

UNIVERSITY OF MALAWI



KAMUZU COLLEGE OF NURSING

**KNOWLEDGE, PRACTICE AND PERCEPTION OF CLINICIANS
AND NURSE/ MIDWIVES IN THE PROVISION OF BASIC
EMMERGENCY OBSTETRIC CARE IN MULANJE DISTRICT**

**RESEARCH DISSERTATION SUBMITTED TO THE FACULTY OF
NURSING IN PARTIAL FULFILLMENT FOR THE AWARD OF
BACHELOR OF SCIENCE IN COMMUNITY HEALTH NURSING**

**SUBMITTED BY
JOYCE CHIMWEMWE SISKI**

**SUPERVISED BY
MRS CHALANDA**

NOVEMBER, 2009

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DECLARATION

I here declare that this dissertation is the result of my own work and has not been presented or submitted in candidature for any other degree at any other university.

STUDENT: JOYCE SISKI

SIGNATURE: 

DATE: 25/11/09

SUPERVISOR: MRS. CHALANDA

SIGNATURE: 

DATE: 25/11/09

DEDICATION

This work is dedicated to my husband, Wisdom, my children, Wanangwa, Alinafe and Bernadette for their moral support during the time I was away from home. They were so patient and understanding and persevered a life without mother and a companion for two years.

The work is also dedicated to my father and late mum who opened the doors for education and instilled in me the desire to continue with high education. I also give thanks to God Almighty for keeping me safe throughout the entire program.

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I also thank my roommate, H. Mwale and all my friends who supported and encouraged the author during dissertation writing.

My sincere and profound gratitude goes to my daughters, Wanangwa and Bernadette for their encouragement and perseverance during the study period. May the Almighty God bless them all.

ABSTRACT

A quantitative study on Knowledge, Practice and Perception of clinicians and nurse/midwives in the provision of Basic Emergency Obstetric Care was conducted in Mulanje district. The purpose of study was to assess knowledge, practice and perception of clinician and nurse/midwives in the provision of Basic Emergency Obstetric Care. The study was conducted at two hospitals, Mulanje district and Mulanje mission and in four health centres, namely: Chonde, Namasalima, Namulenga, and Mpala. The health promotion model was used. The study comprised of n= 30. Twenty were nurse/midwives and ten clinicians. Purposive sampling was used to draw up the sample. Data was collected using a questionnaire which comprised of both open ended and closed questions. Prior to data collection pretesting was done at Bwaila hospital and two health centres, namely Kawale and area 25 to find out validity and reliability of the instrument. Data was analysed manually and presented in frequency tables, pie charts, and graphs using Microsoft excel programme. The results showed that clinicians and nurse/midwives have knowledge in provision of Basic Emergency Obstetric Care despite working under pressure and with low material resources. The study has also shown that the level of education and knowledge base is the pre requisite to the application of new knowledge into practice. It was recommended to train all clinicians and nurse/midwives in BEmOC, regular supervision by BEmOC trainers and to provide adequate material resources in order for quality care to be provided hence to reduce maternal mortality and morbidity.

LIST OF ABBREVIATIONS

BEmOC: Basic Emergency Obstetric Care.

DFID: Department for International Development.

DHMT: District Health Management Team.

EmOC: Emergency Obstetric Care.

LSS: Life Saving Skills.

MA: Medical Assistant

MICS: Multiple Indicator Cluster Survey.

MDS: Malawi Demographic Survey.

MDHS: Malawi Demographic Health Survey.

MDG: Millennium Development Goals.

MVA: Manual Vacuum Aspiration.

MoH: Ministry of Health.

NMT: Nurse Midwife Technician

UNICEF: United Nations Children's Fund.

UNFPA: United Nations Population Fund.

USAID: United States Agency for International Development.

SIDA: Swedish International Development Authority.

WHO: World Health Organisation.

CHAPTER ONE: INTRODUCTION & BACKGROUND

1.0 INTRODUCTION

Pregnancy is normal, which most women aspire at some stage in their lives. Yet this normal, life-affirming process carries with it serious risk of death and disability.

Worldwide about 210 million women become pregnant; of these 30 million develop complications which lead to the death of over 500,000 of them. Eighty percent of these deaths are globally caused by severe bleeding, unsafe abortion, eclampsia, sepsis, and obstructed labour. For every pregnant woman who dies, about 30 suffer from serious obstetric complications that can affect them for the rest of their lives.

According to Ministry of Health Road map for accelerating the reduction of maternal and newborn mortality and morbidity state that almost all maternal deaths are preventable. It also estimates that 80% of the causes of maternal deaths are avoidable.

Maternal mortality in developing countries has decreased slightly over the past decade but is rising in some parts of Africa. Malawi is reported to have one of the highest numbers of women who die as a result of pregnancy and childbirth. The maternal mortality ratio has fallen from 1120 deaths per 100,000 live births in 2000 to 984 deaths per 100,000 births in 2004 [MDS 2000 and 2004] however according to recent estimates, maternal mortality in Malawi is at 807 deaths per 100,000 births [MICS, 2006].

In view of the now growing global evidence that availability of Emergency Obstetric Care [EmOC] and skilled attendance at birth are crucial prerequisites to the reduction of maternal mortality, this has made the government to change its policy so that, clinicians and nurse/midwives can perform six signal functions of Basic Emergency Obstetric Care at health centres or at district if certified competent.

According to obstetric live Saving Skills Training Manual for Malawi of (2007), described, comprehensive Emergency Obstetric Care that is made up of eight signal functions which are parenteral oxytocic drugs, parenteral antibiotics, parenteral anticonvulsants, and manual removal of placenta, removal of retained products, assisted vaginal delivery, surgery, and blood transfusion.

Basic Emergency Obstetric Care is the provision of normal antenatal, intra-partum, newborn and management of obstetrical complications through the above six interventions which has been described in Emergency Obstetric Care [EmOC] excluding surgery and blood transfusion.

Reports in Health Management Information System bulletin of [2007] indicated that EmOC in Malawi has improved from 18.5% to 29.6%. The percentage of health centres offering Basic Emergency Obstetric Care service seems to be increasing. More staff is being trained in Basic Emergency Obstetric Care skills and 27 health facilities were renovated and equipped to provide Basic Emergency Obstetric Care services in 2006 alone.

Mulanje district for the past two years is one of the districts with four Basic Emergency Obstetric Care sites and trained staff in Basic Emergency Obstetric Care and two Emergency Obstetric Care sites. This approach aimed at reducing maternal and neonatal mortality and morbidity rate. Thus there was a need to examine the knowledge, practice and perception of clinicians and nurse/ midwives in the provision of BEmOC in Mulanje district.

1.1 BACKGROUND.

Malawi has an estimated population of 13,187,632 [National statistical office, 2007], comprising of 49% males and 51% females of which 42.2% is within the reproductive age of 15- 49 years. The population is young, with 45% below the age of 15 years. Life expectancy at birth is 42.8 years for men and 45.5 years for females. About 83% percent of population lives in the rural areas, [MDHS 2004].

The assessment of [2005] of the status of Emergency Obstetric care services in Malawi, showed that ruptured uterus and obstetric prolonged labour were the most common cause of maternal deaths to 36% of all maternal deaths recorded at the health facilities surveyed in Malawi. Other major causes were postpartum sepsis accounting for 19%, and obstetric haemorrhage accounting 14% of maternal death in hospitals. Pre- eclampsia/ eclampsia and complications of abortion accounted for 8% and 5% of the reported maternal deaths respectively.

The country is reported to have one of the highest maternal mortality ratios globally. Adolescent pregnancies comprise 25% of all births and 20% of maternal deaths. The life time risk of maternal deaths in Malawi is estimated at 1: 7, one of the highest globally, this is according to Ministry of Health [2007] Road map for accelerating the reduction of maternal mortality and morbidity in Malawi.

The government of Malawi through the Reproductive Health unit of Ministry of Health, and with support from development partners, DFID, WHO, UNICEF, UNFPA, and USAID, implemented several initiatives to address the problem of high maternal and neonatal deaths. One of the initiatives was the development of training manual of obstetric Life Saving Skills training [LSS] in 2000 and many service providers have since trained in obstetric care. Despite safe motherhood initiatives maternal mortality is still high in Malawi.

A report of a national wide assessment in Emergency Obstetric Care, [2005], indicated that Mulanje district was the fifth district with high maternal deaths out of twenty-one. The district had 18 maternal deaths and 289 women with obstetrical complications resulting in case fatality rate of 6.2%.

Mulanje district is a town situated in the southern region of Malawi close the boarder of Mozambique. The district covers an area of 2056 square Kilo Metres and has a population of 428,322. The district also receives referrals of women with obstetric complications from Mozambique.

According to Millennium Development Goals, Report of [2008], goal number five, which state about improvement of maternal health. Malawi should attain the aspired goal of maternal mortality rate of 155deaths per 100,000 live births by 2015. The projection reveals that the country will achieve a maternal mortality ratio of 338 deaths per 100,000 live births if progress is sustained. In order to attain the indicator targets of the country, government has developed the Road map for accelerating the reduction of maternal and neonatal mortality and morbidity. One of strategy is to construct and upgrade health facilities to offer essential health services particularly focusing on rural and underserved areas. The good news is; for past two years Mulanje is one of the districts providing Emergency Obstetric Care and Basic

Emergency Obstetric services, which aims at reducing maternal and neonatal mortality and morbidity.

1.2 PROBLEM STATEMENT

Malawi is reported to have one of the highest numbers of women who die as a result of pregnancy and childbirth related causes. The maternal mortality ratio has fallen from 1120 per 100,000 live births in 2000 to 984 deaths per 100,000 live births in 2004 [MDHS 2000 and 2004]. However according to Multiple Indicator Cluster Survey, [MICS, 2006] reported that maternal mortality ratio in Malawi is at 807 per 100,000 live births. This is the highest mortality in the Southern Africa Region and despite interventions the impact seems to be minimal.

1.3 SIGNIFICANCE OF THE STUDY

This study seeks to determine what impact Basic Emergency Obstetric Care [BEmOC] has had on the knowledge, practice and perception of health care providers in order to reduce maternal and neonatal mortality rate.

The findings of the study will provide information on the existing gaps; the availability of this information will enable the Ministry of Health to institute or change certain policies concerning Basic Emergency Obstetric Care [BEmOC].

The results will also be used as an evaluation tool for District Health Management Team [DHMT] concerning knowledge, practices and perception of clinicians and nurse/midwives on Basic Emergency Obstetric Care.

