KAMUZU COLLEGE OF NURSING

COMMUNITY MEMBERS' VIEWS ON BANNING OF TRADITIONAL BIRTH ATTENDANTS FROM CONDUCTING DELIVERIES IN RURAL AREAS OF NTCHEU DISTRICT

MSc. (MIDWIFERY) THESIS

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Declaration

I, Sophie Cecilia Khumbizeni Chimwenje, hereby declare that this thesis is my own work and it has never been submitted before for any award of degree or examination at this or any other University.

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Full Legal Name

Signature

Date

Certificate of Approval

The undersigned certify that this thesis represents the student’s own work and has been submitted with our approval.

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Co-supervisor

Dedication

I dedicate this thesis to my husband, John for the support and encouragement throughout the study period. To my children, Chikondi, Chimwemwe and Chisomo for the support and endurance during my absence from home many times when they needed me close. It is also dedicated to my late parents, Mr. and Mrs. Chimwenje, who tried their level best to deliver all their babies at a health care facility with assistance from skilled birth attendants.

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Abstract

A Qualitative study was conducted to explore the views of the community members in Traditional Authorities, Masasa and Phambala in Ntcheu district on the banning of TBAs from conducting deliveries. The study objectives were to assess knowledge of community members on the availability and accessibility of maternal and neonatal care services; to assess perceived roles of TBAs before and after being banned from conducting deliveries; to describe community members perceptions about banning of TBAs and; to describe opinions of community members regarding accessibility and utilization of maternal and neonatal care services.

Purposive sampling was used to select both the study areas and the study participants. Group Village Headman Mwenye and Masese were chosen from TAs Masasa and Phambala respectively. These were some of the areas with difficult accessibility to health facilities. Fourteen in-depth interviews from five women, five men and four chiefs were conducted and this was the point at which saturation was reached. Thematic content analysis was used to analyse the data and six key themes emerged, namely: access to maternal and neonatal health services; dangers of home delivery; experiences of giving birth at a TBA versus health facility; participants' perceived trend of maternal and neonatal mortality; need for consultation with stakeholders; and health Worker- TBA Partnership.

The study findings revealed that the community members welcomed the idea of banning TBA from conducting deliveries. However, the community members view implementation of the policy to be difficult because of prevalent factors affecting accessibility and utilization of safe delivery services. It is recommended that safe delivery services be made closer to them by constructing health facilities; deploying and retaining

staff in non-functional health facilities; improving health worker attitude towards women of child bearing age and; community awareness on maternal and neonatal health issues.

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Abbreviations and Acronyms

COMREC:	College of Medicine Research and Ethics Committee
IDI:	In-Depth Interviews
FGD:	Focus Group Discussion
EmONC:	Emergency Obstetric and Neonatal Care
GoM:	Government of Malawi
HEW:	Health Extension Workers
HSEP:	Health Service Extension Programme
HIV:	Human Immunodeficiency Virus
MDG:	Millennium Development Goal
MDHS:	Malawi Demographic Health Survey
MOH:	Ministry of Health
MTCT:	Mother to Child Transmission of HIV
NMCM:	Nurses and Midwives Council of Malawi
SBA:	Skilled Birth Attendant
SDG:	Sustainable Development Goal
TA:	Traditional Authority
TBA:	Traditional Birth Attendant
UNFPA:	United Nations Food and Population Agency

Operational Definitions

For the purpose of this study, the following are the definitions of some of the terms used in the document:

Community members: All people aged above 18years, married and with birth experience

Skilled attendance at birth: means that deliveries should take place in the presence of a specifically trained professional who can promptly identify and respond in a timely manner in case complications arise

Traditional birth attendant: a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through traineeship from other TBAs (Falle et al., 2009). Includes TBAs both trained by government and not trained.

Rural remote areas: Areas with poor road network and where accessibility to health facilities is difficult.

Delivery services: Assisting women during pregnancy, when giving birth and after delivery.

Safe delivery: Delivering a baby with a skilled birth attendant at a health facility

Chief : A person either male or female, above eighteen years old, with birthing experience and leads a village.

Chapter One

INTRODUCTION AND BACKGROUND OF THE STUDY

Introduction

In 2007, Malawi banned Traditional Birth Attendants (TBAs) from conducting deliveries because they contribute to high maternal and neonatal mortality rates. The World Health Organization (WHO) defines a TBA as a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through traineeship from other TBAs (Falle et al., 2009). TBAs are also referred to as indigenous midwives and have additional medical knowledge particularly herbalism and other traditional healing techniques (Tegulle, 2013). A trained TBA is the one who has received a short course of training through the modern health care sector to upgrade skills (WHO, 1992). TBAs usually work in rural, remote and other medically underserved areas.

The policy review by the Malawi ministry of health in 1997 indicated that TBAs did not meet the criteria for the definition of Skilled Birth Attendant (SBA). WHO (2008) defines a SBA as a specially trained person such as a midwife, doctor or nurse to safely manage a pregnant woman during the perinatal period.

Malawi is not the only country to ban TBAs in the Sub-Saharan region. Countries like Kenya, Uganda, Zambia, and Ethiopia banned TBAs from practicing in an effort to curb the high maternal mortality ratio (MMR) (Santos, 2011; Masina, 2011; Nove, 2011). Reports indicate that TBAs do not have desired competencies and adequate resources to safely conduct child delivery especially in the wake of HIV/AIDS pandemic (Santos, 2011; Masina, 2011; Nove, 2011). Conversely, countries are encouraging delivery by SBA at health facilities in order to improve the poor maternal and neonatal health indicators.

While TBAs are said to contribute to the poor maternal and neonatal health indicators, literature shows that the causes of high MMR and neonatal mortality ratio (NMR) are multivariate. The study was therefore, conducted to explore views of community members on banning of TBAs.

Background of the Study

Alliance of African Midwives, 2012, reports that TBAs have been providing maternity services for a long time. In low income countries, pregnant women especially in hard-to-reach communities, resort to seeking maternal health care from TBAs who do not have requisite competencies to handle obstetric emergencies. While TBAs are culturally more appealing and accessible than most health facilities, delivery at TBAs remains one of the contributing factors to high maternal deaths in developing countries where transportation and communication are inherent challenges. Government of Malawi banned TBAs from conducting deliveries to encourage safe delivery.

Globally, over 800 women die each day from pregnancy and childbirth related causes (WHO, 2015). Ninety-nine percent of the deaths occur in developing countries and Africa accounts for over half of the deaths (Prata et al., 2011). The risk of a woman dying as a result of pregnancy or childbirth during her reproductive age is about one in six in the poorest parts of the world compared with about one in 30, 000 in Northern Europe (Ronsmans, Graham, & Lancet Maternal Survival Series steering group, 2006).

Delivery at health facility by skilled birth attendants can help to reduce high maternal and neonatal deaths. Fifty one percent of women in low income countries benefit from safe delivery services (WHO, 2015). This means that millions of births in these areas are not attended to by professional midwives. Interesting to note is that over 90% of such births occur in Southern Asia and Sub-Saharan Africa. The 2014 State of

the midwifery report by UNFPA reports that high MMR are attributable to delays at TBAs in referring the pregnant woman to the next level of health care.

In Malawi home deliveries are twice as common in rural areas (26%) as in urban areas (13%) (NSO, 2011).According to the 2010 MDHS out of over 98% of women in Malawi who receive some antenatal care (ANC) from a skilled provider, 73% of them deliver in health facilities of which 71% are conducted by a skilled provider (NSO, 2011). This indicates that over 27% of pregnant women are not assisted by SBAs. The question would then arise as to what could be the factors that can explain the 27% deficit of pregnant women opting to deliver at home despite exposure to antenatal health information at the health facility.

The 2010 Malawi Demographic and Health Survey (MDHS) revealed that the MMR was at 675 per 100, 000 live births and NMR of 31per 1000 live births (NSO, 2011). The direct causes of the high MMR in Malawi include haemorrhage, sepsis, pre-eclampsia, prolonged and obstructed labour, ruptured uterus and complications of abortions (MOH, 2009). On the other hand, the high neonatal mortality rate (NMR) is due to sepsis, prematurity, asphyxia, and low birth weight (LBW) (MOH, 2009). The outlined causes of high MMR and NMR cannot be managed by a TBA.

Much as delivery at TBAs contributes to high MMR and NMR, there are other factors that play a role. Delays in deciding to seek care, reaching a health facility and receiving appropriate treatment at the facility significantly contribute to the poor MNH indicators (reference). Literature indicates that two thirds of these delays occur at the community level (MOH, 2007; Zimba, Kinney, Kachale, Waltenspergrer, Blencowe, Colbourn, Malawi New-born Change and Future Analysis Group, 2012).

Malawi has a population of over 17 million and a population density of 130 per square kilometre, and is densely populated relative to the rest of sub-Saharan Africa

(Nove, 2011; ICEADA, 2012). Above 80% of Malawi's population is classified as rural (ICEADA, 2012), making it one of the least urbanised countries in Africa. Maternal healthcare services in Malawi are provided formally by midwives, nurse-midwives, clinical officers, general medical doctors, and gynaecologists/obstetricians whilst informally the services are provided by TBAs (Combs et al., 2012; Masina, 2011).

The health sector continues to face skilled health worker shortage which is more pronounced in rural health facilities. The WHO recommends a ratio of one (1) midwife for every 175 child bearing women per year. The "Malawi's health profile" report, last updated in May 2013, states that there were 3.4 nurses- midwives per 10,000 population (WHO, 2013). This means that the nurse/midwife ratio is one third of the recommended 10 nurse-midwives for every 10,000 population, leaving the health facilities in Malawi with a nurse-midwives vacancy rate of 65% (WHO, 2013).The Malawi health sector is also faced with uneven distribution of staff. Many health practitioners prefer to work in urban areas as compared to rural areas (Nove, 2011). Nurse midwives coverage in rural health facilities is at 35% (VSO Malawi, 2013).

One target under the sustainable Development Goal 3 is to reduce the global maternal mortality ratio to less than 70 per 100,000 births, with no country having a MMR of more than twice the global average between 2016 and 2030 (WHO,2015). Delivery by a SBA at a health facility is one strategy employed by some countries like Malawi in the fight against poor maternal and neonatal indicators. Despite these efforts the country still face a number of challenges that hinder some women of child bearing age from accessing safe delivery. From the author's work experience in Ntcheu district, there are severe shortages of SBAs particularly in rural areas. Additionally, reports indicate that there are some health care providers with poor attitudes towards patients. This attitude prevents pregnant women from accessing safe delivery. Furthermore,

health facilities in the district are far apart, beyond the minimum prescribed radius of 5 KM by the WHO. Many families in the rural areas are poor to pay for transportation costs. The geography in many parts of the district is of poor terrain and there are many rivers without bridges making access to health facilities difficult. Many pregnant women lose life on the way and on arrival to a health facility because of transportation challenge (Combs, Sundby, & Malata, 2012.

The United Nations (UN) recommends for at least 5 EmONC facilities for every 500,000 population and that at least one of which should provide comprehensive care (MOH, 2010). Report of the Nation Wide Assessment on Emergency obstetric care services in Malawi conducted in 2010 found that 47% of the 89 hospitals assessed were offering comprehensive services. Of the 210 health centres assessed, 2% were offering basic services. This is mainly due to critical shortage of staff (Banda, 2013). This reveals that Malawi does not meet the UN recommendation regarding EmONC and BEmONC services.

Mac Donagh (2005) argues that investment in the development of SBAs, referral system and EmONC services should be complementary strategies because they are important for the achievement of skilled attendance at birth. Given the situation in most parts of Malawi, and Ntcheu in particular, accessibility to SBAs may be difficult for the majority of childbearing women residing in rural settings. Several studies have recommended the training of community based birth attendants in regions where births in the home without a SBA are common (Prata et al., 2011; Ronsmans et al., 2001; Temesgen, Umer, Buda, & Haregu, 2012; Vyagusa, Mubyazi, & Masatu, 2013; Imogie, 2011; Wilson et al., 2011; Kityo, 2013; Santos, 2013).

In an effort to improve midwifery services especially in rural areas, the GoM in January, 2011, embarked on training community midwives to replace the TBAs in the

communities (Masina, 2011). Contrary to the program goal, the cohorts of community midwives that have graduated and certified by the Nurses and Midwives Council of Malawi (NMCM) are deployed in the existing health centres. It is reported that there are no structures in the communities where this cadre of midwives would be operating from. Consequently, women still have to walk long distance to get to the nearest health facilities in order to access skilled delivery services. The study therefore, was conducted to get views of community members on banning of TBAs from conducting deliveries.

