat, P/Bag 360, Chichiri Blantyre 3, kapena kuyimba foni pa nambala iyi; 01989766.

Gawo Lachiwiri: Kalata ya chivomelezo

Ndayitanidwa kutenga nawo mbali mu kafukufuku wofuna kudziwa zomwe amayi amene amachilira ana awo ku chipatala amakumana nazo. Ndawerenga ndondomeko ya kafukufukuyu, kapena andiwelengera. Ndinapatsidwa mwayi ofunsa mafunso ndipo ndakhutitsidwa ndi mayankho awo. Kotero, ndikuvomereza kutenga nawo mbali mu kafukufukuyu mosakakamizidwa.

Dzina la wotenga nawo mbali……..

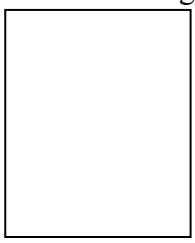
Sayini ya wotenga nawo mbali……

Tsiku…… (Tsiku/Mwezi/Chaka)

Ngati wotenga nawo mbali satha kulemba

Ndawonelera kuwerenga kwa ndondomeko ya kafukufuku kwa wofuna kutenga nawo mbali. Wofuna kutenga nawo mbaliwo anapatsidwa mpata ofunsa mafunso okhudzana ndi kafukufukuyu. Ndikuyikirapo umboni kuti sanakakamizidwe konse kutenga nawo mbali mu kafukufukuyu.

Dzina la mboni…… Chidindo cha chala cha wotenga nawo mbali



Sayini ya mboni……..

Tsiku……..(Tsiku/Mwezi/Chaka)

Mau ochokera kwa ofufuza

Ndawerenga moyenera ndondomeko ya kafukufuku kwa wofuna kutenga nawo mbali mu kafukufuku. Ndikuyikirapo umboni kuti ofuna kutenga nawo mbali anapatsidwa mpata wofunsa mafunso okhudzana ndi kafukufuku, komanso ndawayankha moyenera malingana ndi kuthekera kwanga. Ndikuyikiraponso umboni kuti wofuna kutengapo mbali mu kafukufukuyu sanakakamizidwe kutero.

Kalata yofotokoza za ndondomeko ya kafukufuku komanso kalata ya chivomelezo zaperekedwa kwa wotenga nawo mbali.

Dzina la ofufuza……..

Sayini ya ofufuza……

Tsiku……(Tsiku/Mwezi/Chaka)

Appendix D: Interview Guide

Code number…….

Date of interview…….

Name of interviewer……

Section A: Demographic Data

I am going to ask you questions on your personal information

1. What is your age?.....
2. Where do you live?.....
3. What is your marital status?
    a. Single
    b. Married
    c. Divorced
    d. Separated
    e. Widow
    f. Cohabiting
4. (i) What is your education level?
    a. Primary

b. Secondary

c. Tertiary

d. None

(ii) If you are married, what is the education level of your husband?

a. Primary

b. Secondary

c. Tertiary

d. None

5. What is your occupation?

a. Self employed

b. Employed

c. House wife

d. Other Specify……

6. What is your parity?

a. One

b. Two

c. Three

d. Four

e. Five and above

Section B: In-depth Interview

Women's Perceptions of Delivery Care at a Health Facility

1. How do you view a health facility delivery?

   Probe: advantages and disadvantages.

2. What motivated you to choose this health facility for child birth?

   Probe: who made this decision for you?

3. Where did you get information about health facility delivery?

4. Describe the care you received from the time you arrived to this health facility to the time you were leaving the labour ward to the postnatal ward.

   Probe: Reception, environment, medication, interaction with health care providers, presence of family, care given to you and the baby after delivery.

5. What did you like about the care?

6. What did you not like about the care?

7. Who do you feel is the best health care provider as far as health facility child birth is concerned and why?

Women's Satisfaction with Hospital Delivery

1. What aspects of health facility delivery care were you satisfied with? Why?
2. What aspects of health facility delivery care were you dissatisfied with? Why?

   Probe: will you use the health facility for delivery again or not? Why?

3. Does your spouse support health facility delivery? Please give reasons.

Women's expectations towards hospital delivery

1. What services would you appreciate if offered to you during child birth at a health facility and why?

Apart from what we have already discussed, what do you suggest can be done in order to encourage pregnant women to use the health facility for child birth?

Thank you for your participation

Appendix E: Translated Chichewa Interview Guide

Code number…….

Date of interview…….

Name of interviewer……

Gawo Loyamba

Ndikufunsani mafunso okhudzana ndi inuyo.