The information will also assist the safe motherhood coordinator to plan for in-services training for midwives and clinicians on Basic Emergency Obstetric Care in Mulanje district.

Nursing and medical learning institutions can also use the information to intensify in their training on Basic Emergency Obstetric Care.

Lastly the information can also be used for further research on a large scale to find the true impact of Basic Emergency Obstetric Care [BEmOC] in Malawi.

1.4. OBJECTIVES OF THE STUDY

GENERAL OBJECTIVE.

To assess knowledge, practice and perception of clinicians, and nurse / midwives in the provision of Basic Emergency Obstetric care.

SPECIFIC OBJECTIVES

- 1 .To assess the knowledge of clinicians and nurse/midwives on the elements of Basic Emergency Obstetric Care.
2. To measure the number of clinicians and nurse/midwives who know the criteria of BEmOC in the management of client at the health centre or at the district hospital.
3. To determine the challenges that is encountered in BEmOC and their perceived effects on client outcome.
4. To determine the possible strategies the health care providers perceive would impact on BEmOC.

1.5 OPERATIONAL DEFINITIONS

Maternal mortality: is defined as the death of woman from pregnancy- related causes, when pregnant or within 42days of termination of pregnancy [MDGS 2008].

Breech presentation: is when the foetus lies longitudinally with the buttocks in the lower pole of uterus.

Retained placenta: is defined as the failure to deliver the placenta within 30minutes after birth.

Manual Vacuum Aspiration: is the method of choice for the management of incomplete or inevitable abortion for gestation of 12weeks or less, because it has fewer complications compared to curettage.

CHAPTER 2: LITERATURE REVIEW.

2.0 INTRODUCTION.

Literature review is an important area in research because it does not only develop a comprehensive picture of state of knowledge on the topics, but also acquits the researcher with what has already been done in relation to the study there by minimize unintentional duplication, [Pilot & Hungler, 1991].

It gives relevant information about what is known about the topic and the relationship between dependent and independent variables in the study.

This chapter will discuss related research done on knowledge, practice and perception of clinicians and nurse/ midwives in the provision of Basic Emergency Obstetric Care.

2.1 STUDIES DONE RELATED TO THIS RESEARCH.

An exploratory study was conducted by a gynaecologist, Croft, JF. et al, in (2007), at South mead hospital in north Bristol NHS Trust in United Kingdom. The study was conducted to assess the acquisition of knowledge of doctors and midwives after six weeks training on Obstetric Emergency. A sample of 140 participants was used; these were 22 junior doctors 23 senior doctors, 47 junior and 48 senior midwives. A prospective randomised control trial carried out. The research findings indicated the significant increase in knowledge following training. Out of 133, 122 [92.5%] increased their knowledge. It was concluded that Obstetric Emergency training increases midwives and doctors knowledge on Obstetric management. Accessed from [File:///f:/knowledge % 20 on 20bemoc.htm](File:///f:/knowledge%20on%20bemoc.htm), in April, 2009.

Another study was conducted by a gynaecologist, winter, C. et al, in south west Nigeria. The study was conducted to assess knowledge concept of Emergency Obstetric Care [EmOC].The study included 152 health workers [doctors, midwives and community health extension worker offering maternity care in five cities of 2 states]. The data was collected using a questionnaire and non- participant observation

checklist. The research findings indicated that 91% of the maternity staff had poor knowledge concerning the concept of EmOC. It was concluded that there was an urgent need to reorient the staff in line with global best practices.

An evaluation study was done by Belay, T. et al, of Family Health Department of the Ministry Of Health in Ethiopia, in (2007). It was conducted to assess the intervention implemented by WHO, UNICEF, and SIDA on “Making Pregnancy Safer”. The qualitative approach examined clients and community perception, provider perspectives and program manager’s views at different levels with regard to service provision, quality of care, service utilisation and the impact of the “Making Pregnancy Safer” strategy.

The research findings indicated positive trends in the process, indicators of maternal health services utilisation, staff who received training in EmOC were better off in both skills and knowledge acquisition. Majority of facilities had basic resources and functions for Emergency Obstetric Care. It was concluded that “Making Pregnancy Safer” established a stronger and better quality of Emergency Obstetric and neonatal care. File:///f:making%20pregnancy%20 safer.htm, down loaded in May 2009.

An evaluative study was conducted by Meda, et al, of the Immpact Burkina Evaluation study group, in 2007, in Bukinafaso. The study was done to assess the most important intervention strategies for safe motherhood in low – resources settings, particularly in Africa. The study attempted to identify five priority areas as real chances of improving the safety of mother hood. These areas were: enhancing national coverage of delivery by professionally skilled attendants, providing a net work of 24hrs Basic Emergency Obstetric Care within 5km, to have effective referral system, equipped and resourced to undertake a reasonable number of sections, to promote community mobilisation activities as a lever to increasing delivery care utilisation, to implement strategies to remove financial barrier to delivery care. <http://hinari-gw.who.int/whalecomwww.ncbi.nlm.nih.gov/whalecom...>

Another evaluative study was conducted by Zarab, T. et al, of African Population Health Research Centre, in Nairobi, in Kenya in (2007). The study was conducted in order to assess quality Emergency Obstetric Care in terms of staffing, skills, equipment and supplies. Twenty five maternity health facilities were used .The

subjects were the staff in-charge of maternity wards. Data collection included interviews with the staff – in charge of maternity wards using structured questionnaires. The research finding indicated that out of twenty five facilities only two met criteria for comprehensive Emergency Obstetric Care. Lack of skills, equipment and supplies hamper the facilities from providing Emergency Obstetric procedures. It was concluded that Emergency Obstetric services in Nairobi was poor and needed to improve .Specific areas that required attention included supervision, training of staff and ensuring basic equipment supplies.
<http://hinarigw.who.int/whalecowwww.ncbi.nlm.nih.gov/whalecom0/pumed/19284626>

Another study was conducted by Pierre, F. et al, in (2005) in Mali .This was an evaluative study on improved access to comprehensive Emergency Obstetric Care and its effect on institutional maternal mortality. The research findings indicated that the number of women receiving Emergency Obstetric Care doubled and rate of major obstetric interventions [mainly caesarean section] performed for absolute maternal indication increased from 0.13% to 0.46%. Maternal mortality rates decreased among women referred for Emergency Obstetric Care than those who presented themselves to the district health centre without referral. Nearly half [47.5%] of the reduction in deaths was attributable to fewer deaths from haemorrhage. Bull World Health Organ 2009;30-38|doi:10.2471/BLT.07.047076 down loaded in May, 2009.

A number of studies have assisted to shed more light on maternal mortality situation in the country. These studies have suggested an urgent need to further strengthen the ministry of Health for provision of quality health care services in order to reduce the high maternal deaths and newborn mortality. The ministry of health conducted a national assessment in [2005] on the availability, access, utilisation and quality of EmOC services and the research indicated that; Malawi had almost doubled recommended minimum number of comprehensive EmOC facilities per 500,000 population, but only 2% of the recommended number of BEmOC facilities. Out of 94 health centres assessed, 92 did not qualify as BEmOC facilities as they were not providing all six BEmOC signal functions. The met need for EmOC was 18.5% which was below the United Nations recommended level of 100%. Of expected births in Malawi 2.8% were by caesarean section which was below the recommended minimum of 5% indicating that many women were not receiving the care they needed.

The health providers who were mainly covering the facilities for 24 hrs were enrolled/midwives and nurse/midwives technicians, representing 74% who were only allowed to perform three functional signals out of six BEmOC signal functions. .

This research finding made the Ministry of Health to review the policies on midwifery practice with the aim of enabling nurse- midwives to perform all the basic EmOC signal functions by providing competency based training and strong system of supportive supervision, upgrading BEmOC sites.

2.2 CONCLUSION

In summary the seven studies which has been reviewed, two of them were assessing acquisition of knowledge of doctors and midwives in Emergency Obstetric Care. One was assessing the impact of Making Pregnancy Safer, one was identifying the most important interventions for safe mother hood in low- resource setting and the other one was assessing the impact of Emergency Obstetric Care. The last two studies were assessing the quality and utilisation of Emergency Obstetric Care.

These studies strongly indicate that there are gaps because they did not further study the practice and the perception of clinicians and nurse/ midwives in the provision of BEmOC.

Many households' surveys reports a reasonably high proportion of women delivering in health facilities and personnel were not assessed for knowledge and skills in Emergency Obstetrics. Accessed at [file:///f:/knowledge%20 on bemoc.htm](file:///f:/knowledge%20on%20bemoc.htm).

Therefore it was relevant for this study to be carried out in order to determine the knowledge, practice and perception.

CHAPTER THREE: CONCEPTUAL FLAMEWORK

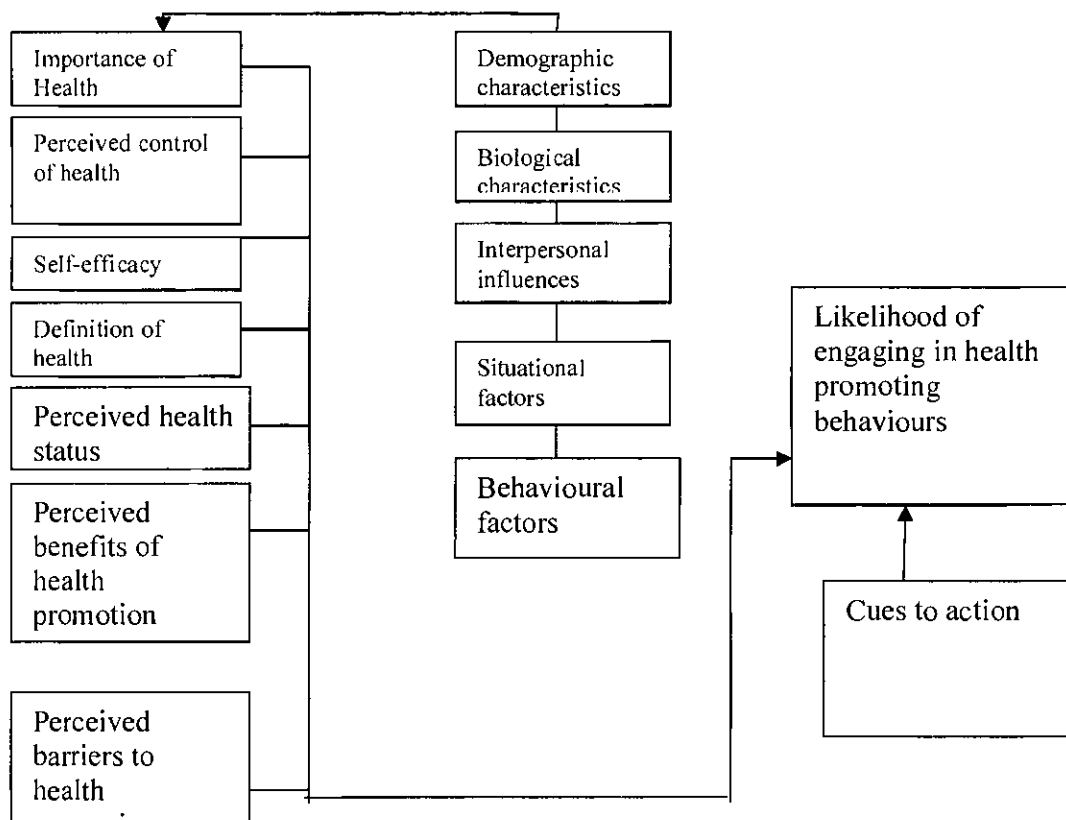
3.0 CONCEPTUAL FLAMEWORK: PENDER HEALTH PROMOTION MODEL

Conceptual models are used to guide and organize nursing knowledge in educational programs, research and practice. In research, the framework offers a systematic approach to identifying questions for a study, selecting appropriate variables and interpreting finding [Bullough, 1991]. In practice, it assist nurses to describe, explain and predict every days experiences and they also serve to guide assessment, intervention and evaluation of nursing care [Creasia & Parker, 1991].