Statement of the Problem

Home deliveries are still registered despite government's efforts that all pregnant women should seek safe delivery services. The policy of banning TBAs from conducting deliveries in Malawi seem to have come early when Malawi did not address the issues that prevent pregnant women from seeking services of skilled birth attendants. Anecdotal records at Ntcheu DHO indicated that the policy of banning TBAs from conducting deliveries has overstretched the already resource constrained health care system. The majority of health facilities in the district are manned by one Skilled Birth Attendant and some have Health Surveillance Assistants (HSAs) {Health Management Information System for Ntcheu (HMIS), 2015}.

Pregnant women who deliver at the nearest health facilities in the district face several challenges. They are kept in congested waiting shelters where there are no insecticide treated mosquito nets to prevent them from malaria. The environment is unhygienic because of overcrowding conditions and this predisposes the women to health problems that may arise due to overcrowding.

There is also shortage of space in the hospital to keep pregnant women after delivery. For instance, it was observed that women share bed in postnatal ward of the district hospital. Consequently, postnatal mothers are discharged earlier than expected

because of inadequate space. Again, health facilities do not have adequate essential supplies to manage the too many women who seek skilled midwifery services.

Research Question

The study intended to answer the research question: What are the community members' views on banning of TBAs from conducting deliveries in Traditional Authorities (TAs) Masasa and Phambala of Ntcheu district?

Objectives of the Study

Broad Objective

To understand the views of community members on banning of TBAs from conducting deliveries in TAs Masasa and Phambala of Ntcheu District.

Specific Objectives

i. To assess knowledge of community members on the availability and accessibility of maternal and neonatal care services
ii. To assess perceived roles of TBAs before and after being banned from conducting deliveries.
iii. To describe community members perceptions about banning of TBAs.
iv. To describe opinions of community members regarding accessibility and utilization of maternal and neonatal care services

Significance of the Study

The study will give answers on why the district still registers home deliveries despite government's efforts of encouraging pregnant women to give birth in health facilities. The results of the study will help to advance understanding on obstacles women in remote rural communities face in the course of accessing skilled attendance at

birth, and thus, might influence policy. The study findings will help inform the health care delivery system in Malawi on how maternal and neonatal services can be improved by taking the community members' views on the banning of TBAs.

The results from the study will also help to reveal new roles of TBAs and if they are still conducting deliveries despite the ban. The study will help Ministry of Health (MOH) in Malawi to initiate research on a broader scale to address the challenges women of child bearing age face as regard to child birth in rural areas of Malawi.

Theoretical Framework

Introduction of the Framework

The "three delays" model by Thaddeus and Maine (1994) was used to guide the study in order to relate access and utilization of SBAs with banning of TBAs. The model was applied to the study because any delay in all the phases of delay stipulated in the model can contribute to continued home deliveries as well as seeking deliveries at TBAs.

The three delays model proposes that pregnancy-related mortality is overwhelmingly due to delays in deciding to seek appropriate medical help for an obstetric emergency; reaching an appropriate obstetric facility; and receiving adequate care at the health facility (Thaddeus and Maine, 1994). The three delays model acts as a guide in understanding the socio-cultural, environmental and health system based factors that have direct bearing on utilization of maternal health services.

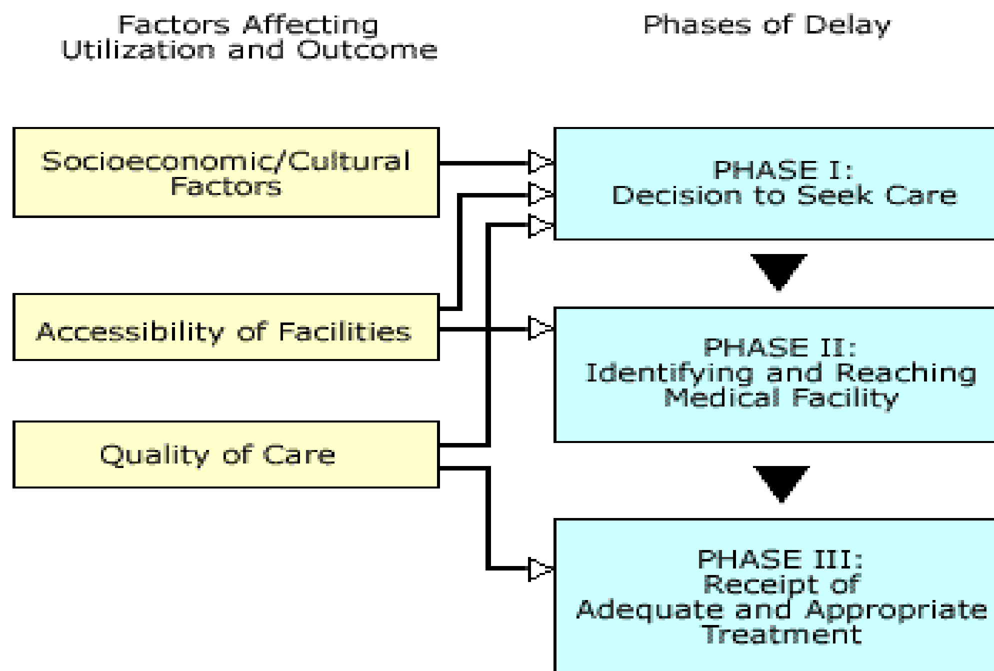


Figure 1: The Three Delays Model by Thaddeus and Maine, (1994)

Description of Terms used in the Model

First Delay Factors

The first delay factors affect decisions to seek services by skilled attendants at health facility. The factors comprise lack of women decision making power on their reproductive health issues; socioeconomic empowerment; Poverty; and privacy to the pregnant woman.

Second Delay Factors

The second delay factors revolve around movement of client from the community to the nearest health facility. Availability of mode of transport, difficult terrain, and long distances to get to the health facility are the key factors.

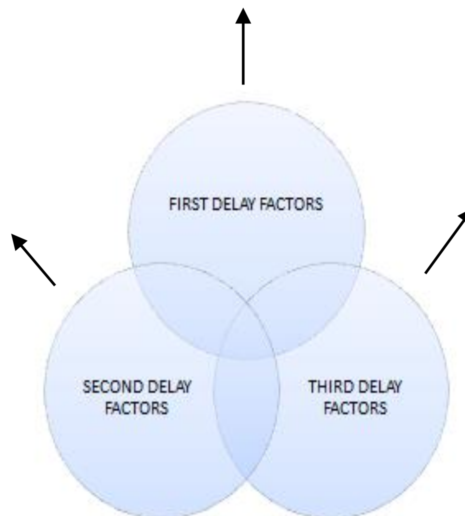
Third Delay Factors

These factors contribute to delay in accessing quality care. This is another life threatening delay when the health facility is reached. Several factors like knowledge and skill level of SBAs, availability of material resources, availability of water and electricity, poor attitude and negligence by health workers, bad previous experience, all contribute to this delay.

Conceptualization of the Three Delays Model

The model entails that there are many interrelated factors faced by women in the course of accessing timely and effective midwifery care services. The factors in the model, if not addressed, may force women to seek care from the TBAs despite efforts to have every pregnancy attended to by a professional midwife in a health facility.

- Cost of services and financial implications
- No culturally sensitive care
- Inability to recognize danger signs
- Decision making capacity of women
- Age
- Education
- Marital status



- long distance
- availability of and cost of transport
- geography of the area (mountainous terrain, impassable roads, rivers)
- issues of insecurity (e.g., at night)
- Lack of health facility

- shortage of SBA
- no medical supplies and equipment
- no water
- no electricity
- poor attitude of staff
- perceived low quality of care
- bad previous experience

Figure 2: Conceptualization of the Three Delays Model

Chapter Two

LITERATURE REVIEW

Introduction

The chapter provides a review of literature on the studies others have done in relation to the banning of TBAs from conducting deliveries. The review helped to generate a picture on what is known and not known about the banning of TBAs (Burns & Grove, 2011). The review of literature was guided by the three delays model and research objectives.

Different data bases which included Hinari, Pubmed, were searched to do literature search. Traditional birth attendant, utilization of traditional birth attendants, views on utilization of traditional birth attendants, and opinions on use of traditional birth attendants were used as key words. Boolean operators like AND, OR, NOT were also used during the search. Literature search centred on articles published between the years 2005 and 2016. However, some articles with information not available in recent articles were included.

Maternal and Neonatal Mortality

The global maternal mortality is unacceptably high. About 830 women die from pregnancy- or childbirth-related complications around the world every day and 2.7 million babies die during the first 28 days of life and an additional 2.6 million babies are stillborn (WHO Fact Sheet, 2016). Quality care during pregnancy and childbirth could help to prevent most of these deaths.

Over 99% of the deaths occur in developing countries and Africa accounts for over half of the deaths (Prata et al., 2011). The majority of the deaths happen during labour and delivery or within the first 24 hours after delivery (Ronsmans & Graham, 2006). The risk of a woman dying as a result of pregnancy or childbirth during her

lifetime is about one in six in the poorest parts of the world compared with about one in 30, 000 in Northern Europe (CarineRonsmans, Graham, & Lancet Maternal Survival Series steering group, 2006).

The contributors to maternal deaths are multifactorial. A study conducted in Lilongwe, Malawi, whose objective was to identify the socio-cultural and facility-based factors that contributed to maternal mortality revealed that some of the contributing factors to maternal and neonatal mortality were delay in receiving treatment upon reaching the facility due to referral delays, missed diagnoses, lack of blood, lack of drugs, or inadequate care, and severe mismanagement (Combs Thorsen, Sundby, & Malata, 2012). These factors are also prevalent in Ntcheu district and district data indicates 30, 26 and 23 maternal deaths for fiscal years 2013/14, 2014/15 and 2015/16 respectively (Ntcheu District data, 2016). Although there is a decrease in the number of maternal deaths in the district, these figures are still high and alarming.

Global picture on Place of Delivery Globally

The global statistics indicate that 25% of deliveries take place at home without the assistance of a SBA (UNICEF, 2015; Ebuehi & Akintujoye, 2012). These statistics are not different from Malawi where seventy-three percent of Malawian births take place in health facilities despite over 95% antenatal care (ANC) attendance (NSO, 2011). About 27% of Malawian women give birth without being assisted by a SBA. 14% of the births in Malawi are assisted by a TBA and 9% by untrained relatives or friends (NSO, 2011). Literature indicates that fear of being ill-treated by health workers; long distance, inadequate staffing/training and referral systems and preference for traditional birth attendants are some of the factors that deter skilled birth attendance at birth (Wilunda et al., 2014; Anastasi et al., 2015).

Countries' Rationale for Banning TBAs from Conducting Deliveries

Although TBAs have been conducting deliveries for many years, many countries and various governments have banned them from practicing. Literature reveals several reasons that led to the ban. In Kenya, TBAs were banned from practicing because they are not well equipped and could encourage the spreading of HIV (Makokha, 2011). The department of Health in Philippines prohibited TBAs from conducting deliveries in an effort to curb the country's MMR (Santos, 2013). A survey conducted in Philippines revealed that TBAs lack adequate medical training to facilitate child delivery. However, home births were not banned because there were other factors that would prevent women from having births in a health facility. It was further reported that the health care infrastructure did not have the capacity to take on the yearly estimated births (Santos, 2013).

Factors Contributing to Continued use of TBAs

First Delay Factors: Socioeconomic and Cultural Factors

Several factors contribute in preventing community members in deciding to seek safe delivery services. Literature reveals that respect for culture, poverty and bad previous experience are some of the contributing factors to continued home births and continued use of TBAs (Shiferaw, Spigt, Godefrooij, Melkamu, & Tekie, 2013. In many African communities, TBAs are highly respected because they perform important cultural rituals and provide essential social support to women during childbirth and their beliefs and practices are influenced by local customs and sometimes by religion (Shiferaw, et al, 2013; Kabayambi, 2013). In Ethiopia, 28% of births are helped by TBAs and women prefer to give birth at home because most TBAs are ready to make house visits, which allow the mother the confidentiality that many prefer. The TBA provides a personal service like massaging women during labour and looking after her

children after she has just given birth, tasks a doctor and midwife rarely do (Shiferaw et al., 2013)

Poverty is another factor that forces women to seek the services of a TBA. Poor and marginalized women usually fail to access SBA (Hoope-Bender, et al, (2011). Malawi is amongst the poorest countries in the world ranking number 171 out of 187 on the Human Development Index (HDI) in 2011 (ICEADA, 2012). Kityo, (2013) and Kabayambi (2013) state that TBAs are affordable, and accessible. A study conducted in Malawi revealed that delivery at TBA's home is also influenced by the wealth status of the women whereby Poor women are more likely to deliver at the TBA's home than rich ones (Palamuleni, 2011). These factors make many community members to find the services of TBAs cheaper and nearer to them than the services provided by the formal health care providers. Home deliveries are rampant in Ntcheu district as confirmed by a study conducted in the district which revealed that about 9% of women deliver outside a health facility (Mazalale et al., 2015). TBAs are often trusted members of the community, speak the woman's language and understand her tribal culture.