1. Muli ndi zaka zingati?.....
2. Mumakhala kuti?.....
3. Kodi pa nkhani ya banja mbali yanu ndi iti?
    a. Mbeta
    b. Wokwatiwa
    c. Banja linatha
    d. Tinapatukana kaye
    e. Amuna anga anamwalira
    f. Timangokhalira limodzi osamanga ukwati
4. (i) kodi maphunziro anu munalekeza pati?
    a. Pulayimale

b. Sekondale

c. Koleji

d. Sindinapite ku sukulu

4 (ii) Ngati muli pa banja, kodi amuna anu analekeza pati maphunziro awo?

a. Pulayimale

b. Sekondale

c. Koleji

d. Sanapite ku sukulu

5 Mumagwira ntchito yanji?

a. Yozilemba ndekha

b. Yolembedwa

c. Ya pakhomo ngati mzimayi wa pa banja

d. Tchulani inuyo……..

6 Muli ndi ana angati?

a. Mmodzi

b. Awiri

c. Atatu

d. Anayi

e. Asanu kupita mtsogolo

Gawo Lachiwiri

Maganizo a amayi okhudzana ndi chisamaliro cha ku chipatala pa nthawi yochira

1. Nkhani yochilira mwana ku chipatala mumayiwona bwanji?

   Kufunsitsitsa: Ubwino ndi zofowoka zake.

2. Kodi chinakupangitsani kuti musankhe chipatala chino kuti mudzachilireko mwana wanu ndi chiyani?

   Kufunsitsitsa: kodi chisankho chimenechi anakupangirani ndi ndani ndipo chifukwa chiyani?

3. Munamvapo kuti zokhudzana ndi kuchilira mwana wanu ku chipatala?

4. Tandifotokozereni chithandizo chomwe munalandira kuyambira nthawi yomwe munafika pa chipatala pano kufikira nthawi yomwe munachoka ku chipinda chochilira kupita ku makanda.

   Kufunsitsitsa: kalandiridwe, malo ochilira, mankhwala, kachezedwe ndi ogwira ntchito pa chipatala amene amakuthandizani, achibale okuyang'anirani, chisamaliro cha inu ndi mwana mutangochila kumene.

5. Kodi chinakusangalatsani pa chisamaliro chomwe munalandira ndi chiyani?

6. Kodi chomwe sichinakusangalatseni pa chisamaliro chomwe munalandira ndi chiyani?

7. Mmaganizo anu kodi wachipatala yemwe amapereka chisamaliro choyenera kwa mzimayi yemwe akuchilira ku chipatala ndi ndani? Chifukwa chiyani?

Kukhutitsidwa kwa amayi ndi kuchilira ku chipatala

1. Ndi mbali iti ya chisamaliro chomwe munalandira imene munakhutitsidwa nayo pa nthawi imene mumachilira mwana wanu ku chipatala? Chifukwa chiyani?

2. Ndi mbali iti ya chisamaliro chomwe munalandira imene simunakhutitsidwe nayo pa nthawi imene mumachilira mwana wanu ku chipatala? Chifukwa chiyani?

   Kufunsitsitsa: Mtsogolomu mutapezeka kuti ndiinu oyembekezera, mutha kuzachiliranso mwana wanu ku chipatala? Chifukwa chiyani?

3. Kodi amuna anu amasangalatsidwa ndi khani yochilira ana ku chipatala? Chonde perekani zifukwa.

Chiyembekezo cha amayi pa nkhani yochilira ana awo ku chipatala

1. Kodi mungasangalatsidwe ndi chisamaliro chanji pa nthawi yochilira mwana wanu ku chipatala?

Kupatula zomwe takambilana kale mukuwona ngati a chipatala angapangepo chiyani kuti amayi ochuluka azipanga chiganizo chokachilira ana awo ku chipatala?

Zikomo kwambiri potenga nawo mbali mu kafukufuyu.

Appendix F: Permission from Chiradzulu District Hospital

University of Malawi
Kamuzu College of Nursing

P.O Box 415,

Blantyre

Email: phiri2014colette@kcn.unima.mw

Cell: 0888901777

Approved!
Please share the results after your study
11/4/16
Research Chairperson

The District Health Officer

Chiradzulu District Hospital

P.O. Box 21

Chiradzulu

Chairperson should Count in writing

Ministry of Health & Population
The District Health Officer
2016 -04- 12
P.O. Box 21, Chiradzulu

Dear Sir

REQUEST TO CONDUCT A RESEARCH STUDY

I am a second year postgraduate student pursuing a Master of Science Degree in Midwifery at Kamuzu College of Nursing. I write to seek permission to conduct a research study entitled "Women's experiences of Hospital delivery at Chiradzulu District Hospital". The study will be carried out as a requirement for the completion of the masters program.

The study findings will help in designing of midwifery interventions aimed at enhancing health facility delivery with the assistance of skilled birth attendants.

I commit myself to share the study findings with you and your consideration will be greatly appreciated.

Yours faithfully,

Colette Phiri.

Appendix G: Certificate of Ethical Approval from COMREC

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.05/06/1943 – Women's experiences of hospital delivery at Chiradzulu District Hospital by Miss Colette A.K. Phiri

On 15th June 2016

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC as indicated on the next page

Dr. C. Dzamalala- Chairperson (COMREC)

Approved by
College of Medicine
15 JUN 2016
(COMREC)
Research and Ethics Committee

15th June, 2016
Date