This study was guided by Pender's Health Promotion Model. This model includes the multiple factors that determine how an individual thinks or perceives participation in health promoting behaviours, factors that modify initial thoughts and perceptions and influences that are cues to action [Creasia & Parker, 1991]. Polit & Hungler [1991], define health promotion model as activities directed toward the development or resources that maintain or enhance individuals well being. This model is helpful in assessing an individual client as well as including factors to consider in providing a supportive environment for health improvement. The cognitive perception factors and modifying factors are illustrated on page overleaf.

HEALTH PROMOTION MODEL BY:

Cognitive-perceptual factors. Modifying factors. Behaviour out Come



(Pender, 1987)

3.1 APPLICATION OF THE MODEL TO THE STUDY

The goal of nursing is to assist individual to promote, maintain and restore their health so that they can function in their roles. Polit and Hungler [1991], define health promotion model as activities directed toward the development or resources that maintain or enhance individuals well being. According to Pender health promotion is directed toward increasing the level of well being and self- actualisation of individual or group. Training nurses/ midwives and clinician in Basic Emergency obstetric care is one way of preventing mortality and morbidity there by enhancing individual well being. Midwives and clinician aim at assisting pregnant women by preventing obstetrical complications and have a live and health baby.

There are several factors that influence an individual to make decision about certain course of action. The factors include: behavioural, situational, interpersonal, biological factors and other demographical characteristics for example social demographic factors particularly educational attainment are believed to have indirect effect on behaviour by influencing the perception of susceptibility, severity, benefits and barriers [Glanz, 1990]. Some of these factors related to age, sex, religion, knowledge, attitudes and experience

These modifying factors can trigger clinicians and nurse/ midwives to seek for in-service education in order to maintain, promote lives and health and well being of the individual. The midwives and clinician are also influenced by these factors to decide for a course of action in providing Basic Emergency Obstetric Care. If clinicians and nurse/ midwives perceived these factors and understand the importance of providing Emergency Obstetric Care, there will be reduction of maternal and neonatal mortality rate hence health is promoted.

There are also perceived barriers to health promoting behaviours such in adequate time of training, in adequate human resource, lack of essential drugs which can lead to complications and maternal deaths. If clinicians and midwives perceive these complications and modifying factors as barriers to health promotion, there is a likelihood of engaging in health promoting behaviours. Cues of action will be community

involvement and participation in reducing maternal mortality and encouraging them to utilizing BEmOC services. Having that knowledge gap, challenges and perceived effects on client outcome in Basic Emergency Obstetric Care, appropriate policies or procedure manuals will be put in a place as regard to management of pregnant women in BEmOC.

Health promotion is viewed as collected responsibility of society, which needs to be prioritized by government and organization in decision making [Naidoo & Wills, 2000].

CHAPTER FOUR: METHODOLOGY.

4.0 RESEARCH DESIGN

A research design is a set of logical steps by the researcher to answer the research problem, [Robert & Burke, 1989].

The research design forms the blue print for the study and determines the methods used by the researcher to obtain subjects, collect data, analyse data and interpret the findings,[Burns & Grove 2001].

In this study a quantitative design was used .Quantitative study design is a study in which data collected is in numerical form [Polit & Hungler, 1991].

The purpose of this study design helped in quantifying a wide range of information from the subjects, about knowledge, practices and perception in the provision of Basic Emergency Obstetric care.

4.1 SAMPLING

The sample comprised of nurse/ midwives and clinicians. The total $n = 30$, twenty nurse/midwives because they are the majority of health care providers and ten clinicians because of minority. The sample was chosen through purposive sampling because the researcher was targeting those were trained in Basic Emergency Obstetric Care (BEmOC).

4.2 SETTING.

The study was conducted at four health centres namely Namulenga, Chonde, Namasalima, and Mpala, [BEmOC sites]. And two hospitals Mulanje mission and Mulanje district hospital,[EmOC facilities].The sites were chosen because health care providers were trained and secondly they serve a large population of mothers. According to Burns & Groves, [2001], the setting is the location where study will be conducted.

4.3 DATA COLLECTION

Data collection is the precise and systematic gathering of information relevant to the research purpose or the specific objectives, question or hypothesis of a study, [Burns & Groves 2001].

Data was collected through direct person to person interview using a prepared questionnaire and recorded all the answers which were given by the provider, which were written English.

Data was collected by interviewing the subjects in order to get relevant information concerning Basic Emergency Obstetric Care. The one to one interview was seeking to establish a relationship between the interviewer and the respondent and to get information. Through this method, the information comes from the thoughtful reflection of one person aided by exchange with the interviewer's point of view.

The researcher conducted the interviews on her own to ensure consistency in asking questions.

4.4 INSTRUMENT

The questionnaire helped the interviewer to collect data in a systematic way and provided the researcher with the chance to adapt to questions from the subject.

The researcher developed the instrument using the set objectives as guide. Relevant literature was reviewed in order to come up with this questionnaire so that contents are relevant to the topic.

The instrument composed of a section on demographic data and a section of open-ended questions designed to answer the research questions. Creswell [2002] states that closed- ended response can be useful information to support theories and concept on literature while open-ended response allows participants to provide personal experiences that may be outside or beyond those identified in the close –ended questions options.

The open-ended questions were used during the interviews to allow participants to reply the question in their own words. The open-ended questions attempted to elicit

information of clinicians and nurse/midwives on BEmOC. The questionnaire was developed in English.

4.5 PILOT STUDY

Prior to the actual study, a pilot study was conducted to test the instrument. The instrument was pre-tested at Bwaila hospital and two health centres; namely: Kawale and Area 25 in Lilongwe, it was noted that the instrument had no problems. Pre-testing allows for feasibility and validity of the instrument.

4.6 DATA ANALYSIS

Data analysis is the process of organising and interpreting the collected data to make meaning, [Burns & Groves, 2001]. After data collection, questionnaires were checked whether recording was correct. Then data was analysed using descriptive static, such as percentages and / or frequencies and compiled on each category analysed according to the variables of the study. Data was presented in tables, pie charts, and graphs using Microsoft Excel programme on the computer.

4.7 ETHICAL CONSIDERATION

Prior to commencement of the study letters were written to Kamuzu College of Nursing- Ethics and Research committee, Mulanje District Health Officer, Director Mulanje Mission Hospital to seek permission to carry out this study. Upon getting the permission, the researcher wrote the In charges Maternity Department of Namasalima, Chonde, Mpala, Namulenga, and Mulanje district hospital, and Mulanje mission hospital to inform them about the study which took place. This was done to protect the rights of participants which were essential, as it gave the researcher a legal and ethical mandate to conduct the study.

In order to gain support from the participants, informed consent obtained from each participant after thorough and detailed explanation of aims and objectives of the study. Pilot and Hungler [1991] states that informed consent ensures that the researcher obtained voluntary participation of the participants after informing them that there are no risks and no benefits to them as individuals. The subjects were assured about their anonymity by using code numbers and not names. Confidentiality achieved, by face to face sessions in a private place on a one to one basis. The

subjects were allowed to discontinue at any time should they wished to do so. The data collected was put in an envelop and sealed, kept under lock and key. Only the principal researcher had access to data. After the study the questionnaires were burnt.

4.8 PLANS FOR DISSEMINATION OF RESULTS

The research findings were communicated through written reports and copies of the research work was made available to Kamuzu Collage Nursing Basic studies Department and Mulanje District Health Office. Finally, a copy was made available to Kamuzu Collage of nursing library for conference purposes.