Second Delay Factors

Good decisions to access safe delivery services might be made in time by communities but their efforts are defeated by some factors that impede them from accessing the services. This leads to continued home deliveries by TBAs (RIPPLE Africa 2003-2014; Tegulle, 2013).

Literature indicates that the inherent challenges within the main-stream health-care delivery system force many women not to prefer services by SBAs (Tegulle, 2013) In Jakarta, Traditional birth attendants (locally known as *paraji*) are still highly esteemed among local residents, especially those in remote areas where medical care is

still lacking (Faizal, (2013). Availability of delivery services is crucial in making sure that women deliver safely.

In Philippines, the department of health passed an administrative order calling for no home birth policy in order to reduce maternal mortality (Umil, 2013). TBAs were forbidden to deliver babies and penalties were provided upon violation of the policy. However, progressive health group argued that imposing such a policy was not going to solve the problem of maternal mortality rate but increase maternal deaths especially in remote areas where hospitals are hours away from where people live. It was then suggested that TBAs should be seen as complimentary to public health workers in rural areas and should be provided with tools for more effective and efficient provision of basic health services.

Despite officially banning TBAs in Uganda in 2010, TBAs have continued to practice and 10% of the deliveries are conducted by TBAs (Kabayambi, (2013, May, 10). Literature reveals that the continued dominance of TBAs in the health system and their overwhelming popularity among rural population in Uganda, is due to their readily availability in places without health facilities (Kityo, 2013). In Zambia Lack of geographic access to emergency obstetric care is a key factor explaining why most deliveries still occur at home without skilled attendance (Gabrysch, 2011)

Home deliveries are prevalent in Malawi despite existence of an administrative law of banning TBAs. The Malawi Demographic and Health Survey conducted in 2010 confirms the disparities between the numbers of women attending antenatal care and delivered by the skilled birth attendants, which are over 95% and 73% respectively (NSO, 2011). A large number of Malawians are affected by the limited access to health services. About 46% of Malawians live within a 5 km radius of any kind of health facility (WHO, 2013), and this leaves the majority with poor access to health services.

An EmONC study conducted in Malawi revealed that 40% of MDs were associated with delays in arriving at a health facility because of long distance (MOH, 2010). A report by Plan International (2011) revealed that women in Kango and Sankhani villages, in Lilongwe district of Malawi, rely on TBAs because of long distance and lack of transport to the nearest health facility. From the author's experience during maternal death audits as well as verbal autopsies, it was observed that long distances to the nearest health care facility, poor socioeconomic status of families coupled with inadequate resources in health facilities are some of the obstacles that prevent women from utilizing health care facilities.

Third Delay Factors

Pregnant women may successfully reach the health facility but the quality of care they receive affect decision making in subsequent visits or even influence others negatively. Studies reveal that poor quality of care, previous negative experiences with health facilities, and economic constraints during referral are some of contributing factors to the low level of service utilization (Shiferaw et al., 2013; Kumbani, Bjune, Chirwa, Malata, & Odland, 2013).

Malawi is one of the African countries badly hit by shortage of SBAs with a nurse-midwife vacancy rate of 65% (VSO, Malawi, 2013; WHO, 2013; Nove, 2011). The World Health Organization in the Malawi's health profile, last updated in May 2013, reported that there were only 2 physicians per 10,000 population and 3.4 nurses-midwives per 10,000 population. The human resource shortage means that the working conditions of the existing maternity care professionals are poor, and this creates a vicious cycle in terms of the difficulty to retain staff and number of experienced practitioners available to support and supervise the newly qualified. Additionally, the

already few health workers are not evenly distributed in the healthcare system. The human resource shortage is particularly marked in rural areas.

In many developing countries like Malawi, the majority of maternity care professionals are based in urban areas, leaving the rural health centres understaffed (Kongnyuy, Hofman, Mlava, Mhango, & Van den Broek, 2009). This is pathetic as Malawi's over 80% of the population lives in rural areas (NSO, 2011). About 87% of all births in Malawi take place in rural areas, compared to 13% in urban areas where most health centres and hospitals are concentrated (Nove, 2011). Nove further states that the poorest people in Malawi have 45% access to a SBA compared to 84% in the richest category. This means that Malawi's poorest people who are the majority, have approximately two times less access to skilled care compared to the urban counterparts.

Bad previous experience is one factor that forces women to continue delivering outside the health facility. Studies revealed that TBAs are preferred as compared to skilled health workers in the manner they handle their clientele (Titaley, Hunter, Dibley, & Heywood, 2010 ; Kumbani, Bjune, Chirwa, Malata, & Odland, 2013; Karkee, Lee, & Pokharel, 2014). A qualitative study conducted in rural Southern Malawi on why some women fail to give birth at health facilities revealed that health worker' poor attitudes contributed to the women delivering at home (Kumbani et al, 2013).

Inadequate infrastructure and material resources in most health facilities also contributes to continued home deliveries. Some health facilities have just one room for delivery which compromises the right to privacy and confidentiality (Plan International, 2011). Shortage of equipment and essential supplies for conducting safe deliveries as well as space makes these health centres struggle to cope.

The Road Map (2009) identified several contributing factors to Malawi's high MMR, of which are limited availability of maternal health care services, weak referral

systems. These factors have contributed to the general mistrust of the national health care system and hinder some women from accessing and utilizing the SBAs.

Summary of Literature Review

Good outcome of pregnancy requires vigilant approach to all the three delays. Universal access to emergency obstetric care requires that all women and new-borns with complications should have access to well-functioning facilities. It is obviously better if the delivery takes place in or very near to a facility capable of providing at least the basic emergency obstetric and new-born care.

Ensuring that all births take place in appropriate health facilities is a long term plan for Malawi considering the inconsistencies facing the health care system. Literature suggests that addressing the third delay factors first, will result in the greatest impact in reducing maternal deaths (Barnes-Josiah, Myntti, Augustin, 2013). It is practically important to address the third delay factors first, than facilitating giving birth in a health facility which is not available, not well staffed, not well-equipped and where the SBAs have poor attitude. Availability of health facilities which are within reach, well-staffed, well-equipped, can help to manage all five of the major causes of maternal mortality (haemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour).

Chapter Three
METHODOLOGY OF THE STUDY

Introduction

This section gives details of research methods that were used to achieve the research objectives. It gives details on the research design, setting, study population, inclusion and exclusion criteria, sampling method, data collection methods and processes, data analysis, trustworthiness, ethical consideration and plan for dissemination of study findings.

Research Design

The study used qualitative study design. This design was chosen because it generates rich data and provides flexibility to the interviewer to rephrase questions during collection of information from the participants. This resulted in getting realities and sufficient details on the community members views on banning of TBAs (Polit& Beck, 2008).

Study Setting

The study was conducted in two Traditional Authorities (TAs, Masasa and Phambala in Ntcheu district. These are some of the areas that face challenges in accessing health facilities as a result most pregnant women were benefiting from the services of TBAs.

Ntcheu district is in the central region of Malawi bordered by Balaka, Mwanza, Mangochi, Mozambique and Dedza district to the South East, South, North East, West, and North respectively. It lies half way between Malawi's major cities of Blantyre and Lilongwe. Ntcheu district is located approximately 175km south of Lilongwe which is the capital city of Malawi. It covers a distance of 33000 sq. km. It has 36 health centres, and one District hospital.

Ntcheu district has a projected total population of 588,038 of which over 250,000 people live in hard-to-reach areas (National Statistics Office data, 2016). Remote areas pose a challenge to the accessibility of health services, including maternal health care. The number of women of child bearing age in the district is estimated at 135,249, of which 29,402 are likely to be exposed to the event of pregnancy in the year 2016/17. During fiscal year July, 2013 to June 2014, the district recorded a total of 16 MD (Ntcheu District Database, 2014). The NSO data also indicate a projected figure of 99,966 Under Five Children and 282258 children of less than one year. It has 874 villages, 124 GVH and 10 TA s.

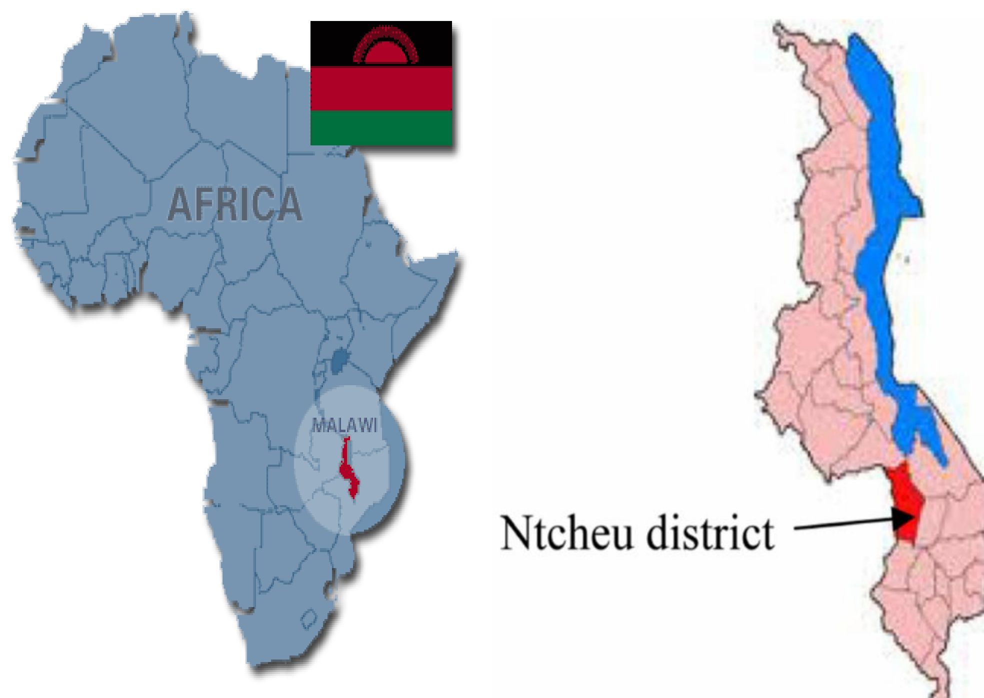


Figure 3: Maps of Africa (left) depicting Malawi (right) and the location of Ntcheu district (red) (Source: https://www.google.com/search?q=map+of+africa+)

Study Period

The study was conducted from September, 2015 to November, 2015. This period included data collection and data analysis.

Study Population

The study population was community members, that is, women of reproductive age group, men and chiefs. This group was selected for investigation because it is the group that is involved in decision making concerning utilization of skilled birth attendants.

Sampling Method

Two TAs, Masasa and Phambala, were randomly sampled so that all the TAs that met the selection criteria had an equal chance of being picked. The names of all TAs in rural areas in Ntcheu were written on small pieces of paper which were put in a basket, shaken to mix the pieces and then two pieces were picked. Two Group Village Headmen (GVH) Masese and Mwenye from Masasa and Phambala respectively, which previously had high numbers of TBAs, were purposively sampled. Finally, purposive sampling was used to select men, women and local leaders as study participants. The participants were those who met the inclusion criteria in order to get rich data on the phenomenon of interest for the study.

Inclusion Criteria

Participants to the study were community members who had birthing experience at TBA or health facility. They included women, men whose spouses experienced pregnancy and traditional leaders. Men in Malawi play a critical role in maternal and neonatal health issues and they often dominate in decision making in the society at large (Kululanga, Sundby, Malata, &Chirwa, 2012).

Exclusion Criteria

Men and women who had no experience in pregnancy were not included in the study. This category of community members was perceived to have no direct experience

on maternal and neonatal health issues hence not better placed to provide the desired responses to the study questions.

Sample Size

The number of study participants was guided by the concept of saturation; hence fourteen from a target sample size of sixteen. Saturation of data was achieved when no additional data was being found and this made the researcher to become empirically confident that a category is saturated and hence concluded that further data collection was perceived to add little value (Mitchell and Boyle, 2010). Five women, five men and four chiefs participated in the study.

