

Traditional Birth Attendants (TBAs) are not Allowed to Assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?

MSc. (Community Health Nursing) Thesis

By

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Declaration

I, Atisiya Clara Mwase, hereby declare that this thesis is a result of my own effort and has not been presented for any other award at the University of Malawi or any other University. The other peoples' work has been acknowledged.

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Signature

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Date

Certificate of Approval

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

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Dedication

I dedicate this thesis to the Almighty God for his super abundant grace on my life throughout my studies.

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Abstract

Policy change for Traditional Birth Attendants stipulates that TBAs should not conduct deliveries because they contribute to high maternal mortality. TBAs are supposed to encourage women to deliver at a health facility with the assistance of skilled birth attendants. The study aimed at investigating the reasons women in Mzimba District specifically at catchment areas of Mkoma and Manyamula Health Centres and Mzimba District Hospital still prefer giving birth with the assistance of TBAs. A descriptive and exploratory qualitative method was used in this study to explore reasons women were still giving births at TBAs. Purposive sampling was used to select 3 health facilities within Mzimba District where many women prefer to deliver with the assistance of TBAs. Purposive sampling was also used to select both women and male participants for the study. Nineteen women of childbearing age of between 18-49 years; and men participated in the study. Data was collected through indepth face to face interviews and focus group discussions. Data was analyzed manually using thematic content analysis. Descriptive statistics was used to analyse the demographic data using Statistical Package for the Social Science (SPSS) version 16.0. The demographic data showed that the majority of the participants were 18-24 years old; all were Christians and married; had primary level of education and their main source of income was peasant farming; and on average the participants had given birth to 3 children. Three main themes emerged from the qualitative data: awareness on policy change for TBAs, women's lack of decision making power, and barriers to deliver with skilled attendants. Based on the results, it is

recommended that a multi-sectoral collaborative approach should be used to address the challenges.

Key Words: Policy change, Traditional Birth Attendants, women preference, skilled birth attendants, barriers.

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List of Abbreviations/Acronyms

ANC	Antenatal Care
COMREC	College of Medicine Research and Ethics Committee
HSA	Health Surveillance Assistant
MDGs	Millennium Development Goals
MDHS	Malawi Demographic and Health Survey
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
WCBA	Women of Childbearing Age
WHO	World Health Organization

Operational Definition of Terms

Traditional Birth Attendant : Traditional Birth Attendant is defined as a person who assists the mother during child birth and who initially acquired her skills by delivering babies herself or through an apprenticeship to other TBAs (Watson, 2013).

Trained Traditional Birth Attendant: A Trained Traditional Birth Attendant is defined as a TBA who has received a short course of training through the modern health sector to upgrade her skills. The period of actual training is normally not more than one month, although this may be spread over a longer time (WHO, 1992).

Skilled Birth Attendant : This term presently refers to a doctor, midwife or nurse. Skilled attendants must be able to manage normal labour and delivery, recognize complications early and perform any essential interventions, start treatment, and supervise the referral of mother and baby to the next level of care if necessary (Saravanan, 2008).

Skilled Attendant : In Malawi, a skilled attendant is defined as a health professional that is trained to manage normal labour and to identify and refer obstetric complications during labour, delivery and postnatal period. Additionally, a Skilled Attendant is trained to identify and refer complications in a newborn. In Malawi Skilled Attendants include doctors, clinical and medical officers, nurses and midwives. This excludes a patient attendant, a trained or untrained traditional birth attendant (National Statistical Office, 2011)**.**

CHAPTER ONE

INTRODUCTION

Introduction

Traditional Birth Attendants (TBAs) attend to the vast majority of non institutional births each year (Madhivanan, Kumar, Adamson & Krupp, 2010). They are mostly women embedded in the community with no formal medical training who play a major role around childbirth. They are usually older women who are respected in the community for their knowledge and experience. They are often illiterate and have learned their skills from older and more experienced TBAs. They attract clients by reputation and word of mouth. They usually receive some remuneration for their services (Ayede, 2013). TBAs have existed for centuries and still continue to be the major providers of care for families in poor and remote areas where they assist up to 50% to 80% of deliveries (Shamsu-Deen, 2013).