CHAPTER FIVE: PRESENTATION OF RESULTS

The results have been presented in frequency tables, percentages, pie charts, graphs and relationship. The focus is on demographic data, knowledge, practice and perception of clinicians and nurses/ midwives in the provision of Basic Emergency Obstetric Care (BEMOC)

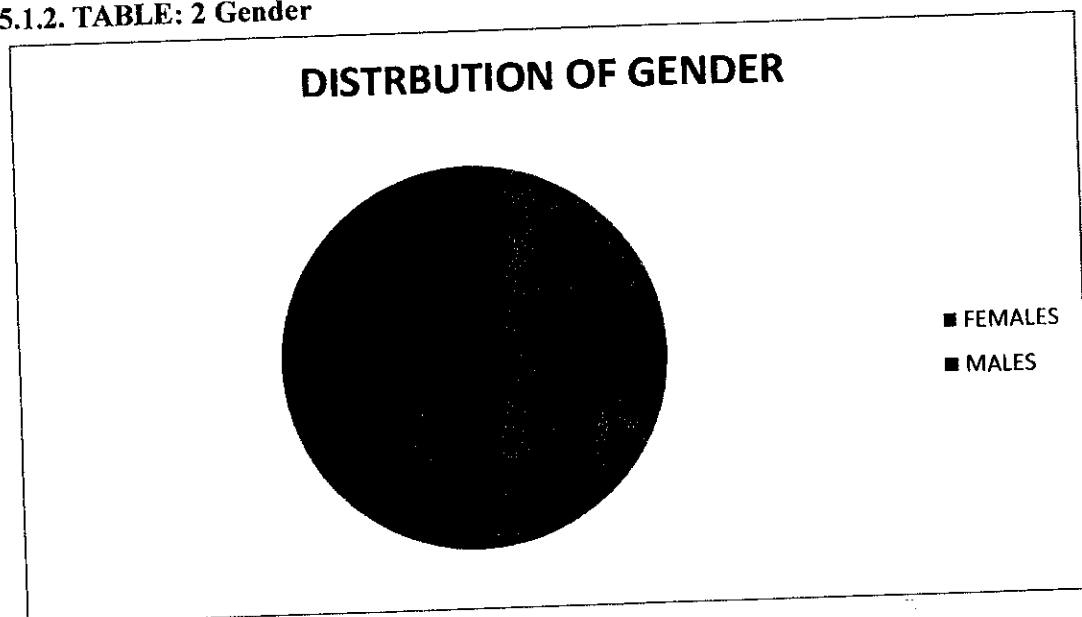
5.1 Demographic Data

5.1.1. Table 1: Age range of the respondents

AGE RANGE	FREQUENCY	PERCENTAGES
20-24	2	6.7%
25-29	5	16.7%
30-34	7	23.3%
35-39	12	40%
40+	4	13.3%

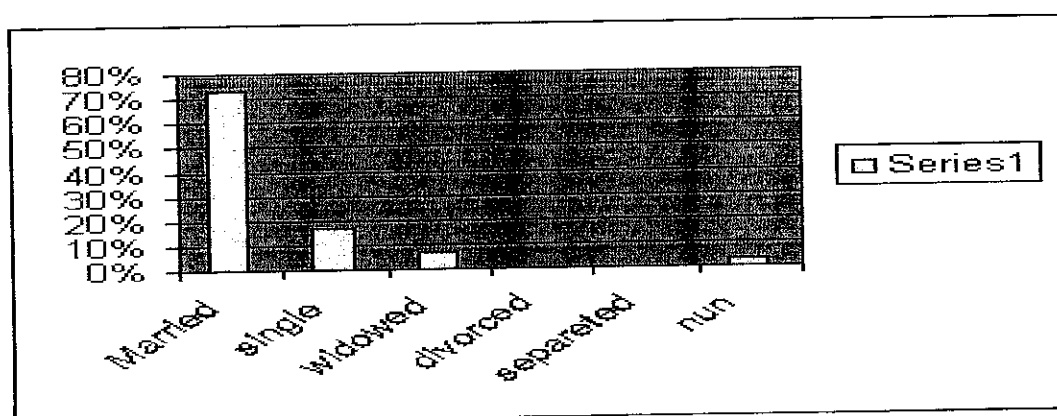
Table 1 showed that 40% of the respondents were in the same range of 35-39 years

5.1.2. TABLE: 2 Gender



This shows that 63% of the participants were females

5.1.3 Figure:3 Marital status



This shows that 73% of the respondents were married

5.1.4 Table 4: Denomination

DENOMINATION	FREQUENCY	PERCENTAGE
C C A P	7	23.3%
Moslem	1	3.3%
S D A	7	23.3%
RC	10	33.3%
Assemblies of God	2	6.7%
Anglican	3	10%
Total	30	100%

Table 4: shows that 33.3% of the respondents belong to Roman Catholic Church.

5.1.5 Figure 5: Respondents level of education

EDUCATION LEVEL	FREQUENCY	PERCENTAGE
Diploma in nursing	6	20%
Diploma in clinical medicine	5	16.7%
M S C E	17	56.7%
J C E	2	6.7%
TOTAL	30	100%

Table 4: shows that 56.7% of the respondents had Malawi School Certificate Education (with certificate in nursing and midwifery)

5.2 Knowledge

5.2.1 Table 6: Clinicians and Nurse/ Midwives

Knowledge and practice in six (6) signal functions of Basic Emergency Obstetric Care (BEMOC)

PERFORMANCE

Number of respondents (frequency)	Number of signal functions scores	Unsatisfactory	Satisfactory	Good	Excellent
20	6	-	-	-	100%
7	5	-	-	83.3%	-
1	4	-	66.7%	-	-
-	3	-	-	-	-
2	2	33.3%	-	-	-
Total 30	6				

Table 5; shows that 20 respondents (67%) each scored 100%

5.2.2 Table 7: Summary on the relationship between age range and cadre on knowledge of clinician and nurse/midwives on 6 signal function of Basic Emergency Obstetric Care (BEMOC)

Age	Performance					
	Unsatisfactory	Satisfactory	Good	Excellent	Total	Cadre
20-24			1(83.3%)	1(100%)	2(7%)	2NMTs
25-29			1(83.3%)	4(100%)	5(17%)	1MA 2NMTs 2EM/M
30-34		1(66.7%)	2(83.3%)	4(100%)	7(23%)	3MAs 1EM 3NMTs
35-39			4(83.3%)	8(100%)	12(40%)	6RN 5CO 1NMT
40+	2(33.3%)			2(100%)		2MA 2EN/M

Table 6: Shows 12 (40%) of clinicians and Nurses with Diploma scored 100% (highest marks) and age range was 35- 39 years

5.2.3 Table 8: Summary on relationship between knowledge and length of training on 8 criteria for performing vacuum extraction.

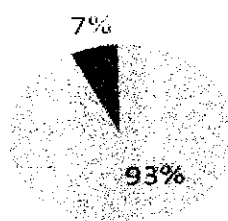
No. of criteria	Length of training			
	No. of respondents (frequency)	Percentage	7 weeks	3 weeks
8	12	40%	11	1
7	2	7%	2	
5	4	13%	2	2
4	3	10%	1	2
3	4	13%	2	2
2	3	10%	1	2
1	2	7%		2
Total	30	100%	19	11

This table shows that 12 (40%) of the participants who attended 7 weeks were knowledgeable on 8 criteria for performing vacuum extraction.

5.2.4 Figure 9: Summary of knowledge on the indication of manual vacuum aspiration (MVA) N=30 participants who were questioned on the indication for MV.

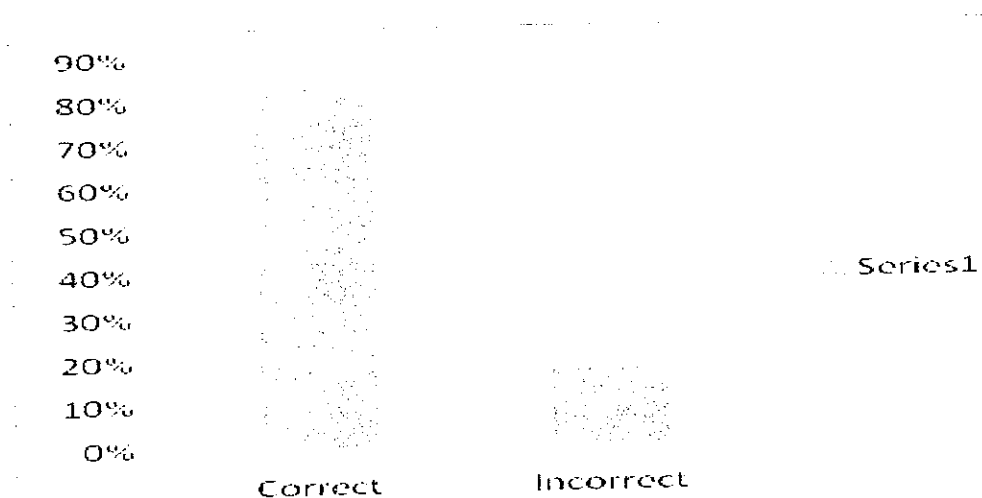
Knowledge on the indication of manual vacuum aspiration

Correct answers Incorrect answers



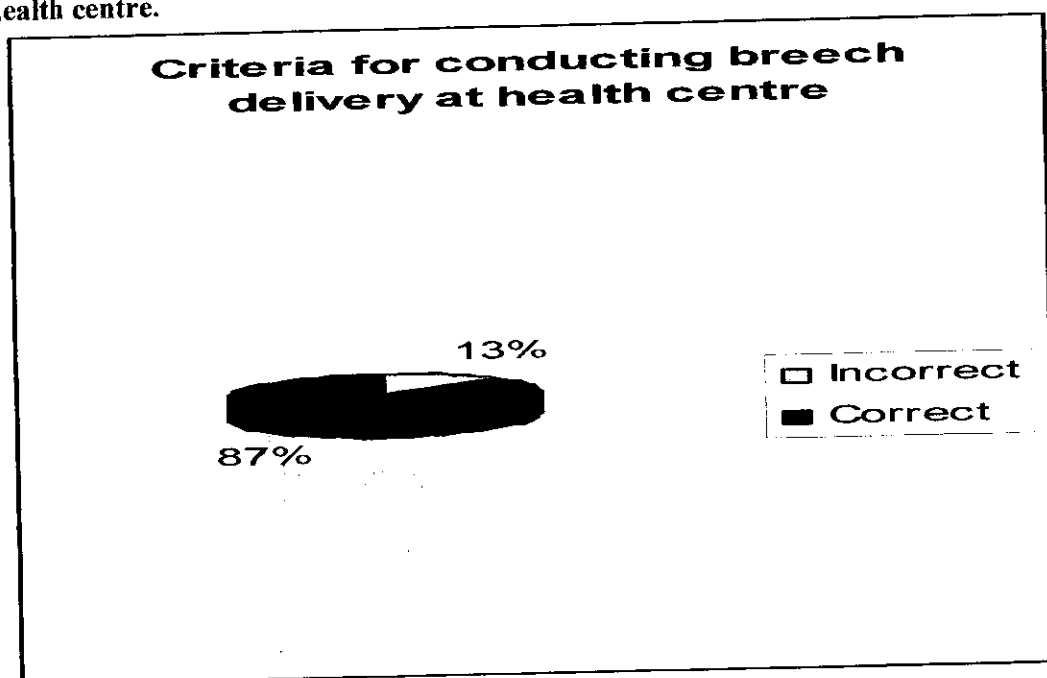
This shows that 97% of the respondents gave the correct answers

5.2.5 Figure 10: Summary of the participants on knowledge on standard management of manual removal of the placenta.



This shows that 83% of the participants had knowledge in standard management of manual removal of the placenta.

5.2.6 Figure 11: Summary on criteria for conducting breech delivery at the health centre.



This shows that 87% of the respondents gave the correct answer and scored 100% each.