Data Collection Methods and Tools

Face to face in depth interviews were conducted with men, women and chiefs to collect data. The IDIs helped the researcher to obtain as much detail as possible from the participants (Polit & Beck, 2010). This method also gave the community members an opportunity for explanations and hence gave the researcher extensive information on the topic under study.

A semi-structured interview guide was developed in order to make sure that the interview yielded the desired outcomes. A semi-structured interview is a focused interview where researchers have a list of topics that must be addressed in an interview (Burns & Grove, 2011). The tool was developed in English and translated into Chichewa for easy understanding (Appendix E & Appendix F).

The opening section of the interview guide contained introductory details and consent information. Relatively simpler questions were in the first section of the interview guide in order to create rapport with the participant. Key questions that sought to answer the critical issues in the study were contained in the subsequent section. The last section of the guide had closing questions so that there was no abrupt end of

interaction with the study participant. This enhanced the logical flow of questions in the tool. There was an ongoing revision of the interview guide as data collection exercise progressed in order to accommodate emerging issues.

Questions were posed in an open ended manner in order to create more room for the participants to give a detailed account of the issue at hand. The respondents were guided by probing, prompting and clarification in order to give more comprehensive narratives of the issues (Peters & Halcomb, 2015). However, much as the participants were given an open room to share their views on the ban of TBAs, the researcher made an effort to direct the narratives towards answering the study objectives.

A voice recorder was also used to collect data in order not to miss any data. Before recording, the researcher sought permission from each of the participants to have the IDIs recorded. Interviews were conducted privately in Chichewa by the researcher in order to ensure consistency of the data collection process. The recorded data was also transferred to flash discs in order to ensure enough back up in case of loss or damage of the computer or voice recorder. The voice recorder was kept under lock each time when it was not in use. The researcher also used a field diary in which field notes and observations were documented. Some photos of difficult places like rivers with no bridges were also taken.

Data Collection Process

The researcher started data collection after the study's ethical approval by College of Medicine Research and Ethics Committee (COMREC). Before data collection, the researcher pre-tested the interview guide at Kasinje in Ntcheu district, an area with similar features as the selected setting for the study. Four pilot IDIs were conducted. The pilot study helped in determining whether the instrument was useful in generating the desired information (Polit and Beck, 2011). Piloting the tool assisted the

researcher to refine, amend, rearrange the interview guide and come up with more appropriate follow up questions and probes. For instance, it was discovered during the exercise of pre-testing the tool that some questions were yielding the same answers and as such corrections were made. Pretesting of the interview guide also assisted the researcher to familiarize with the questions and obtain feedback on two way communication as well as timing of the whole interview.

Prior to data collection, the researcher reported to the District Health Officer (DHO) for Ntcheu District to make a personal introduction and to explain the intention to commence data collection for the study (appendix G). The DHO was contacted because he is the overall in charge if health related issues in the district. The DHO referred the researcher to the District Environmental Health Office (DEHO) who referred the researcher to the concerned Disease Control and Surveillance Assistant (DCSA) formerly known as Health Surveillance Assistants (HSAs) for the selected study settings. The researcher introduced herself to the DCSAs and gave an explanation on the intention to seek permission to start recruiting the participants from their catchment areas.

The DCSAs escorted the researcher to the concerned TAs. During the meeting with the concerned TAs, the researcher introduced herself and explained the study objectives and the intention to start collecting data. The TAs referred the researcher to the concerned GVHs where the researcher also introduced herself, explained the study objectives and then went further in explaining the intention to start collecting data from the eligible participants. The GVHs accepted the researcher to go ahead with data collection.

The DCSAs assisted the researcher in the identification of eligible participants. The identified participants were given full explanation of the study (Appendix A) which

was translated to Chichewa language (Appendix B) before data collection. A consent form (Appendix C) also translated to Chichewa language (Appendix C) was signed by those who consented to participate. Good rapport with the participants by doing self-introduction, demonstrating active listening and being flexible in rescheduling interviews as wished by the participants was maintained.

Every evening of a data collection day, two hours were spent for data review. The reviews gave the researcher an opportunity to follow the iterative process in order to gather rich data. Refinements were made to core topics and questions.

A total of fourteen (14) in-depth interviews were conducted after reaching saturation, at which point no new issues were emerging from the interviews (Walker, 2012). Four of the interviews were with village head men; five with men and; five were with women. The duration for interviews ranged from 35 to 46 minutes, with majority above 40 minutes. On average each interview lasted 40.5 minutes.

Data Analysis

Data analysis was done simultaneously with data collection by the researcher herself. This assisted the researcher to ascertain a point of saturation of data. Thematic Content Analysis approach was used to analyse the data in order to capture key issues that emerged from the textual data generated from the in-depth interviews.

Thematic content analysis refers to the process of analysing any narrative data for the purpose of identifying prominent themes, as well as relationships or patterns among themes (Norwood, 2010). The transcripts were read and the audio tapes listened to by the researcher and then proceeded to analyse the data using the five steps of thematic and content analysis according to Graneheim & Lundman (2004) namely: transcription of raw data; condensation of data; grouping of data into codes; creating categories; and development of meaningful themes. Here are the steps in detail.

Step 1: Transcription of Raw Data

All the audio-recorded interviews were turned into verbatim transcript and translated from Chichewa to English by the researcher. A verbatim transcript was important as it captured information in participants' own words, phrases and expressions. This allowed the researcher to uncover deep meaning from what was said. The words also reflected participants' feelings and emphasis in relation to the issue being discussed. The transcriptions were cross-checked by the researcher for accuracy and completeness and then re-checked by the supervisor.

Step 2: Condensation of Data

Condensation of data is a process of shortening the text while still preserving the central content (Graenheim&Lundman, 2004). The researcher achieved this by paraphrasing the data material to reduce the data into its basic content. Long sentences were therefore, turned into short forms called condensed meaning units.

Step 3: Grouping Data into Codes

This involved putting together condensed meaning units into codes based on their similarities and differences (Graenheim&Lundman, 2004). This entailed reading, rereading and vigorous study of each question to come up with concepts in the responses. This allowed the researcher to understand the information in a new and different way while focusing on the context. This helped to reduce effort that would be needed to locate specific sections of interest in the text. For each transcription, issues relating to the study aims were identified and coded without predefined categories. Some codes were determined as the participants answered a specific question of the study while other codes represented larger concepts that emerged from the study.

Step 4: Creating Categories (Categorization)

This is the key aspect of qualitative content analysis and it is the stage when the data was grouped according to their similar and different units (Graenheim&Lundman, 2004). The researcher ensured that the categories were comprehensive and had mutually exclusive meaning. At this point the researcher was sure that no data related to these meanings was omitted due to lack of a suitable category.

Step 5: Developing Themes

After the completion of the coding process, the researcher developed main themes from the categories based on the content areas in relation to the objectives. Additionally, sub themes were developed depending on the flow of information from the categories as presented in the results. The researcher finally presented the identified themes as main findings of the study.

Enhancing Trustworthiness of the Study

Trustworthiness is used in qualitative research in order to assess the quality of data and findings (Lincoln and Guba, 1985 cited Polit& Beck, 2010). Trustworthiness was achieved by meeting the four criteria, which are credibility, transferability, dependability and confirmability (Polit and Beck, 2010).

Credibility

Credibility was achieved by ensuring that the participants recruited were knowledgeable about the phenomenon. The researcher used purposive sampling to select participants who live in remote areas, as their information would be based on accurate views about banning of TBAs. A tape recorder was used to capture the data and information shared during the interview. This process was helpful in ensuring that no information was missed. The participants' own words were used during transcription to ensure correct representation of their voices. Prolonged engagement was achieved by

the researcher's continuous commitment to data collection and analysis. Member checking was carried out for the clarification and confirmation of data with the participants (De Vestal, 2002).

Transferability

Transferability refers to the extent to which the findings can be applied to other settings (Polit & Beck, 2008). To ensure transferability, information on descriptions of the settings, inclusion and exclusion criteria were followed to allow the reader to envision the context and type of settings in which the findings or the methods may be applicable.

Dependability

Dependability refers to the reliability of data over time and the conditions under which it was obtained (Polit & Beck, 2008). This was achieved by involving different ethnic groups in different geographical areas, that is, two different TAs, as study participants. Additionally, an independent co-coder helped to ensure the consistency of findings.

Confirmability

Confirmability refers to a mechanism of ensuring that the data represents the information that the participants provided (Polit & Beck, 2008). It helps in the maintenance of neutrality of data that is potential for congruence between two or more independent people about data accuracy, relevancy and meaning. In order to ensure confirmability the researcher observed and documented own personal biases or reactions that could affect or influence data collection and interpretation. The researcher also involved independent people, the research supervisor for verification of participants' responses against the set questions. The study findings were sent to the

supervisor and another independent person specialized in research was involved to do back translation of findings.

Confirmability was also maintained by checking of facts and through follow-up questions to check if the researcher understood exactly what the participant said and what the statement meant. Records of main decisions and events were kept by the researcher during the field work in the form of dates, venues and the mode of entry into the field. An independent co-coder was also used during data analysis.

Ethical Considerations

The study was conducted in Malawi, under the University of Malawi. The study proposal was therefore, submitted to COMREC for approval. COMREC is a body that is legally mandated to scrutinize and approve studies in the University of Malawi. The outline of the study proposal comprised the following sections: title, objectives, specific aims, methods of data collection, and the type of participants. Feedback was received on July, 22, 2015 after recommending some modifications to the study proposal in order to meet the University of Malawi requirements **(Appendix I).**

The project proposal was also sent to Ntcheu District Health Office (DHO) for project site approval. Permission to conduct the study in TAs Masasa and Phambala was granted by the District Health Officer (DHO) of Ntcheu on July, 2, 2015 **(Appendix G).**

In line with standards of ethical conduct, the first section of the interview guide included details on obtaining informed consent from participants. The details included: interviewer self-introduction, the purpose of the study, why the particular participant was chosen, and the emphasis on voluntary participation. Furthermore, the participants were informed about the study and asked for permission for the interviews to be audio-recorded. An explanation was given to the participant that recording of the proceedings was done in order not to miss any verbatim details of the information provided.

Participants were also assured of anonymity during data analysis, presentation, dissemination and publication of the findings (Stamer et al., 2015). Furthermore, the participants were assured that all the study documents would be under lock and key.

Participants were also informed in advance that there was no monetary benefit for taking part in the study. Before signing consent, the researcher informed participants on the expected risks to be encountered during data collection including psychological, social, and emotional. This could happen due to long interview and waiting time as some participants would be slow to answer questions or other unforeseen circumstances prior to the interview.

Dissemination of the Results

The results of the study will be communicated to the concerned people in order to be useful. Dissemination of results will be done locally, nationally, regionally and globally. The health committee of parliament will be disseminated with the study findings because the results may influence policy and distribution of health-related resources. The bound Copy of the report will be submitted to COMREC secretariat, Kamuzu College of Nursing (KCN) library and MOH- Safe motherhood initiative. A presentation on the report will also be done at the scientific research annual conference and other fora. The report will also be published in a local newspaper and as a journal article.

Chapter Four
PRESENTATION OF FINDINGS

The findings are presented under the following themes: access to maternal and neonatal health services; dangers of home delivery; experiences of giving birth at a TBA versus health facility; participants' perceived trend of maternal and neonatal mortality; need for consultation with stakeholders; and health Worker-TBA Partnership. The themes relate to maternal and neonatal health services with regard to government's ban of TBAs from conducting deliveries. Presentation of the results has taken the pattern of a description of the themes supported by excerpts from participants' narratives.

To assess knowledge of community members on the availability and accessibility of maternal and neonatal care services

To assess perceived roles of TBAs before and after being banned from conducting deliveries.

To describe community members perceptions about banning of TBAs.

To describe opinions of community members regarding accessibility and utilization of maternal and neonatal care services

Access to Maternal and Neonatal Health Services

It was pleasing to note during interviews with participants that the community members have knowledge of where they can get safe delivery services. Participants P01 (a village head woman) and P05 (a male community member) demonstrated knowledge on where to get safe delivery services.

> (P01) said *"Good maternity services are found in health care facilities because there are beds which are clean, while at a TBA the women delivers on the floor, full of dust. Furthermore, a TBA cannot transfuse blood or infuse fluids to a pregnant woman when needed…"*
> *P05:"I personally understand that delivering at a health facility with assistance from a midwife is beneficial. It is like we are rude by delivering at a TBA, ..but we have no*

option because health care facilities are very far from this area and the one close to us has no midwife".