Data from the World Health Organization (2008) on births attended by a skilled health worker show that worldwide, 34% of births, that is, 45 million births, occur at home assisted by TBAs. This scenario is found especially in developing, poor and remote areas. In some countries such as Afghanistan, Bangladesh, Chad, Ethiopia, Laos, Mali, Nepal, Niger, Timor-Leste and Yemen, around 80% and even more of all births, take place outside of the medical system. At the same time, these settings account for the highest number of morbidity and mortality of mothers and newborns worldwide. The role of TBAs started to be taken seriously in the early 1950s when high maternal mortality became a concern in many developing countries. Bilateral and international donor agencies, nongovernmental, local organizations donated resources into TBAs training

programmes with the expectation that TBAs would contribute in the reduction in maternal mortality (Shamsu-Deen, 2013).

Worldwide, each year, an estimated 529,000 mothers die due to pregnancy related causes (Ayede, 2013). TBAs have been involved in national and international health programs. However, it was debated that TBA training was not cost effectiveness to show impact of reducing maternal mortality. By 1997 senior policy makers decided to shift priorities on the provision of Skilled Birth Attendants (SBA). The definition of SBA excluded TBAs and resulted in subsequent withdrawal of funding for TBA training and exclusion of TBAs in policies and programs worldwide (Shamsu-Deen, 2013).

Lack of evidence to demonstrate that trained TBAs can reduce maternal mortality led to controversy over their training in relation to safe motherhood and a policy shift to skilled birth attendance (Sibley & Sipe, 2006). However, Saravanan (2008) points out that researchers have observed that at present there is a serious shortage of professionally trained midwives in developing countries and therefore they have cautioned that TBAs will continue to exist despite changes in policies.

The Millennium Development Goals (MDGs) adopted by all United Nations member states in the year 2000 aimed to achieve, by 2015, universal access to reproductive health, which is measured in terms of the percentage of institutional births and births assisted by skilled birth attendant. Furthermore, the United Nations (MDGs) aim to achieve a three-quarters reduction in the maternal mortality ratio between 1990 and 2015 (United Nations, 2000). The Republic of Malawi (2007) states that experiences within the country support the view that the original TBAs training is not effective in improving maternal and neonatal health outcomes and recommends use of skilled birth

attendant.

TBAs in Malawi have been assigned the following new roles: encouraging women to deliver at health facilities, referring any woman who presents to TBA for delivery to the nearest health centre and reporting the case to the Village Health Committee/Village Headman, conducting deliveries only in unavoidable circumstances, providing information to communities on: danger signs of pregnancy, Prevention of Mother to Child Transmission of HIV (PMTCT), exclusive breastfeeding and; educating couples on birth preparedness (Republic of Malawi, 2007: Government of Malawi, 2007). However, the "unavoidable circumstances" for which a TBA can conduct delivery have not been clearly explained. They are, therefore, vague and ambiguous.

This research sort to find out the reasons women in Mzimba District precisely around catchment areas of Mkoma and Manyamula Health Centres and Mzimba District Hospital still preferred giving birth with the assistance of TBAs and not skilled birth attendants. The evidence from this research will help to improve community health nursing and midwifery practice to reduce maternal deaths.

Background Information

The effort to increase access to a safe pregnancy and childbirth through assistance of trained birth attendants was initiated by the World Health Organization (WHO) in 1987 in Nairobi, Kenya, through the launching of Safe Motherhood Initiative (Titaley, Hunter, Dibley & Heywood, 2010). This was attributed to the fact that maternal deaths occurred to mothers who gave birth at home, alone or with the assistance of TBAs. Ayede (2013) states that one of the major factors responsible for high maternal deaths in

Nigeria, is the use of TBAs in conducting deliveries. It is estimated that about 59,000 pregnant women die each year in Nigeria.

In a study by Titaley et al. (2010) in West Java Province, Indonesia it was found that childbirth is often perceived as a normal event rather than an event requiring medical attention. As such, mothers delivered with the assistance of TBAs because of lack of knowledge on the importance of having a safe delivery with the assistance of a skilled birth attendant. Additionally, a study by Shamsu-Deen (2013) in Ghana found that 78% of women delivered at home with the assistance of TBAs as a result of high illiteracy among women.