5.2.7 TABLE: 12 Summaries of the results on maximum deliveries conducted at institutional in 24 hours and number of vacuum extraction per month

Facility	Number of deliveries in 24 hrs	Total number of vacuum extraction performed monthly
Mulanje District Hospital	10	13
Mulanje Mission Hospital	8	11
Chonde health centre	7	4
Namulenga health centre	5	2
Namasalima health centre	5	2
Mpala health centre	4	2
Total		

This shows Mulanje was leading at district level and Chonde health centre was leading at health centre level.

5.2.8. Risk factors for retained placenta

N=12 scored all five risk factors for a retained placenta representing 40%

N= 7 scored 4 risk factors for retained placenta representing 23.3%

N= 7 scored 3 risk factors, representing again 23.3%

N= 2 scored 2 risk factors, representing 6.7%

N=2 scored 1 risk factor, representing again 6.7%

This shows that 40% of the respondents scored 100% each which the highest and the lowest got 20%.

Facilities with oxytocin in stock

All six facilities surveyed had oxytocin in stock representing 100%

5.2.9. Four principles of managing client with eclampsia

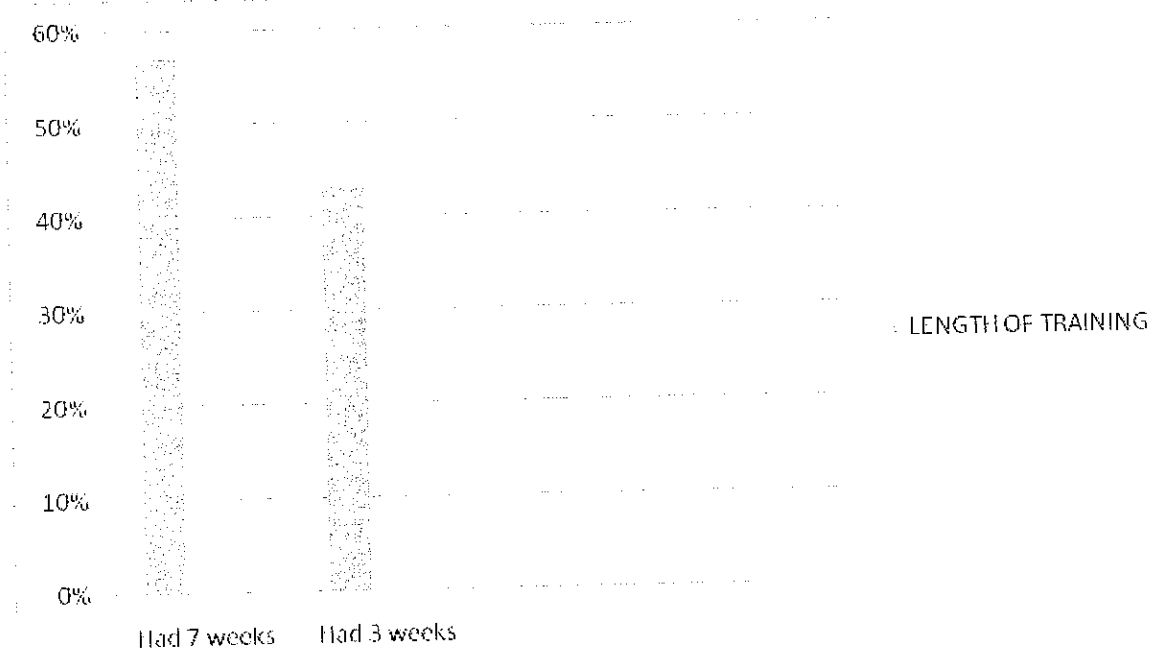
N= 25 scored all four principles, representing 83.3%

N=3 scored 3 principles, representing 10%

N= 2 scored 2 principles, representing 6.7%

This shows that 83.3% of the respondents scored 100% each and the lowest scored 50%

5.3. TABLE: 13 Length of training



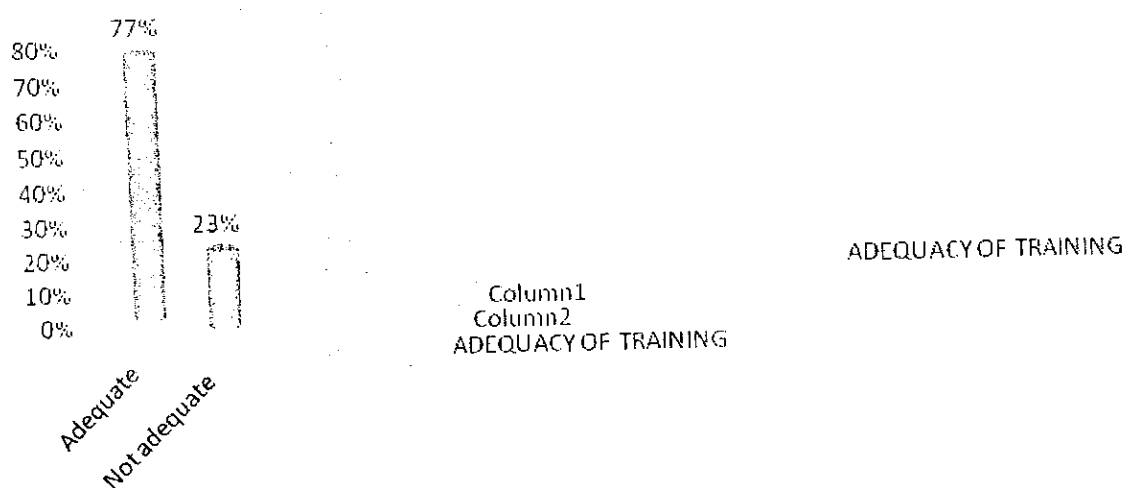
This shows that 57% of the participants attended 7wks training and 43% attended 3wks

Parenteral antibiotics which were in stock in all health centers

- Benzyl penicillin
- Gentamycin
- Metronidazole
- Chloramphenical

This shows that facilities were equipped with essential drugs needed in Basic Emergency Care (BEmOC).

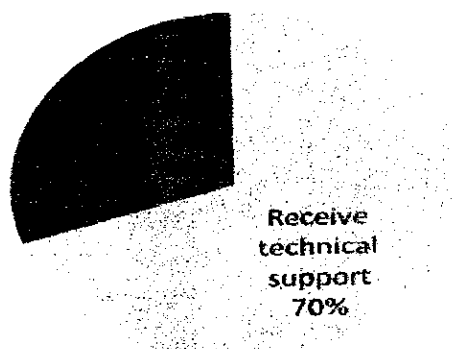
5.4. Table 14: Adequacy of training



This shows that 77%(23) felt that the training was adequate

5.5. Table 15: Technical support

Technical support



This shows that 70% of the participants were receiving technical support.

5.6. Clinicians and nurse/midwives perception in Basic Emergency Obstetric Care

Participants were asked to explain their perceived effect of BEmOC on client outcome. Majority of the participants indicated that BEmOC is a genuine answer to client problems because there is early identification of the problem hence saving life of the client. They further explained that clients are managed in good time hence reduction of maternal and neonatal deaths.

5.7. Challenges encountered in utilizing the BEmOC concept

Ninety percent of the participants gave a number of challenges low supply of material resources for example : MVA instrument, cidex, long period of stock out of essential drugs, lack of transport to refer client to main hospital since there is no motor bike as per promised and shortage of staff.

When these clients were asked how the above challenge affected their personal attitude, all the participants indicated that they felt inadequate when supplies were low or absent because they could not perform the skills they had acquired. Majority also indicated that overworking which end up displaying negative attitude towards assisting clients.

5.8. Suggestion on the possible strategies that would have an impact in BEmOC

Participants were asked to give their suggestions on possible strategies which will have an impact on BEmOC. All participants mentioned about training all staff in BEmOC in order to reduce over working. Majority also emphasized to have enough material resources for all centers providing BEmOC concept, for them to work better.

Participants were also asked if BEmOC training has made them to be better midwives or clinicians. All participants indicated that BEmOC training has made them to be better midwives and clinician because it has helped them in managing some cases that could otherwise referred to other health professional.

5.9. The impact of training health providers on maternal and neonatal reduction

Clinicians and nurse/midwives were also asked to explain if training of health provider on BEmOC has an impact on maternal reduction.

All participants indicated that the life threatening conditions to mothers and babies are in the management pack of BEmOC so if health providers will be trained in BEmOC they will be applying the knowledge and skills gained to those conditions there by reducing maternal and neonatal deaths.

CHAPTER 6

DISCUSSION

This chapter presents the discussion of the findings on the knowledge, practice and perception of clinicians and nurse/midwives in the provision of Basic Emergency Care (BEmOC). The focus will be demographic data, knowledge and perception of the clinicians and nurse midwives in the provision of BEmOC. Implications, conclusion and recommendations will be made at the end.

6.1. AGE GROUP

The findings indicated that the majority of the respondents, 40% (n = 12) were in the middle-aged. This signified that it was a good age group for reinforcement of obstetric skills and knowledge due to maturity in terms of age and life experiences. Victor (1990) who stated that middle-aged nurses are mature in terms life experiences who opt for career advancement in any aspect of nursing profession and this was regarded as being an advantage for working with patients. In this case the findings would suggest that upgrading of skills among middle-aged staff would have an impact in providing quality care amongst the patients.

6.2. GENDER

Sixty three percent (n = 19) of the respondents were female nurse/ midwives and clinicians. The majority being predominantly female may be attributed to the fact that nursing has been viewed as a female dominated profession through out the world. These findings correlate with those of Swan (1991), who stated that women are seen as having innate qualities for nursing. Similarly Moemela and Phaledze (2001)

observed that women are the people who bear the burden of caring for sick. Women are traditionally the main care givers within the family and wider community.

The community expects women to be providers of care. Men by contrast are not expected to be care givers. This may be attributed to cultural reasons. Women spend more time with children at home than men who are seen as bread winners, and are often away either looking for employment or engaged in money producing activities which will enable them better provide food for their families.