However, community members viewed banning of TBA from conducting deliveries that it had come early before addressing some of the prevalent factors that affect accessibility and utilization of safe delivery services. The community members' narratives highlighted factors like inadequate finances; lack of awareness programs on maternal and neonatal health issues; long distance; effect of weather on mobility; mode of transport; attitude of health care providers; health facilities without skilled birth attendants; status of maternity waiting homes as some of the factors that are contributing to continued use of TBAs in their areas. These factors are also reflected in the three delays model.

Inadequate Finances

Participants' narratives demonstrated community realisation on the need for safe delivery. However, low socioeconomic status prevents them from accessing and utilizing safe delivery services. Community members therefore view the banning of TBAs not to be a success because of this factor that greatly affects their decision making power. A female participant (P12) points out the issue of financial constraints as one of the reasons why pregnant women in the community do not timely start antenatal care and deliver at health facility.

P12: "We have a health facility at Namisu but it is not functional because there is no skilled birth attendant. Most of us lack money to start antenatal care during first trimester at Senzani Private Clinic."

Awareness Programs on Maternal and Neonatal Health Issues

Community members' narratives indicated lack of awareness programs to contribute to continued use of TBAs. They view awareness programs to help the communities understand the necessity of banning TBA. A village head man (P09) underscores the need for awareness programs on MNH issues

P09: "*We should be frequently educated at village level on issues of child birth to prevent pregnancy related complications. If people properly understands the importance of hospital delivery, they can ably make decisions in time to wait for labour at the health facility"*.

Cost of Services

Cost of services especially in communities that are served by Mission and private health facilities is another issue that was viewed to continue forcing the communities not to seek SBA services. This scenario is, however, interesting to note that even at TBAs services is at a fee. There could be other factors that make services at TBA more attractive. A female participant (P10), highlights the issue of service fees paid to Mission and private hospitals.

P10: "….for normal delivery at Senzani private clinic we pay MK3, 500.00 and MK5, 000.00 if an episiotomy was performed, the cost for initial antenatal visit is MK1, 000.00 and MK300.00 for subsequent visits."

Participant P10 also highlights the effects of user fee on the utilisation of maternal and neonatal health services. She cites late starting of initial antenatal visit.

P10: "there are no free health facilities in the midst of financial challenges as a result we start antenatal clinic late, we usually start antenatal clinic at six months, eight or even nine months pregnant"

Long Distance to the Nearest Health Facility.

Distance has a direct bearing on the access to health services. Communities that are hard to reach are likely to utilize services that are available within their localities. Community members indicated that TBAs are found closer to the communities than health facilities. This renders the TBAs competitive edge in attracting maternal clientele despite government's efforts to encourage safe delivery. A female participant ,P05, articulates the time it takes for pregnant women in the area to reach the nearest health facilities.

P05: "Hospitals are very far from this area. From here to Kasinje which is a free government facility we take four hours, to Nankumba (Bvumba) we also take four hours on a bicycle, Mostly we deliver on the way to a health care facility, sometimes we seek services from a TBA. The problem is worse during rainy season when rivers become full of water and difficult to cross because the rivers that surround us have no bridges"

The same sentiments about inaccessible safe delivery services are reflected in the narrative by participant number P04 who shares her personal experience of delivery of a baby on the way to hospital because of long distance.

*P*04: "*The baby in my hands currently breast feeding, was born at a TBA because I was already in established labour, I could not manage to walk the long distance, as a result I simply branched to a TBA although I knew that it was against the rule"*

Effect of Weather on Mobility

Poor road infrastructure is a common phenomenon in developing countries. This makes travelling of pregnant women to health facilities a challenge. This becomes a problem especially in rainy season when road network becomes impassable. Community members view banning of TBAs not to be a success because they are still surrounded by rivers with no bridges and the TBA is in the TBA available in their area is their only hope. Participant P02 shares the predicament she went through when she was in labour. The baby was delivered on the way because of bad condition of the road after heavy rains.

P02: "I delivered at a TBA because the rivers that surround us, that is, both Nagondwa and Nakaole, were full of water and there is no bridge, I couldn't make it to the other side of the river"

The issue of poor road network due to heavy rains makes child bearing a difficult experience. To overcome the situation, communities especially men try to employ local means to still enable the pregnant woman reach the hospital as cited by a

village head man (P01). Nevertheless, such challenging situations can prevent deliveries at health facilities.

> *P01: "Traveling to health care facilities in this area is difficult more especially during rainy season. The rivers become full so men use strong ropes to pull pregnant women and her escorts to the other side of the river. From there they use bicycles to the health facilities."*

Mode of Transportation

The mode of transport is one of the critical elements in creating an enabling environment for safe delivery. It came so often during the interviews that pregnant women usually fail to timely reach a health facility because of transportation problems. Rural settings where there is rough terrain compound transportation problems because vehicles usually do not operate in those routes. Walking, use of bicycles, use of stretchers and ox-carts are the commonly used mode of transport. Usually these modes of transport are not fast enough to quickly ferry the pregnant woman with an obstetric condition to reach the hospital. Such situations force women to have home deliveries. A female participant (P11) gives an account of how poor transportation made her end up having unsafe delivery. Both participants P06 (male) and P11(female) narrate situations that arise due to transportation problems

> *P06: "It is difficult to find transport here, most of us walk and as a result our women deliver on the way or seek the services of a TBA*
> *P11: "We are in trouble here hospitals are far from this area. For us to reach Senzani private hospital, it takes us almost two hours and thirty minutes walking on foot with the woman on "m'gomb"a (a stretcher made from tree branches), and we take almost two hours cycling"*

The mode of transport of pregnant woman from community to health facilities brings about another dimension of issues of privacy especially when delivery occurs on the stretcher on the way to hospital. Culturally, it is still not widely accepted for men to witness giving birth.

P11: "Women privacy in terms of child birth is being violated. Men see women delivering, a thing which could not happen before."

Attitude of Health Care Providers

The banning of TBAs from conducting deliveries rests on the understanding that they make no difference in terms of preventing high maternal and neonatal deaths in the country. The assumption is that health facilities would provide a conducive and safe environment for child bearing. It is however, discouraging to note that there are some factors within the hospital system that can scare pregnant women from seeking maternal and neonatal services such as attitude. A female participant (P10) shares the ordeal she went through at a hospital she had hoped to get the attention and care she deserved.

"To say the truth we face problems in the health care facilities especially Balaka. I remember my last pregnancy I was bleeding vaginally; I was passing out blood clots from the vagina. I managed to go to Senzani mission hospital. The watchman told us that we could not be seen by a skilled birth attendant because it was at night. I slept and met the skilled birth attendant the next morning, and then I was referred to Balaka DHO. It took long time for me to be attended to by a skilled birth attendant at Balaka DHO... I delivered my baby already dead. I still feel that my baby could have been born alive if I were reviewed and assisted in time…"

Health Facilities without Skilled Birth Attendants (SBAs)

Participants verbalised the availability of health facilities in the community. However, the biggest challenge is that the facilities do not have SBAs. Hence the community members view the banning of TBAs not to be a success. The unavailability of SBAs leaves the communities with the option of seeking maternal and neonatal health care from traditional sources. Participant number P3 (male) attests to the unavailability of the SBAs.

"I have never seen Phanga health facility being functional; there are no skilled birth attendants at the facility, other health facilities are four hour walking distance. What else do we do other than using the services of a TBA at Masese II….and she knows her job well, most of the kids you are seeing in this community were delivered by her, she tell guardians to find transport when she sees she cannot manage"

Status of Maternity Waiting Homes at Health Facilities.

Focussed antenatal care encourages pregnant women especially those with potential obstetric complications to wait at the hospital when labour and delivery is close. This is part of safe motherhood initiative strategies to fight high maternal deaths. Much as the government of Malawi has made strides in construction of these structures, there are still some health facilities which either do not have any or they have a waiting shelter with limited space to accommodate the many pregnant women in our communities. The problem of limited waiting space is exacerbated with the campaign to encourage all pregnant women to deliver at health facilities. The narrative by a female participant (P02) illuminates the challenges pregnant women face because of limited waiting space. Additionally, pregnant women and their guardians who come for waiting are not provided with food. This becomes a huge problem especially for those who come from distant places and view banning of TBAs with a second thought. In the end, the clients feel like it is more convenient to deliver at TBAs because they are usually located in their communities.

> *P02: "There is no enough space; there is usually congestion in the waiting area. Another problem faced is lack of food because here at Masese we do not harvest enough food crops because of floods and therefore, we find it easier to wait in our homes until when labour start, it is easier that way…."*

Community Perceived Roles of TBAs Before and After the Ban

Previously, TBAs provided antenatal, delivery, health education and referral services. The introduction of the ban trimmed the scope of maternal and neonatal services they provided. TBAs are only allowed to make referrals of the pregnant women to health facilities. However, it repeatedly came out from participants' narratives that TBAs secretly conduct deliveries because of prevailing circumstances. A village head woman (P01) gives evidence that some TBAs are still conducting deliveries.

P1: **"***The TBA we have at Masese still conducts deliveries .....and if it is a difficult case she tells guardians to find means of transport to take the woman or neonate to a health care facility*"

The Dangers of Home Deliveries

Home deliveries contribute to high maternal deaths in Malawi. The communities seem to support the need to stop the TBAs from conducting deliveries. However, there are issues that are to do with decision making at community level and transportation and poor quality of midwifery services that go against their will to go for a safe delivery. Pregnant women are therefore, left with no option but to seek the interventions by the elderly women and TBAs in their communities. The challenge with delivery by these people is that they make no difference when obstetric complications arise. The pregnant woman may end up losing her life and that of the new born. A female participant (P04) shares how a woman is assisted in the community when she has failed to make it to the hospital.

P04: "If a woman has failed to go to health facility some elderly women in this village help her deliver right here, but the problem is that those elderly women cannot resuscitate the baby if there is need, while skilled birth attendants in health care facilities know how to assist a baby who did not cry at birth. In addition, the woman cannot be removed retained products of conception by either elderly women or TBAs here at home."

Experiences of Giving Birth at a TBA versus Health Facility

Safe Motherhood considers delivery at health facility as safe. This is because health facilities have requisite resources to handle obstetric complications. While it is true that TBAs cannot handle obstetric emergencies, they seem to be more culturally acceptable by pregnant women. Participants number P10 (female) and P11 (male) highlight this notion. Conversely, participant number P04 (female) puts across the risks associated with deliveries at TBAs.

P10: "A TBA is friendly, always there comforting a labouring woman. At a health care facility, it is by chance to find a friendly birth attendant. TBAs were better than the care we receive in hospital."

P11: "*TBAs were of great help, were easily accessible ......*"
P04: "At a health care facility intravenous fluids or blood can be given to a pregnant woman if there is need and not at a TBA. In addition, TBAs use the same material for example, used razor blade, for many women and thereby transmitting infections like HIV".

Participants' Perceived Trend of Maternal and Neonatal Mortality

While there were mixed reactions, as judged from participants' point of views on the policy of banning TBAs from conducting deliveries, there appears to be community appreciation that the prevalence of maternal and neonatal deaths have gone down. Participant number P10 (female) underscores the point about the positive impact of the policy.

P10: "Previously we used to have more neonatal deaths but since the time the government started encouraging women to be delivering in hospital the neonatal deaths have tremendously reduced."

However, it is very evident from other participants that the ban has brought with it some challenges associated with child bearing. Participant number P02 mentions some of the challenges as a result of the ban.

P02: "Banning TBAs has brought more suffering to women especially those who stay in areas far away from health care facilities, we are forced to walk long distance to find a health facility"

Need for Consultation with Stakeholders

Participants' narratives highly indicated that consumers of health care were not adequately involved before effecting the policy. The tendency of not consulting various stakeholders brings about bottlenecks in program implementation. Participant number P12 (village head woman) gives a reflection of the consequences of top-down approach in policy formulation and implementation.

P12: "We accepted it because it is a directive from the government, there was nothing else we could do. This area is really difficult in terms of transport and there are rivers that make transportation difficult, it is really sad to see a pregnant woman dying because there is no one to assist the woman. TBAs were helping us a lot."

P09 (village head man) suggests the procedure the government would take before effecting the ban.

> *P09: "It could be very good if the government asked our views first as you are doing before banning TBAs. We could assist the government in coming up with solutions to the problems we are facing in as far as midwifery services are concerned in this area. Without solving the prevalent challenges like shortage of staff, long distance, what else do you expect?, as a chief I cannot stop the TBA in my area from conducting deliveries, she is supporting the needy, if it is a complicated case we find means and send her to the health facility which is over 17km away. We are suffering here as if we are not Malawians"*

Health Worker-TBA Partnership

Initially, TBAs were allowed to conduct antenatal, delivery and postnatal services on pregnant women. Government used to provide them with material and technical support until 2007. After noting that pregnant women were experiencing problems at TBAs, referral was the only task that was left with the TBAs. In view of the challenges that the ban has brought about, participants in the study indicated that it would be imperative for government to revisit the policy and try to create health worker–TBAs partnership that would see TBAs managing uncomplicated cases under the close supervision by SBAs. Participant P14 (village head woman) emphasises the need for health worker-TBA partnership.