6.3. PROFESSIONAL QUALIFICATION AND KNOWLEDGE IN BASIC EMERGENCY OBSTETRIC CARE

The smallest cadres of the respondents were registered nurses and clinical officers who are holding diploma in nursing and diploma in medicine respectively (20% and 16%). This is really jeopardized the quality of nursing care through the proper provision care in Basic Emergency Obstetric Care (BEmOC). This is because by virtue of education of the registered nurse/ midwives, should carry out nursing activities as an independent function while an nurse midwives technicians, enrolled nurse/midwives and medical assistants should carry out nursing/midwifery activities under supervision of the registered nurse/ clinical officer. They need to be supervised in order to ensure that there is quality care in the provision of Basic Emergency Obstetric Care. (Mellish, 1982)

However, it was assumed that the smallest number of registered nurse/midwives and clinicians would not affect the nurses' knowledge in the provision of care in Basic Emergency Obstetric Care (BEmOC), since six signal functions of Basic Emergency Obstetric Care were taught in the pre – service training course in nursing programs as well as clinical medicine programs. With this assumption enrolled nurse/midwives, nurse midwives technicians and medical assistants would know how to provide care

in Basic Emergency Obstetric Care (BEmOC) with the baseline knowledge on BEmOC that have acquired in the pre- service training. These findings correlate with those of Kumako and Richardson (1993), who stated that baseline knowledge facilitates nurses' performance on acquisition of new knowledge. This implied that all nurses and medical assistants would not have problems in proper provision care in Basic Emergency Obstetric Care. This has been evidenced in the results in table two where 67% (n =20) of the respondents scored all six signal function of Basic Emergency Obstetric Care (BEmOC), which meant that each respondent obtained 100%. Twenty three percent (n = 7) of the respondent scored 83% which was good. Only 7% (n= 2) of the respondent performed unsatisfactory.

Ninety three percent (n = 28) of the participants were able to mention the right answers on the indication of Manual Vacuum Aspiration (MVA). On the four principle management of client with eclampsia, n = 25(83%) of the participants scored 100% each. On the standard management of manual removal of placenta, 83 % (n = 25) of the participants got right answers (refer table 8). On criteria of conducting breech delivery at the health centre n=15 of the respondents working at the health centre, n =13 (87%) had right answers. This showed that the previous knowledge of nurse midwife technicians, enrolled nurse/ midwives and medical assistance which was acquired during pre – service training has helped them to perform skills and acquire the new knowledge.

6.4. THE RELATIONSHIP BETWEEN AGE RANGE, CADRE AND PERFORMANCE IN SIX SIGNAL FUNCTIONS OF BEmOC

Forty percent (n =12) of the respondents who were the holders of diploma in nursing (RNs) and diploma in clinical medicine (COs) performed well in six signal function of BEmOC and these respondent their age range were 35 – 39years,(refer table 7).

This showed that there was a positive correlation between knowledge and educational background. The ability to apply knowledge was often enhanced with increased educational achievements. A sound education background is a pre – requisite to the acquisition and application of knowledge into practice (Quinn, 2000). Higher education updates and improves the skills of nurses/ clinicians,(Botha, 2000). Similarly Harrington (1989) stated that quality of nursing care can only improve if the nurses are equipped with better knowledge and skills. Victor (1990), who stated that middle-aged nurses are mature in terms of age and life experience, because of those patients would benefit from the experiences of the nurse/midwives and the clinicians. This indicated that level of study of Registered Nurses/Midwives and Clinical Officers has an impact on skills and knowledge acquisition.

6.5. PRACTICE

The results showed that all BEmOC and two EmOC sites had ceftriazone, gentamycin, metronidazole, chloramphenical and oxytocin in stock. Figure 10, also showed that vacuum extractions are also conducted in all BEmOC sites as well as EmOC sites. There was a slight difference between maximum deliveries conducted in 24 hours at BEmOC sites and EmOC sites. This was clearly an indication for providing BEmOC services at the health centres. Out of 94 health centres which was assessed in (2005) by the ministry of health, 92 did not qualify as BEmOC facilities as they were not providing all six signal functions. Health providers who were covering those facilities for 24 hours were allowed to perform three signal functions, out of six. The findings clearly showed that all six signal functions of BEmOC were being provided in the four BEmOC sites which were surveyed. Staffs which were allowed to perform three six signal function of BEmOC were now performing all six BEmOC signal

functions. This was an indication that more women would be receiving the care that they needed in time hence reducing maternal mortality and morbidity rate.

6.6. THE RELATIONSHIP BETWEEN KNOWLEDGE AND LENGTH OF TRAINING

Thirty seven percent (n = 11) of the respondents who attended 7 weeks training on BEmOC scored 100% each on criteria for performing vacuum extraction. Three percent (n = 1) of the respondent who attended 3 weeks training in BEmOC scored 100%. Seven percent (n = 2) of the participants who attended 7 weeks training scored 87.5% each on criteria for performing vacuum extraction. Thirteen percent (n = 4) of the respondents 2 who attended 7 weeks training and n= 2 who attended 3 weeks training scored 62.5% each on criteria for performing vacuum extraction. Three percent (n = 1) of the respondent who attended 7 weeks training scored 50% on criteria for performing vacuum extraction. And the other n =2 who attended 3 weeks training scored 50% each. Thirty percent (n = 9) of the respondents, 3 who attended 7 weeks training and n = 6 who attended 3 weeks training performed badly on 8 criteria for performing vacuum extraction, refer table 7.

Education is known to influence people's perceptions and reception of information. The higher the education the better the understanding and the higher ability to acquire and apply knowledge. This has been evidenced by those 11(37%) who went for 7 weeks training and scored 100% each. However in this study, it has been revealed that acquisition and application of BEmOC information is neither directly influenced by neither the length of training. One respondent who scored 100% went for three weeks training and other n = 4 (13%) who went for 3 weeks has performed

satisfactory than other n = 3 who went for 7 weeks training. This indicated that it was not only the length of training that could help the person to acquire skills and knowledge. Technical support and supportive supervision had also an impact for some one to be motivated and performed well. It might be that the respondents who attended three weeks training and they performed well were motivated because of supportive supervision they received, and the supplies of instruments hence made them to be more motivated and acquired skills and knowledge.

6.7. Clinicians and nurse/midwives perception in Basic Emergency Obstetric Care

Participants were asked to explain the perceived effect of BEmOC on client outcome. Ninety- eight percent of the participants indicated that BEmOC was a genuine answer to client problems because there was early identification of the problem hence saving life of the client. They further explained that clients were managed in good time hence reduction of maternal and neonatal deaths. This statement correlate the Ministry of Health (2006) report on Road Map for Accelerating the reduction of Maternal and neonatal mortality and morbidity in Malawi, that recent global evidence indicated that availability of Emergency Obstetric Care(EmOC) and skilled attendance at birth are key to the reduction of maternal mortality. Car Lough, M & MC call, M. reported that the presence of a skilled attendance at delivery is important in averting maternal and neonatal mortality and morbidity, accessed at <http://we.ebscohost.com/ehost/detail> in November 2009.

6.8. Challenges encountered in utilizing the BEmOC concept

Ninety percent of the participants indicated heavy work load related to shortage of nurses and clinicians as a contributing factor to poor utilization of BEmOC. Most

health centres and hospitals have low staff pattern and also very few who were trained in BEmOC, as such this contributed to heavy work load to the few remaining nurses and clinicians. .

Although most of the nurses and clinicians know how to provide BEmOC services they were unable to give quality care, sometimes they were unable to document all what they have done to clients. Certainly, shortage of staff caused disruption to the continuity of care. Similarly, Zulu and Chalanda (1991), in the study also found that shortage of staff was inhibiting factor to the quality of patient care because of inadequate documentation.

Thirty percent (n= 9) of the participants who attended 3 weeks training in BEmOC reported that the training was inadequate and 20 %(n = 6) of the participant reported that there was inadequate supervision by the trainers or managers. This correlate with the study done by Car laugh, M & Mc call, M reported that for the midwives to meet the definition of skilled birth attendants in Basic Emergency Obstetric care, the midwives must have 15 weeks of training and 6 weeks refresher course. This was different case as evidenced by the study that was done in Nepal from 15 districts 104 midwives and doctors were recruited in the study after being trained for six weeks in Basic Emergency Obstetric Care. The results indicated that midwives and doctors level of knowledge and skilled, were demonstrated in a practice and met the definition of level of skilled birth attendants, accessed from <http://web.ebscohost.com/ehost/detailed>, in November, 2009.

Lack of supervision which was reported by 20% (n = 6) of the respondents could be another factor who contributed to 30% (n = 9) of the participants who performed badly in criteria for performing vacuum extraction. The manager should do supervision in order to improve quality of care in BEmOC. Supervision is essential because it provides encouragement and feedback to employees about their performance, (Sullivan & Decker 2000). Supervision does not only encourage commitment in the nurse practioners also enable the nurse manager/ trainer to quickly detect short falls because the nurse manager/trainer is always there to support the nurse/midwife. Supervision ought to be seen as an integral process of guiding a person from novice to expert (Sullivan & Decker).

Forty five percent (n = 14) of the participants gave a number of challenges, low supply of material resources for example : MVA instrument,cidex, long period of stock out of essential drugs, lack of transport to refer client to main hospital since there was no motor bike as per promised. To reduce maternal mortality not only the essential skills which are required for example taking detailed history, managing a normal labor, recognizing delayed progress in labor and take appropriate action just to mention few; in addition there is general agreement that enabling environment contributes to reduction of maternal mortality rates which are: ensuring safe effective practice, the environment must be one where: essential resources are available; supportive supervision must be in place ; transport for women and babies requiring referral must be available and continuing education should be available in order to maintain skills, (WHO, 2002). If health centres will continue experiencing low supply of essential drugs and lack of transport then they will not be taken as an enabling environment for providing Basic Emergency Obstetric Care.

When these clients were asked how the above challenges affected their personal attitude, all the participants indicated that they felt inadequate when supplies were low or absent because they could not perform the skills they had acquired. Majority also indicated that overworking which ends up displaying negative attitude towards assisting clients. This correlates with the study done Seljesskog (2006) that attitude of health providers towards clients is one of the main three factors influencing women's choice of place of delivery in rural areas. This is one of the factors that influence women to deliver at Traditional Birth Attendants hence increasing the number of maternal mortality and morbidity rate.

6.9. Suggestions on the possible strategies that would have an impact in BEmOC

There were several suggestions that were indicated by the respondents on the improvement of quality care in the provision of Basic Emergency Obstetric Care. The findings had shown that hundred percent of the respondents suggested that there was a need to train all nurse/midwives and clinicians in Basic Emergency Obstetric Care (BEmOC), in order to reduce overworking. Fifty percent ($n = 14$) of the participants suggested that there is a need for an in-service training for all the health personnel at the hospital for the proper provision of care in BEmOC. In-service education is that phase of staff educational programme directed towards providing employees with knowledge, skills and attitudes required for the job and keeping employees abreast of changing methods and new techniques, such as the proper provision of care in BEmOC, (Gillies, 1994). If nurse/midwives and clinicians are given chance for continued education through in-service education programmes would have improved some of the nurse/midwives and clinicians in the provision of quality of care in BEmOC, (Fleck & Fyffe, 1997). Similarly, Shelter (1993) stated that in-service

education for nurses often resulted in improvement of patient care as well as personal development since this improved their knowledge. Knowledge was essential for nurse/midwives and clinicians to provide care effectively in provision of Basic Emergency Obstetric Care.