> *P14: "The government should accept TBAs to be working hand in hand with health care workers; the TBAs should be allowed to handle uncomplicated obstetric cases in the village. Just like in the police service there is community policing and chiefs who work hand in hand with police officers, the same should be applied in the health care field and more especially in areas where accessibility to health care facilities is difficult."*

Chapter Five
DISCUSSION OF FINDINGS

This chapter discusses the study results presented in chapter four. The themes that affect access to maternal and neonatal health services will be discussed first followed by the rest of the themes which are; dangers of home delivery; experiences of giving birth at a TBA versus health facility; participants' perceived trend of maternal and neonatal mortality; need for consultation with stakeholders and health Worker-TBA Partnership.

Access to Maternal and Neonatal Health Services

Access is defined as the opportunity or right to utilise or reach health care (medicinenet.com). The banning of TBAs from conducting deliveries is premised on the national efforts to combat poor maternal and neonatal health indicators that Malawi is grappling with.

Knowledge on the Availability of MNH Services

The study findings reveal that the communities are aware of health facilities where they can get safe delivery. They are also knowledgeable of the consequences associated with delivery at TBAs. However, it was revealed in the narratives that under very compelling factors such as long distances to health facilities and poor attitudes by health care providers, pregnant women are forced to seek maternal and neonatal health care at TBAs or some elderly women in their midst. Such practices lead to missing out of vital statistics that help in planning of health services.

Low Social Economic Status

Participants' narratives indicated low socioeconomic factors as one of the challenges that force women to deliver at home or at a TBA. It is common phenomenon in most developing countries that health facilities are sparsely located. This forces

pregnant women to travel long distances to access safe deliveries. Travelling long distances to access health services has cost implications. Often, in Malawi CHAM health facilities are located in rural settings. However, health services at these facilities are at a fee. In contrast, TBAs are often within communities hence easily accessible. This finding concurs with many study findings conducted both in Malawi and globally which revealed that financial limitations prevent some women from seeking safe delivery services (Palamuleni,2011; Titaley, Hunter, Dibley, & Heywood, 2010).

Additionally, much as the TBAs also charge their services, there is flexibility in terms of what the pregnant woman is supposed to pay. For instance, TBAs may receive nonmonetary forms of fee for the services they provide. Such differences between health facility and TBAs make the communities view the policy with a second thought despite being fully aware of the risks associated with delivery at TBAs.

Awareness Programs on Maternal and Neonatal Health Issues

The study findings revealed that low awareness on MNH issues as well as advantages of skilled attendance at delivery contributes to home and TBA deliveries. This explains why some women in Ntcheu district do not seek safe delivery services (Mseu, Nyasulu & Muheriwa (2014). WHO, (2015) also highlights lack of information as one of the factors that prevent women from seeking safe delivery services worldwide.

Traditionally, MNH issues in Malawi are a preserve for women. It is therefore, high time, in the wake of high maternal and neonatal deaths, that stakeholders in maternal and neonatal services embarked on robust awareness campaign to sensitize community members; men and women as well as gatekeepers on the importance of safe delivery. Such awareness campaigns would further make the communities understand the importance and appropriateness of the ban.

Cost of Services

Cost of service is one of critical elements that determine access to health care. Health services in public hospitals which constitute over 50% of the health care delivery system are generally free in Malawi. CHAM health facilities contribute about 40% of health care delivery but at a fee while the remainder is provided by the profit making and other sources (Nove, 2011).

Narratives from study participants indicated that besides being more culturally relevant, TBAs provide the services at a competitively lower fee which makes it more attractive to the clients. These results agree with findings from a study conducted in Nigeria that TBA services are affordable (Ebuehi&Akintujoye, 2012). This explains the tone in participants' narratives that denote lack of whole support to the ban.

Long Distance

It was revealed in the study that long distance is one challenge that prevents women in rural areas from seeking safe delivery services. Community members view the policy of banning TBAs not to be fully abided by with this factor in existence. Over 80% of the Malawi population resides in the rural settings where health facilities are not only few but also distant from communities (NSO, 2011). Consequently, communities in rural settings are at higher risk of obstetric complications.

These findings concurs with results from a cross sectional household survey conducted in Ethiopia which revealed that out of the 71% of mothers that received antenatal care from a health professional for their most recent birth in the one year preceding the survey only 16% of deliveries were assisted by health professionals, while a significant majority (78%) was attended by traditional birth attendants. Long distance was one of the main reasons for not seeking safe delivery (Shiferaw, 2013). The effects of long distances in accessing health facilities are compounded by the poor road

network. This set up makes TBAs more easily accessible to the pregnant women. The end result is that the policy to ban TBAs from conducting deliveries looks unfavourable to the communities that traditionally benefited from them.

Effects of Weather on Mobility

There are several factors that affect access to health facilities especially in rural areas in Malawi. These challenges become more prominent during the rainy season when roads become more impassable. Study participants complained that rivers surrounding them like Nagondwa and Nakaole have no bridges and become full during rainy season (figure 3). In such situations the communities resort to seek services of the TBAs who are usually located within the communities despite knowledge of the ban. It therefore, becomes a great challenge when an obstetric complication arises whilst at TBA. This explains why home deliveries as well as community maternal and neonatal deaths are still on the higher side.

Figure 4: Nagondwa River without a Bridge

Mode of Transportation

Mode of transportation to health facilities is one of the factors that affect decision making in terms of where pregnant woman can easily access MNH services

(Thorsen et al, 2012; Gabrysch, Cousens, Cox, & Campbell, 2011). It came out many times from the participants that rough topography and poor road infrastructure especially without bridges is a huge hindrance to access safe delivery services. TBAs, therefore, become the only option because of their proximity despite knowing the risks associated with delivering at such places.

Attitude of Health Care Providers

There have been efforts by MOH, in the wake of high maternal and neonatal deaths, to encourage pregnant women to deliver at health facility. However, participants' interviews revealed that there are some health care providers who pose hindrance to utilization of services. Some health care providers insult clients, sometimes it takes long for patients/clients to be reviewed. Community members view this as a hindrance to efforts of making sure that every pregnant woman seek safe delivery services. These findings agree to the findings from a qualitative study conducted in Malawi which revealed that clients want to be treated with respect, kindness and dignity (Kumbani et al, 2012).

Anthropologists who observed professional midwives giving perinatal care in Tanzania and Papua New Guinea report that professional midwives often treat women badly during birth, ignoring their needs and requests, talking to them disrespectfully, ordering them around, sometimes shouting at them and even slapping them (Davis, 2000). One wonders why this maltreatment to clients.

The anthropologists further report that the health care systems often treat the professional midwives badly. They are frequently mistreated by physicians who rank above them in the medical hierarchy, and generally work long hours under stressful conditions including inadequate facilities and equipment and too many women with too

few midwives. Further investigations should be conducted to prove if the bad attitude towards clients is a projected behaviour.

Poor attitude puts across a dilemma to clients because the hospital is where they expect to receive quality healthcare. As a result pregnant women are pushed away and end up delivering in their homes or at a TBA. For instance, literature indicates that there is a huge gap between antenatal attendance and skilled birth attendance in Malawi which are above 95% and 73% respectively, which strongly suggests that not all pregnant women deliver at health facility (NSO, 2011). Approaching clients with an attitude of respect can help to pull women to deliver in health facilities.

Health Facilities without SBAs

Some communities from where participants were drawn have health facilities within short distances which would make it easier for pregnant women to access safe delivery. However, the challenge was that such health facilities were not staffed with SBAs. This situation is as a result of staff deployment challenges the ministry of health encounters. A study conducted in Malawi revealed that demotivating factors within the Malawian health system push the professional health care providers into private, non-governmental, and other non-health related positions (Chimwaza, 2014).The Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages in Malawi, reports that there is a staff vacancy rate of 65% nurse midwives (UNICEF, 2015)

Most suitably qualified health care providers do not like to be deployed in rural remote areas mainly because of poor social amenities (ICEADA, 2012). This indicates that improving the social amenities in hard to reach areas would help ease deployment issues and retain the staff. A study conducted in Afghanistan revealed that women were more likely to use maternal and child health services in communities where midwives had been deployed (Turkman et al, 2013). The unavailability of SBAs in the health

facilities that are close to communities makes the TBAs a readily available alternative to get MNH services. The ultimate result is that communities are forced to act against the policy despite the merits.

Status of Waiting Homes at Health Facilities

It is one of the principles of safe motherhood to advise pregnant women, especially those with obstetric complications to go and wait at health facility when pregnancy is close to term. One of the strategies, within the safe motherhood initiative, is the construction of maternity waiting homes. Again, it is Malawian tradition for pregnant women to be in the company of significant others to serve as guardian. All these people need space.

While some health facilities have waiting shelters to accommodate pregnant women and their guardians, some facilities do not have waiting shelters and in some facilities the waiting shelters are too small to accommodate the huge numbers of pregnant women and their guardians that come to give psychosocial support to the pregnant women . It came out from participants that inadequate space brings about congestion and patients are not provided with food. Overcrowding conditions bring with it a good environment for transmission of some infections like scabies, meningitis, diarrhoeas, just to mention but few. This forces pregnant women to wait in their homes until when labour begins. This challenge is compounded with long distance to health facilities, and lack of transport as indicated in participants' narratives. It is a known fact that a labouring woman finds it difficult to walk long distance. When this is measured against the existence of TBAs, pregnant women choose to deliver at TBAs. It is not surprising therefore, that there are continued reports of home deliveries in the district.

Community Perceived Roles of the TBAs Before and After the Ban

Participants in the study observed that before the ban, TBAs had expanded roles in maternal and neonatal health care as well as reproductive health services. They were providing the whole range of antenatal, delivery, postnatal, referral forms of care, and family planning. With the ban the roles reduced to educating mothers on the importance of hospital delivery. They further stated that some TBAs have quitted the service because of heavy penalties introduced. However, participants mentioned that some of the TBAs are forced to secretly deliver women because of emergency obstetric situations. WHO Report indicates that with the ban TBAs should be playing the role of referrals and teaching lactating mothers on the importance of breast milk (WHO, 2011).

To mitigate the impact of the ban, government intention was to introduce community midwives to take up the roles of the phased out TBAs. However, the implementation of the community midwifery program has failed to address the intended purpose because the qualified community midwives are deployed in the already existing health centres instead of allocating them right in the villages. Admittedly, communities are left with no other option than going back to the TBAs.

Participants' Perceived Trend of Maternal and Neonatal Mortality

It came out from participants' observation that since the ban was effected in 2007 many women deliver in health facilities and there has been reduction in maternal and neonatal deaths in the study areas. Participants were able to point out the advantages of safe delivery. This highlights the importance of participants' understanding of hospital delivery. However, participants were quick to mention that pregnant women still resort to delivery at TBAs because of some impediments associated with accessing hospital delivery as discussed above. Reports from other countries indicate that banning TBAs does not significantly reduce mortality rates.

In India the government was offering cash to women who delivered in health facilities following high mortality rates (Vyawahare (2014). The number of institutional deliveries rose from 40% to 70% but with no significant fall in mortality numbers. Nongovernmental Organization and Health experts fought for the incorporation of traditional midwives into the health care system. The TBAs were therefore, trained in modern child birth practices, equipped and supervised. This initiative helped to significantly lower the mortality rates.

Need for Consultation with Stakeholders

From participants' narratives, it came out evident that community accepted the implementation of the ban because it was a directive from government. However, participants felt it would be better if there were thorough consultations before effecting the ban. This is in line with findings from a study conducted in Malawi which revealed that stakeholders were not adequately consulted before implementing the ban (Banda, 2013). Participants viewed the policy of banning TBAs to be implemented with challenges because of inadequate consultations. They emphasized that bottom-up approach would make communities fully understand and own the policy hence becomes easier to implement.

For an effective change to take place there must be consultations amongst stakeholders (WHO, 2003). This brings about common understanding and ownership of the issue at hand and ultimately makes easy implementation of the program. The researcher illustrates how the community members felt demand side and supply side should interact for easy implementation of programs in the community in Figure 4.