Participants were also asked if BEmOC training had made them to be better midwives or clinicians. All participants indicated that BEmOC training had made them to be better midwives and clinician because it has helped them in managing some cases that could otherwise be referred to other health professionals.

6.10. CONCLUSION

This chapter has discussed findings concerning knowledge, practice and perception of clinician and nurse/midwives in the provision of Basic Emergency Obstetric Care. The study revealed that clinicians and nurse/midwives have knowledge in Basic Emergency Obstetric Care. This study has shown that the level of education and knowledge base is the pre-requisite to the acquisition and application of new knowledge into practice. It was also learnt that the providers were overworking due to shortage of staff and few nurse/midwives and clinicians were trained in Basic Emergency Obstetric Care. Low supplies of essential drugs and equipment was also a problem.

It was also interesting to learn that not only the length of training could facilitate one to acquire skills and knowledge. Technical support and supervision had also an impact for one to be motivated to perform well.

Health promotion model was used in this study to raise the level of wellness for individual, families, populations and communities. The clinicians and nurse/midwives

were trained to be providers of Basic Emergency Obstetric Care; this has facilitate their interpersonal influences where by they were able to perform the skills in obstetric care and teaching skills to mothers in relation to obstetric during antenatal, intrapartum and postpartum hence reducing maternal and neonatal mortality and morbidity.

6.11. IMPLICATION OF THE STUDY TO:

Nursing and midwifery/ Clinical practice

The findings of the study will provide the nurse/midwife and clinician practioner with knowledge in proper provision of Basic Emergency Obstetric Care in order to improve quality of care. This will continue to remind clinicians and nurse/midwives the importance of quality of care in BEmOC in order to reduce maternal and infant mortality and morbidity.

Nursing education

The findings of the study will help the nurse educator to identify gaps in nursing education curriculum. The gap will be filled by ensuring that the proper provision of care in BEmOC by addressing all signal functions of Basic Emergency Obstetric care in the component of nursing and midwifery. The nurse educators will emphasis the proper provision of care in BEmOC during teaching both at classroom level and clinical setting.

Nurse Manager

The findings of the study will remind the nurse managers that they give support and encouragement to nurse/midwives and clinicians under their charge through regular

supervision. This will facilitate the provision of quality of care in Basic Emergency Obstetric Care. The manager will also appreciate the need for in – service education.

Nursing researcher

The findings of the study will stipulate interest for the nurse researcher to replicate the study and possibly do it on larger scale.

6.12. AREAS OF FURTHER STUDIES

- There is need to replicate the study on large scale because these results are only from thirty participants and confined to six facilities, therefore cannot be generalized.
- The study could be conducted in urban health centres settings in order to differentiate between knowledge, practice and perception of clinicians and nurse/midwives working in rural and urban areas.
- Evaluation should be also done on impact of Basic Emergency Obstetric Care in Malawi.

6.13. LIMITATIONS OF THE STUDY

The study also had some limitations. The study setting comprised six health facilities in Mulanje district in southern region. This arrangement though out of convenience may affect the generalization of the findings at national level. The sample size of 30 was worked out on ground of convenience in response to time and financial availability but does not provide for a comfortable generalization of the findings at national level. The study was for academic purpose and there was no available financial support which made it difficult to conduct the study at a large scale which should have been ideal for purpose of generalization of the findings at national level.

There was limited literature available especially for Malawi possibly due the fact that Basic Emergency Obstetric Care has just been introduced after an assessment of availability of Basic Emergency Obstetric care and Emergency Obstetric Care in Malawi in (2005). Much of available literature was from other countries. The greatest source was through the internet which was hardly accessible to the researcher hence making it as a limitation on comfortable literature source.

6.14. RECOMMENDATIONS

- Nurse managers/safe mother hood coordinator should organize in – service education, seminars on the provision of Basic Emergency Obstetric Care.
- Nurse Managers/ District Health Officer/BEmOC trainers should intensify supportive supervision in all health centres as well as at district hospital.
- It is also recommended that refresher courses be conducted regularly to improve performance..
- Nurse educators should cooperate with service staff by planning and organizing in – service education and training to equip nursing staff in – service training with the current trends and issues in nursing and midwifery issues.
- The Ministry of Health, through the District Health Officer should ensure the availability of essential drugs and equipment in all health centres and at district hospital.
- The District Health Officer should make sure that health centres that do not have ambulances should have motor bike ambulances as promised.

CHAPTER SEVEN: APPENDICES

7.0 APPENDIX I: LIST OF REFERENCES

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7.1 APPENDIX II: QUESTIONNAIRE FOR BEmOC PROVIDER

CODE NUMBER -----

NAME OF FACILITY -----

DESIGNATION -----

DATE OF THE INTERVIEW -----

SEX.....

DISTRICT -----

NAME OF INTERVIEWER -----

PART ONE

DEMOGRAPHIC DATA [please tick]

1. Age in yrs:
- (a) 20 – 24 []
 - (b) 25 – 29 []
 - (c) 30 – 34 []
 - (d) 35 – 39 []
 - (e) 40+ []

2 Denominación: a, CCAP []

 b, Moslem []

 c, SDA []

 d, RC []

e, Others []

3. Marital status:

a. Married []

b. Single []

c. Widowed []

d. Divorced []

e. Separated []

4 Highest Level of Education:

a. PSLCE []

b. JCE []

c. MSCE []

d. Other, specify []

PART TWO.

QUESTIONS TO MEASURE CLINICIANS AND NURSE/ MIDWIVES
KNOWLEDGE AND PRACTICE IN BASIC EMERGENCY OBSTETRIC CARE.

5. Mention 6 elements or signal functions of BemOC ?-----

6. How many deliveries are conducted at your institution in 24hrs?-----

7. How many vacuum deliveries are done per month?-----

8, What are the five indications for performing vacuum extraction : at health centre level?-----

9. What are the 9 indications for performing vacuum extraction at a district hospital level?-----

10. What are six contra indications for performing vacuum extraction at health centre?-----

[illegible][illegible][illegible]

14. What are the five risk factors for retained placenta?-----

15. What type of drug do you use in the active management of third stage of labour?--

16. Do you have oxytocin in stock?

YES [] NO []

If no give reasons-----

17. What are the four principles of managing patient with eclampsia? -----

18. What type of parenteral antibiotics do you have in stock?-----

19. Mention one criteria for conducting breech delivery at the health centre?-----

20. Did you receive training in BemOC?

YES [] NO []

21. What was the length of the training?-----

22. Do you feel what you learnt was adequate?

YES [] NO []

If no, give reasons-----

23. Do you receive technical support and/or in-service training?

YES [] NO []

If yes, specify-----

If no, make suggestions-----

PART THREE.

Questions to identify clinicians and nurse/midwives perception of BemOC.

24. What are your perceived effect of BEmOC on client out come?-----

25. What are the challenges that are encountered in utilising the BEmOC concept at the health centre level?-----

26. What challenges are encountered in utilising the BEmOC concept at the district level?-----

27. How do these challenges affect personal attitude?-----

28. Give your suggestions on the possible strategies that would have an impact in BemOC?-----

29. Do you believe that BEmoc training has made you a better midwife? or clinician?

Yes [] No []

Give reasons-----

30. How do you think BEmOC training of health care providers can have an impact on reduction of maternal and neonatal mortality?-----

7.2. APPENDIX III

University of Malawi
Kamuzu College Nursing
Private Bag 1,
LILONGWE.
4th may 2009

Through: The Research Supervisor
The Research & Publications Committee
Kamuzu Collage of Nursing
Private Bag1,
LILONGWE

Attention: The Research Officer

Dear Sir,

**PERMISSION FOR CLEARANCE TO CONDUCT A RESEARCH STUDY IN
MULANJE DISTRICT**

I am a second year student at the above named college pursuing a Bachelor of Science in Community Health Nursing. As part of partial fulfilment of the programme, a research project is required.

The aim of this letter is to seek your permission to interview some of Nurse/Midwives and Clinicians at Mulanje District Hospital, Mulanje Mission, Namulenga, Mpala, Chonde and Namasalima health centre. The title of my study is; Knowledge, practice and perception of Clinician and Midwives in the provision of Basic Emergency Obstetrics Care (BEMOC). The Midwives and Clinicians will be asked questions related to knowledge, practice and their opinion in Basic Emergency Obstetric Care.

I am looking forward to your favourable consideration.

Yours Faithfully,

Joyce C. Siska

KAMUZU COLLEGE OF NURSING
RESEARCH AND PUBLICATIONS COMMITTEE
APPROVAL CERTIFICATE

INVESTIGATOR(S): Mrs. JOYCE SISK

REVIEW DATE: 22ND July 2009

SIGNATURE: 

CC: supervisor: Mrs M. CHALANDA

UNIVERSITY OF MALAWI
KAMUZU COLLEGE
.....CE. NO. DATE.....
ATE STUDIES AND RESEARCH
BASIC STUDIES DEPARTMENT
PRIVATE BAG 1, LILONGWE.

I/WE fully understand the conditions which I am/we authorized to carry out the above mentioned research and I/we guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/We will resubmit the proposal to the committee.

DATE.....23/11/09..... SIGNATURE(S).....JSA.....

7.4. APPENDIX V

University of Malawi
Kamuzu College Nursing
Private Bag 1,
LILONGWE.
30th July, 2009

Through: The Research Supervisor
The District Health Officer
Mulanje District Hospital
P.O.Box 227
MULANJE

Dear Sir,

**PERMISSION FOR CLEARANCE TO CONDUCT A RESEARCH STUDY IN
MULANJE DISTRICT.**

I am a second year student at the above named college pursuing a Bachelor of Science in Community Health Nursing. As part of partial fulfilment of the programme, a research project is required.

The aim of this letter is to seek your permission to interview some of Nurse/Midwives and Clinicians at Mulanje District Hospital, Mulanje Mission, Namulenga, Mpala, Chonde and Namasalima health centres. The title of my study is; Knowledge, practice and perception of Clinician and Midwives in the provision of Basic Emergency Obstetrics Care (BEMOC). The Midwives and Clinicians will be asked questions related to knowledge, practice and their opinion in Basic Emergency Obstetric Care.