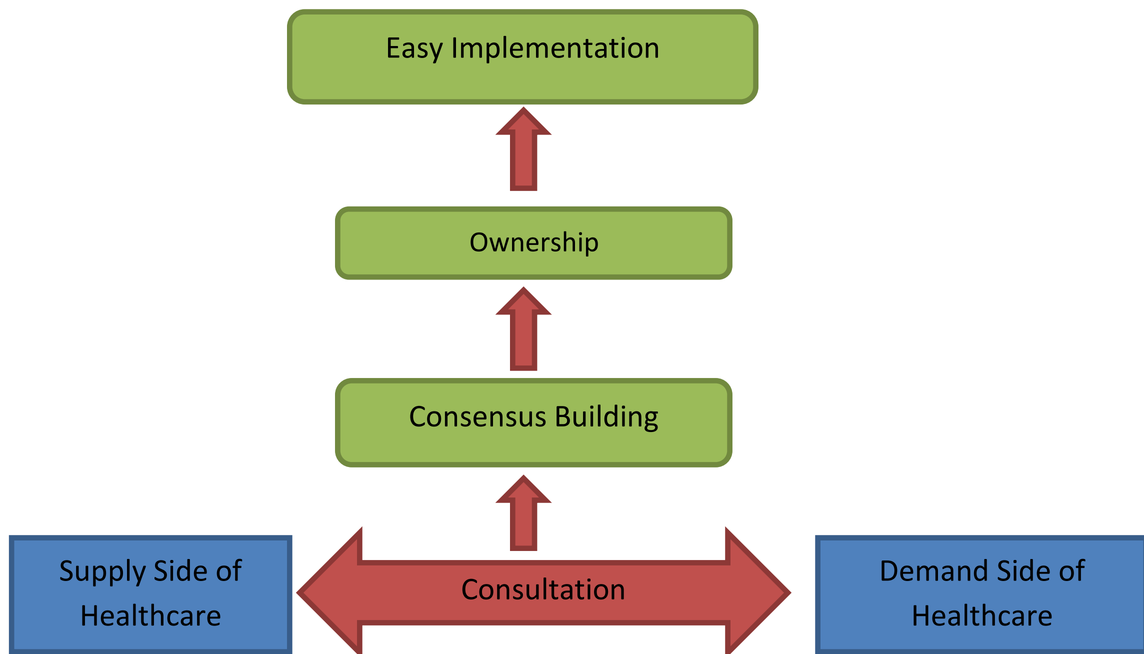


Figure: 4 Illustration of the Pathway to Effective Change

Health Worker-TBA Partnership

Previously, TBAs were allowed to provide perinatal care to pregnant women. Government used to support them with material and technical support until 2007 when, referral was the only task that was left with them. Women of child bearing age in hard to reach areas are finding it difficult to access safe delivery because of lack of transport, long distance and poverty. It would therefore, be imperative for government to revisit the policy and try to create health worker – TBAs partnership that would see TBAs managing uncomplicated cases under the close supervision by SBAs.

Some reports have stated that TBAs are a good link between the community and the health facilities, especially if they have been sensitised to know their limits (Kabayambi, 2013). In so doing, they can be acting as health team-mates to support skilled attendants. This is in line with results from a systematic review with meta-analysis of randomized controlled trials which revealed that perinatal and neonatal deaths are significantly reduced with strategies incorporating training and support of traditional birth attendants (Wilson et al., 2011). With inadequate numbers of skilled

birth attendants in Malawi for service delivery, trained TBAs remain vital contributors in ensuring delivery of adequate MNH services especially in the rural areas.

CONCLUSION, STRENGTH, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

Conclusion

Traditional Authorities, Masasa and Phambala in Ntcheu district, like many rural areas in Malawi, experience high number of home deliveries. Interestingly, the development is against the background of government's ban of TBAs from conducting deliveries. The study findings reveal that communities residing in hard to reach rural settings experience challenges to comply with the policy to seek safe delivery services and view the policy of banning TBAs from conducting deliveries to be implemented with difficulties because of prevailing circumstances that affect accessibility and utilization.

One outstanding feature in the study findings is that the community understands the importance of hospital delivery and where to access the services. There is therefore, need for multi-sectoral collaboration to rectify the challenges that communities face in the course of accessing safe delivery services at all levels of care.

Strength of the Study

The interviews took place in participants' familiar environment (homes) which made them freer to share their experiences hence collection of rich data. Additionally, the study used qualitative methods of data collection which helped understand the context in which the participants' viewed the ban. The study has also a potential impact of global significance as it can directly guide health policy decisions in countries planning to ban TBAs from conducting deliveries.

Limitation of the Study

First and foremost, I believe that since the study was conducted when the ban was already in effect, it is likely that participants responded in the manner that they did not want to look disobedient to government's stand on TBAs. Participants from the same village could differ on the existence and the delivery role played by TBAs.

Secondly, the study only employed qualitative methods. Mixed methods would have made it possible for the study to answer questions that were quantitative in nature.

Recommendations

This section gives recommendations that stem from the information obtained from both the literature search and participants' narratives analysis.

Deployment of SBAs in Hard-to-Reach Health Facilities

Currently the government of Malawi is training all cadres of SBAs. However, majority of the graduates end up deployed in urban settings and not in rural areas where their services are needed most. Government needs to improve social amenities in hard to reach areas to attract and retain them by for example, improving the working conditions, adequate housing, advancing career. Government should also construct structures in the communities where community midwives can be operating their duties.

Improve Health Care Workers Attitudes

Despite efforts to motivate pregnant women to deliver at health facility, poor attitudes of health care providers have been a force acting in opposite direction. There is, therefore, need for all stakeholders to identify and put measures to rectify underlying causes to healthcare workers poor attitudes. Such factors may include poor working conditions, inadequate supervision and lack of scheduled continuous professional development

Improvement of Road Infrastructure

Transportation problem is one of the underlying causes of maternal and neonatal deaths because it leads to delay in reaching a health care facility. A pregnant woman with an obstetric complication may take, for example, 5 hours to reach health facility instead of 1 hour simply because of poor road network. Engaging various stakeholders to improve road network all season round would make a difference in the fight against high maternal and neonatal deaths.

Supportive supervisions to TBAs

The study findings have revealed that there are some TBAs still conducting deliveries. It is important to restart supportive supervisory visits to TBAs. Supervision is one of the management functions. It is only through supervisory visits when authorities can know if TBAs are abiding by the new roles assigned to them. It is also through supportive supervisions when the TBAs can be encouraged to keep data and report deliveries, referrals as well as deaths to relevant authorities. In so doing MOH will not miss out any data.

Provision of Means of Transport in hard-to-reach communities

It was interesting to note that community members understand the importance of safe delivery and where to access the services. Transportation constraints were coming out often as a hindrance from accessing the MNH services. It was also encouraging that there is good support from community members when there is an emergency in the communities. It is therefore, important to support the communities with a means of transport like bicycle ambulance, or motorcycle ambulance in order to ease transportation problem.

Stakeholder Consultations

Much as the policy to ban TBAs from conducting deliveries was in the interest of pregnant women, the process of effecting the ban overlooked one fundamental stage of consulting the recipients of health care. This resulted in lack of ownership by the community. It is therefore, imperative to employ bottom-up approach before implementing any change in the community in order to build consensus and ownership of the change.

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Appendix A: Client information sheet

Please read the information below and sign the form next page if you are taking part in this study

I am Sophie Chimwenje, a student at Kamuzu College of Nursing, pursuing Master of Science Degree in Midwifery. I am conducting a research study on "Community members' views on banning of Traditional Birth Attendants (TBAs) in rural areas of Ntcheu district. You are therefore, being invited to take part in the research study. Participation is voluntary and feel free to ask any question or need for more clarification.

What is the purpose of the study?

The purpose of the study is to explore the views of community members about banning of TBAs in rural areas.

Do I have to take part?

You are free to take part in the study or withdraw at any time you feel like. Your refusal to take part in the study will not affect you in any way. If you agree to take part you will be asked to sign a consent form. Information about you was confidential and no one will identify who answered which question as no names was written on the questionnaires. Code numbers was used instead. The questionnaire and responses was destroyed at the end of the study.

If I take part what will happen to me?

You will be asked some questions about midwifery services in your area and the banning of TBAs. Where necessary, you will be asked to give explanations. You are required to answer the questions truthfully and the interview will take about 45 minutes.

What are the possible risks for taking part?

There are no known risks associated with the study. But it may involve giving out sensitive information because the issue of TBAs has been politicized in our country.

What are the possible benefits of taking part?

The findings of the study will assist in identifying strategies to improve midwifery services in your area and Malawi as a whole because it may stimulate research on a broader scale. The findings from the study may as well help to give answers on the continued home deliveries despite government's efforts of making sure that every woman gives birth in a health facility. The findings will also help in influencing policy regarding traditional birth attendants and their roles.

What will I benefit by taking part in the study?

There are no monetary gains by taking part in the study but upon completion of answering all the questions you was thanked with a packet of 250g table salt, a tablet of U-fresh soap, a soft drink and a snack. This was in appreciation for the time you will spend answering the questions and the views you will give that that will help to promote safe motherhood in Malawi.

If something goes wrong, what will happen?

Complaints concerning how you have been treated during the course of the study can be forwarded to the Chairperson, College of Medicine Research Ethics Committee, Private bag 360, Blantyre, Malawi. Telephone number 0111 871911

Contact for further information

If you need further information concerning the study, please contact Ms. Sophie Chimwenje (Cell number 0999 451 425). Also include the contact of the principle supervisor.

Appendix B: Chichewa Version of Client Information Sheet (KalataYolongosola za Kafukufuku)

Chonde werengani nfundo zili m'musizi ndikusindikiza pa tsamba lakuseli ngati mukulowa nawo mukafukufuku ameneyu.

Zofunika Kudziwa kwa Olowa Nawo Mukafukufuku

Ine ndi Sophie Chimwenje, wophunzira pa sukulu ya ukachenjede ya Kamuzu College of Nursing. Muli kupephedwa kutenga nawo mbali pa kafukufuku wofuna kudziwa maganizo anu pa kuletsedwa kwa azamba kubeleketsa amayi oyembekezera. Kutenga nawo mbali pa kafukufuku ameneyu ndikosaumiriza. Ngati pangakhale funso kapena kuti chilipo china chomwe simunamvetse chokhudzana ndikafukufuku ameneyu mukhale omasuka kufunsa.

Kodi Cholinga cha KafukufukuyuNchiyani?

Cholinga chakafukufukuyu ndikufuna kudziwa maganizo anu pa kuletsedwa kwa azamba kubeleketsa amayi oyembekezera, makamaka m'madera a kumidzi.

Kodi Ndingatenge Nawo Mbali Pa kafukufuku Uyu?

Ndikufuna kwanu kusankha kutenga nawo mbali mukafukufukuyu kapena ayi. Muli ndi ufulu kufuna kusiya nthawi imene mukufuna. Mayankho anu adzasungidwa mwachisinsi ndipo dzina lanu silidzalembedwa pena pali ponse chifukwa tidzagwiritsa ntchito ma nambala. Mapepala onse azaotchedwa pomaliza pakafukufuku ameneyu.

Kodi Chidzachitike ndi Chiyani ngati Nditenge Nawo Mbali?

Mukavomereza kuteng anawo mbali mukafukufukuyu mudzafunsidwa mafunso okhuzana ndi maganizo anu pa nkhani yauchembere wabwino komanso kuletsedwa kwa azamba kuchilitsa amayi oyembekezera. Kufunsa mafunsoku kudzatha pafupifupi

mphindi makumi atatu ndi mphambu zinayi. Palibe zovuta zodziwika mukatenga nawo mbali mukafukufukuyu.

Kafukufuku Ameneyu ali ndi Phindu Lanji?

Maganizo anu adzathandiza kumvetsetsa chifukwa chimene amayi ena oyembekezera amachilirabe kumudzi ngakhale boma likuyesetsa kuti azikachilira kuchipatala. Zotsatira za kafukufuku zidzathandiza kuunikanso ndikukonza ndondomeko ya momwe tingamawagwiritsire ntchito azamba kumidzi.Mwachidule, Maganizo anu adzathandiza kupititsa patsogolo ntchito yauchembere wabwino muno M’Malawi

Kodi Ndidzalipidwa Chiyani Pakutenga Nawo Gawo Mukafukufukuyu?

Palibe ndalama iliyonse yomwe mudzalandire chifukwa chotenga nawo gawo mukafukufukuyu koma kumapeto kwa kuyankha mafunso onse mudzathokozedwa ndi packet yamchere ya 250g, soap mmodzi wa U-Fresh, botolo la chakumwa chozizilitsa kukhosi ndi chomwera chake. Izi zidzachitika pakukuthokozani chifukwa cha nthawi yanu ndimaganizo onse omwe adzathandiza kupititsa patsogolo uchembere wabwino muno m’Malawi.

Patapezeka Zovuta Zokhuzana ndi Kafukufukuyu Ndidzapange Chiyani?

Ngati pangapezeke zovuta kapena nkhawa ina ili yonse yokhudzana ndi kafukufukuyu, khalani omasuka popereka madandaulo anu wa:

- **Wamkuluwa College of Medicine Research Ethics Committee**, Private bag 360, Chichiri, Blantyre 3, Malawi. Pa nambala yalamya iyi: 0111 871911 kapena **01989766**
- Kapena kulumikizana ndi **Dr. U. Kafulafula,** Kamuzu College of Nursing P.O Box 415, Blantyre, panambala zalamya izi: 01873623, 0888878290
- Muthanso kulumikizana ndi ineyo**Sophie Chimwenje**, pa nambala yalamya iyi: 0999 451 425

Appendix C: Consent Form

Make sure you have read the above information before signing below if you are taking part in this study

1. I have read and (or have had another person read to me) the attached information sheet for this study and have understood the purpose of the study and the problems involved. Yes ☐ No ☐
2. I agree to participate in the study, be questioned and provide answers to the best of my knowledge. I understand that I am free to withdraw from the study any time and there are no any risks in participating in the study.
3. I know that I will not suffer any injury or harm during the research process. The information that I will give to the researcher shall not be used against me in future.
4. I understand that confidentiality was maintained in the storage of information and that it will only be accessed by the researcher or those people directly concerned with this study.
5. I understand that there is no financial benefit by taking part in the study.
6. I know the contact details of the researcher if there be need to.

Signature/Thumb print   Date

……………………………   ………..…………………

Name of interviewer   Signature

Date

……………………………   …………………………

THANK YOU FOR YOUR ACCEPTANCE TO TAKE PART IN THE STUDY

Appendix D: Chichewa Version of Consent Form (Kalataya Chivomerezo Yolowela mu Kafukufuku)

Onetsetsani kuti mwawerenga ndikumvetsetsa zakafukufuku ameneyu musanasizkize dzina lanu

1. Ndawerenga (kapena wina wandiwerengera) kalata yolongosola za kafukufuku ali pamwambayu ndipo ndamvetsa cholinga cha kafukufukuyu ndizovuta zake.

   EyaAyi ☐ ☐

2. Ndinapatsidwa mwayi ofunsa mafunso ndipo ndakhutitsidwa ndimayankho omwe ndapatsidwa

   EyaAyi ☐ ☐

3. Ndavomereza kutengapo mbali pa kafukufukuyu mosaumirizidwa ndikufunsidwa mafunso okhudzana ndimaganizo athu pa kuletsedwa kwa azamba m'midzi kuchiritsa amayi apakati. Ndamvetsa kuti ndili ndi ufulu kusiya nthawi ina ili yonse.
4. Ndamvetsanso kuti zonse zomwe ndingapereke mukafukufukuyu zidzasungidwa mwachimsinsi ndikugwiritsidwa ntchito ndiopanga kafukufukuyi kapena okhawo omwe akukhudzidwa ndi kafukufukuyi.
5. Ndamvetsetsa kuti palibepo phindu la ndalama potenga nawo mbali mukafukufuku ameneyu.
6. Ndikudziwa mmene ndikapezere opanga kafukufukuyu ngati ndikofunika kutero

Kusindikiza		**Tsiku**
……………………………		………………………
Dzina la opanga kafukufuku	**kusindikiza**	**Tsiku**
………………………………	……………………	………………

ZikomoPovomera Kutenga Nawo Mbali pa Kafukufuku Ameneyu

Appendix E: In-Depth Interview Guide

a) Study Title:

Community Members' Views on Banning of TBAs from Conducting Deliveries in Masasa and Phambala Traditional Authorities of Ntcheu District.

b) Study Population:

Men and women with children, and traditional leaders

c) Participants code number…………………………………………...

d) Date of interview……………………………………………………

e) Place of interview: ………………………………………………....

f) Personal Information

1. Tell me about yourself in the following.

   (Probe: Number of pregnancies, occupation, education level, religion)

g) **Community members' knowledge on safe motherhood.**

2. What do you understand by the term safe motherhood?

h) **Availability and accessibility ofmaternal and neonatal care services.**

3. How far is the nearest health facility in this area?
4. How do pregnant women travel to health care facilities?

   (Probe: means of transportation)
5. What safe motherhood services are provided at the nearest health facility?

   (Probe: cost of services, timing of service provision, waiting shelters, conditions of waiting shelters)
6. How do healthcare providers interact with pregnant women at the health facility?

   (Probe: Greeting, self introduction, orientation to hospital environment, waiting time, explanation of condition, provision of food)

i) **Community's perceived roles of TBAs before and after the ban.**

7. In case a pregnant woman has failed to make it to the nearest health facility, how is she assisted in the community?
   (Probe on the availability of TBAs in the area)
8. What are the roles of the TBA following the ban?
9. How can you differentiate the services provided by TBAs from that provided by health care workers to pregnant women?

j) **Community members' perceptions about banning of TBAs.**

10. What is your general comment on the ban of TBAs?
11. What can you suggest to be the alternative to the ban of TBAs considering the roles they played in assisting pregnant women?

k) **Community's impression on the maternal and neonatal services in view of the ban.**

12. How has the ban affected maternal and neonatal health services in this community?
13. What should be done to improve the midwifery services in this community?
    (Probe: roles of traditional leaders, religious leaders, men)
14. On top of what we have discussed, is there anything that you perhaps forgot and can share it now?
15. Do you have any questions on the areas that we have discussed?

CLOSING REMARKS

Participant thanked for participating and told that once the report is ready it will be disseminated to the office of the District Commissioner and Ntcheu District Health Office.

Appendix F: Chichewa Version of Interview Guide (M'ndandanda wa Mafunso)

a) **Mutu wa Kafukufuku:** Kufukufuku pa maganizo a anthu pa kuletsedwa kwa azamba akumidzi kubeleketsa amayi oyembekezera m'madera a mfumu yaikulu Masasa ndi Phambala m'boma la Ntcheu.

b) **Oyankha mafunso akafukufuku:** Abambo, amayi omwe anaberekapo ndinso mafumu.

c) **Nambala yozindikilitsa oyankha mafunso:** ……………………………...

d) **Tsiku**:……………………………………………………

e) **Malo**: …………………………………………………....

f) **Mbiri ya oyankha mafunso mwachidule**

1. ndiuzeni zambiri yanu mwachidule.

   (**Kufunsitsa**: achita uchembere kangati, maphunziro analekezere pati, ntchito yomwe amagwira, chipembedzo)

g) **Zomwe oyankha mafunso amadziwa pa zauchembere wabwino**.

2. Kodi uchembere wabwino umatanthauza chiyani?

h) **Kupezeka ndi kufikilika kwa zipatala zothandiza pa nkhani ya uchembere**

3. Chipatala chomwe chakuyandikirani chili mtunda wautali bwanji kuchokera kuno?

4. Kodi amayi oyembekezera amayenda bwanji kuti akafike kuchipatalacho?

   (**Kufunsitsa**: amayenda pa chiyani

5. Ndimathandizo otani okhudzana ndi uchembere wabwino omwe amaperekedwa kuchipatala chomwe chakuyandikirani?

   (**Kufunsitsa**: malipiro, masiku ndi nthawi yolandirathandizo, kupezeka kwa malo odikilirako amayi oyembekezera, ukhondo)

6. amayi oyembekezera amalandilidwa motani kuchipatalako?

(**Kufunsitsitsa**: ogwira ntchito kuchipatala amawalonjera, kudziwa omwe akupereka thandizo, nthawi yodikilira kuti munthu alandire thandizo, kufotokoza zamatenda, kupereka chakudya)

i) **Ntchito zomwe azamba akumudzi ankagwira asanaletsedwe komanso ataletsedwa kuchilitsa amayi oyembekezera**.

7. Nanga zikavuta kuti mayi woyembekezera walephera kufikaku chipatala kuti akachire, amathandizidwa bwanji kuno kumudzi?
   (Kufunsitsa: kupezeka kwa azamba ophunzitsidwa ndi osaphunzitsidwa m'derali, amayi ena othandiza kuchilitsa)

8. Kodi azamba akumudzi masiku ano akumagwira ntchito zanji zokhudzana ndi uchembere wabwino?

9. Kodi inu mungasiyanitse bwanji chisamaliro chomwe amayi oyembekezera amalandira kuchipatala poyerekeza ndi kwaazamba?

j) **Maganizo a anthu kumudzi pa zakuletsedwa kwa azamba a kumudzikuchilitsaamayioyembekezera**.

10. kodinkhaniyowaletsaazambaakumudzikuchilitsaamayioyembekezeramunayilandirabwanji?

11. pambali pakuletsa azamba akumudzi, inu mukanakond apakanachitika chiyani poganizira ntchito zomwe azamba akumudzi ankagwira?

12. Kodi chiletsochi chakhudza bwanji amayi oyembekezera kumudzi?

13. Mungakonde patachitika chiyani popititsa patsogoro chisamaliro cha amayi oyembekezera mdera lino?

(**Kufunsitsa**: mafumu, atsogoleri a mipingo ndi abambo achitepo chiyani?)

14. Kodi kuphatikiza pa zonse zomwe takambilana kale pali zina zomwe mwakumbukira zomwe mungafune kuwonjezera?

15. Kodi muli ndi funso lina lilrilonse pa zomwe takambiranazi?

MAWU OMALIZA

Zikomo potenga nawo gawo mukafukufukuyi ndipo zotsatira za kafukufukuyi zidzatumizidwanso pa chipatala chachikulu cha Ntcheu komanso kwa Bwanankubwa wa bomali.

Appendix G: Letter of Permission to Ntcheu District Health Office

Kamuzu College of Nursing,

P. O. Box 415,

Blantyre,

Malawi.

09th March, 2015

The District Health Officer,

Ntcheu District Health Office,

Private Bag 5,

Ntcheu.

Malawi.

Dear Sir,

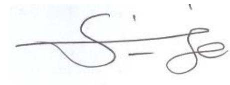
<u>REQUESTING FOR PERMISSION TO CONDUCT A STUDY</u>

I write to seek permission from your office to conduct a study in Ntcheu district, as part of the requirement for the fulfilment the Master of Science Degree in Midwifery program I am currently undergoing. I am a Registered Nurse/Midwife enrolled with University of Malawi, Kamuzu College of Nursing. The study title is “Community members’ views about banning of Traditional Birth Attendant in rural areas of Ntcheu District”.

A copy of the study findings will be given to your office. Further information regarding this study can be obtained by calling on my mobile phone number 0999 451 425/0888

451 425 or from my Supervisor, Dr Kafulafula on 0888 878 290. Attached is the study proposal.

Yours Faithfully,



<u>**Sophie C. K. Chimwenje.**</u>

Appendix H: Acceptance Letter to Conduct a Study

Telephone: +265 01 235 200
Facsimile: +265 01 235 459

All Communications should be addressed to:
THE DISTRICT HEALTH OFFICER

In reply please quote No.
MINISTRY OF HEALTH
NTCHEU DISTRICT HOSPITAL
PRIVATE BAG 5,
NTCHEU.
MALAWI.
2nd July 2015

Kamuzu College of Nursing

P.O Box 415

Blantyre

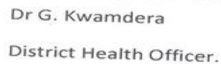
To whom it may Concern,

PERMISSION FOR MRS SOPHIE C.K CHIMWENJE TO CONDUCT A RESEARCH STUDY IN NTCHEU DISTRICT

I write in response to the proposal of Mrs. Sophie Chimwenje to conduct a research study in Ntcheu district in partial fulfillment of her Masters degree on 'Community members' views about banning of Traditional Birth attendants in rural areas of Ntcheu District.'

I am therefore pleased to accept the proposal subject to its successful passage through recommended Ethics Research Committees. It is envisaged that the findings from her research study will assist Ntcheu District Health Office understand some of the reasons behind continued home deliveries being registered in the district and make necessary decisions based on the same.

The District health office wishes Mrs. Sophie Chimwenje the best of luck in her academic endeavors.



Dr G. Kwamdera

District Health Officer.

Appendix I: Approval Certificate 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.07/15/1760 – Community member's views about banning of traditional birth attendants (TBSa) from conducting deliveries in the rural areas of Ntcheu District version 2 June 2015 by Ms Sophie Chimwenje

On 22 July 2015

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) Date