I am looking forward to your favourable consideration.

Yours Faithfully,

Joyce C. Siska

7.5. APPENDIX VI

University of Malawi
Kamuzu College of Nursing
Private Bag 1,
LILONGWE.
30th July, 2009

Through: The Research Supervisor
The In-charge
Namasalima Health Centre
P.O.Box 5,
NAMASALIMA.

Dear Sir,

PERMISSION FOR CLEARANCE TO CONDUCT A RESEARCH STUDY AT NAMASALIMA HEALTH CENTRE.

I am a second year student at the above named college pursuing a Bachelor of Science in Community Health Nursing. As part of partial fulfilment of the programme, a research project is required.

The aim of this letter is to seek your permission to interview some of Nurse/Midwives and Clinicians. The title of my study is; Knowledge, practice and perception of Clinician and Midwives in the provision of Basic Emergency Obstetrics Care (BEMOC). The Midwives and Clinicians will be asked questions related to knowledge, practice and their opinion in Basic Emergency Obstetric Care.

I am looking forward to your favourable consideration.

Yours Faithfully,

Joyce C. Siska.

7.6. APPENDIX VII

University of Malawi
Kamuzu College Nursing
Private Bag 1,
LILONGWE.
4th May 2009

Through: The Research Supervisor
The In-charge
Chonde Health Centre
P.O Box 48,
CHONDE

Dear Sir,

**PERMISSION FOR CLEARANCE TO CONDUCT A RESEARCH STUDY AT
CHONDE HEALTH CENTRE.**

I am a second year student at the above named college pursuing a Bachelor of Science in Community Health Nursing. As part of partial fulfilment of the programme, a research project is required.

The aim of this letter is to seek your permission to interview some of Nurse/Midwives and Clinicians at Chonde health centre. The title of my study is; Knowledge, practice and perception of Clinician and Midwives in the provision of Basic Emergency Obstetrics Care (BEMOC). The Midwives and Clinicians will be asked questions related to knowledge, practice and their opinion in Basic Emergency Obstetric Care.

I am looking forward to your favourable consideration.

Yours Faithfully,

Joyce C. Siska

7.7. APPENDIX VIII

University of Malawi
Kamuzu collage of Nursing
Private Bag 1,
LILONGWE.
4th May 2009

Through: The Research Supervisor
The In-charge
Mpala Health Centre
P.O Box 54,
MPALA

Dear Sir,

PERMISSION FOR CLEARANCE TO CONDUCT A RESEARCH STUDY AT MPALA HEALTH CENTRE.

I am a second year student at the above named college pursuing a Bachelor of Science in Community Health Nursing. As part of partial fulfilment of the programme, a research project is required.

The aim of this letter is to seek your permission to interview some of Nurse/Midwives and Clinicians at Mpala health centre. The title of my study is; Knowledge, practice and perception of Clinician and Midwives in the provision of Basic Emergency Obstetrics Care (BEMOC). The Midwives and Clinicians will be asked questions related to knowledge, practice and their opinion in Basic Emergency Obstetric Care.

I am looking forward to your favourable consideration.

Yours Faithfully,

Joyce C. Siska.

7.8. APPENDIX IX

University of Malawi
Kamuzu College of Nursing
Private Bag 1,
LILONGWE.
30th July, 2009

Through: The Research Supervisor
The In-charge
Namulenga Health Centre
P.O.Box 41,
THUCHILA.

Dear Madam,

PERMISSION FOR CLEARANCE TO CONDUCT A RESEARCH STUDY AT NAMULENGA HEALTH CENTRE.

I am a second year student at the above named college pursuing a Bachelor of Science in Community Health Nursing. As part of partial fulfilment of the programme, a research project is required.

The aim of this letter is to seek your permission to interview some of Nurse/Midwives and Clinicians at Namulenga health centre. The title of my study is; Knowledge, practice and perception of Clinician and Midwives in the provision of Basic Emergency Obstetrics Care (BEMOC). The Midwives and Clinicians will be asked questions related to knowledge, practice and their opinion in Basic Emergency Obstetric Care.

I am looking forward to your favourable consideration.

Yours Faithfully,
Joyce. C. Siska.

Telephone: + 265 01 466 211
Facsimile: + 265 01 466 295

All Communications should be
addressed to:



In reply please quote No.

MULANJE DISTRICT HOSPITAL
P.O. Box 227
Mulanje
MALAWI

23rd September, 2009

Health Centre Incharges

RE: PERMISSION TO CONDUCT RESEARCH

The bearer of this letter Ms. Joyce Msiska has permission to conduct Research on 'Knowledge, Practice and Perceptions of Clinicians and Nurse midwives in provision on basic emergency obstetrics'.

Her work is not expected to interfere with your normal duties.

Your support will be greatly appreciated.

Yours sincerely,


Dr. Grace Banda

For: **DISTRICT HEALTH OFFICER**

CC : Ms. J. Msiska

7.10. APPENDIX XI

University of Malawi
Kamuzu College of Nursing
Private Bag 1,
LILONGWE.

30th July, 2009

Through: The Research Supervisor
The Medical Director
Mulanje Mission Hospital
P.O.Box 45
MULANJE

Dear Sir,


**PERMISSION FOR CLEARANCE TO CONDUCT A RESEARCH STUDY AT
MULANJE MISSION HOSPITAL.**

I am a second year student at the above named college pursuing a Bachelor of Science in Community Health Nursing. As part of partial fulfilment of the programme, a research project is required.

The aim of this letter is to seek your permission to interview some of Nurse/Midwives and Clinicians at Mulanje Mission hospital. The title of my study is; Knowledge, practice and perception of Clinician and Midwives in the provision of Basic Emergency Obstetrics Care (BEMOC). The Midwives and Clinicians will be asked questions related to knowledge, practice and their opinion in Basic Emergency Obstetric Care.

I am looking forward to your favourable consideration.

Yours Faithfully,
Joyce C. Siska.

Church of Central Africa Presbyterian  Blantyre Synod

Mulanje Mission Hospital

P.O. Box 45, Mulanje, Malawi. Tel.: +265 0 467 044 / 095. Fax.: +265 1 467 022
E-mail : mmh@malawi.net

12th August 2009.

Dear Madam,

PERMISSION TO CONDUCT A RESEARCH STUDY AT MULANJE MISSION HOSPITAL.

Reference is made to your letter dated 30th July, 2009 asking for permission to conduct a research study at this hospital. I hereby on behalf of Management of Mulanje Mission Hospital grant you permission to carry out the research study at the hospital.

Wishing you all the best during your research study.

Yours faithfully,


John K. Munthali
Principal Hospital Administrator.

7.12. APPENDIX XIII: PARTICIPANT CONSENT FORM.

To whom it may concern

Good morning/Afternoon

My name is Joyce C. Siska. I am a mature entry year two student from Kamuzu College of Nursing, studying for a degree in Community Health Nursing. In partial fulfilment of the requirement for this degree, I am supposed to conduct a study on "Knowledge, practice and perception of clinicians and Nurse/Midwives in the provision of Basic Emergency Obstetric Care (BEMOC) in Mulanje District.

The interview will take an average time of thirty minutes. You are free to take part or not to take part in this study. You are also free to withdraw the study at any point. Your decision of withdrawing from this study will not have any effect on you. The results of the study may not benefit you directly. However recommendations Would help to promote quality care provided in Basic Emergency Obstetrics.

I would therefore grateful if you allowed me to ask you some questions related to Basic Emergency Obstetric Care. Everything that will be discussed will be in confidence and will be used for Purpose of this research only. The information that you are going to give will be accessible to the investigator and her supervisor only.

The research contact address is as follows;

C/O Kamuzu College of Nursing

Private Bag 1,

Lilongwe.

Tel: 01751200 or 01750808

Could you sign the form below if you agree to participate in this study.

Iagree to participate in the above study. I understand that my participation is totally voluntarily and that I can withdraw at any time. My refusal to answer some questions will neither affect my well being nor care I provide to the community.

7.13 APPENDIX XIV: WORK PLAN/ TIME LINE

Activity	feb	March	April	May	Jun	July	Aug	Sep	Oct	Nov
Selection of topic										
Literature review										
Proposal development										
Submission of proposal										
Pretesting and data collection										
Data analysis and report										
Submission of report and dissertation results										

7.14 APPENDIX XV: BUDGET

Stipulated below is the expenditure to be incurred during research.

ITEM

STATIONARY

AMOUNT

4 reams of photocopying paper@ k750 each	k 3000.00
10 ball-pens@ k20 each	200.00
4 pencils @ k25 each	100.00
1 hard cover @ k550.	550.00
3 plastic folder with covers @ k250 each	750.00
5 A4 envelops @ k80 each	400.
5 small envelops @ k30 each	150.00

b. TRANSPORT COSTS.

Lilongwe to Blantyre 2 trips @ k3000 each	12000.00
KCN to Ministry of Health return @ at k80	160.00

c. MEALS & REFRESHMENTS.

3 meals @ k700 per meal	2100.00
Refreshments for 3days @ k200 per day	600.00

d. PROJECT COPPIES.

4 copies of research proposal @ k3000 each	12000.00
4 copies of 3 finished dissertation@ k4000 each	16000.00
Subtotal	k 48010.0
2% contingency	1200.00
Grand Total	k 49210.00

7.15 APPENDIX XVI: JUSTIFICATION OF THE BUDGET.

a. STATIONARY.

Adequate stationary will be needed to cater for drafts and writing final documents of both the proposal and dissertation. The same papers will be used for drafting and writing letters seeking permission for the research study.

b. TRANSPORT.

The researcher will be based in Lilongwe [KCN] the time the research will be conducted and the study will take place in Mulanje. She will need to travel twice to and from Mulanje, to deliver letters of permission to Mulanje District Health Officer and health centres and the time to collect data. She will also need to travel to Ministry of Health to deliver letters of permission to conduct the research.

C. MEALS AND REFRESHMENTS.

During the collection period, the researcher will need meals for her and refreshments, since she will spend more hours at the health facility till she interviews 30 participants.

D. PROJECT COPIES.

The researcher will be required to produce 4 copies of finished proposal and 4 finished dissertation which will be submitted to the following equally; the college [KCN], Mulanje District Health Officer, Medical Director Mulanje Mission and one to be kept by the researcher herself.

E, 2% CONTINGENCY

This will cater for the rise in transport and material costs. It will also serve as additional money where necessary.