Ayede's (2013) study revealed that women deliver at TBAs because of their social, emotional closeness and intimacy. Additionally, 99% of TBAs also assist in referral by following the patients to the referral facilities. The same proportion also carries out home visits which are highly valued by patients and their relations.

In Malawi, the National Statistical Office (2011) states that 84% of births were attended by a skilled attendant for women in urban areas compared with 69% of births to women in rural areas. Women (67%) in urban areas are more likely than women (60%) in rural areas to be assisted by a nurse or midwife. Women (15%) in rural areas are more likely than women (8%) in urban areas to be assisted by a traditional birth attendant.

In a study by Mbaruku, Msambichaka, Galea, Rockers & Kruk (2009) on Dissatisfaction with Traditional Birth Attendants in rural Tanzania it was found that formal health service utilization for essential maternal health services was inadequate among the poor. This is due to serious deficit in human resources for health in Tanzania.

Additionally, Titaley, et al. (2010) study conducted in West Java Province in Indonesia found that there was frequent absenteeism of midwife at a health facility in rural areas.

Additionally, a study by Titaley, et al. (2010) in West Java Province in Indonesia found that women preferred using TBAs because of difficulty in accessing health care services especially at night, due to physical distance; and scarcity of health infrastructure in Malawi (Masina, 2011). In Ethiopia, it was found that there was poor utilization of delivery services in health facilities by women because of financial barriers as well as low social status of women (Shiferaw et al., 2013).

Titaley, et al. (2010) in West Java Province in Indonesia revealed that, in rural areas, women refused to be assisted to deliver with the assistance of a midwife perceived as young, inexperienced, with no children and lacking maturity. This is because they were adversely psychologically affected. This is in agreement with a study by Temesgen, Umer, Buda & Haregu (2012) which states that people often prefer a TBA to a trained midwife, especially when the midwife is young.

Women preferred to deliver with TBAs because they attended to long standing traditional practices which are rooted in beliefs and cultures of society such as massaging the abdomen with butter (Shiferaw, et al., 2013). Additionally, TBAs were trusted and shared the same culture, tradition and were long serving members of the community (Temesgen, et al., 2012). Also, in the north of Malawi there is a belief that a first child must be born at home (Masina, 2011). Mzimba District the setting of this study is also in the north of the country.

A study by Kumbani, Bjune, Chirwa, Malata & Odland (2013) in southern Malawi found that pregnant mothers delivered at TBAs due to lack of birth preparedness evidenced by the following reasons: physical illness hence could not walk, rapid progress of labour. Additionally, there were no men to escort them at night when labour had started unexpectedly.

Furthermore, the 2010 MDHS shows that in Malawi, there is still a significant proportion of pregnant women (14%) who deliver with the assistance of TBAs for various reasons (National Statistical Office, 2011). It is viewed that delivering at TBAs and seeking antenatal care services from them can be a major barrier in terms of expanding access to PMTCT services. TBAs do not provide such services. Therefore, women should be encouraged to deliver at health facilities in the presence of a skilled birth attendant (Malawi Government, 2012). As such, the National Sexual and Reproductive Health and Rights policy stipulates that TBAs shall not conduct deliveries but should focus on advocacy for health facility delivery for women (Republic of Malawi, 2009a).

Statement of the Problem

The maternal mortality ratio in Malawi is at 675 per 100,000 live births (National Statistical Office, 2011). The Malawi government changed its policy on the roles of TBAs in 2007, following studies claiming that maternal death was more likely with deliveries conducted by TBAs other than with a skilled birth attendant in a health facility (Republic of Malawi, 2007: Republic of Malawi, 2009). Maternal mortality rate for Mzimba District was 469 per 100,000 live births (Mzimba District Health Office, 2012). TBAs refer mothers to health facilities who present to them for delivery. However, in

Mzimba District, the total number of mothers who attended ANC from January to December 2012 was 45,023 but 22,686 mothers, which is 50% of the mothers that attended ANC, gave birth at a health facility, implying that 50% of the mothers did not access delivery at health facilities (Mzimba District Health Office, 2012). This implies that they either gave birth at home, alone or with the assistance of a TBA. Anecdotal observation has shown that women in this area, specifically around the catchment areas of Mkoma and Manyamula Health Centres and Mzimba District Hospital, prefer giving birth with the assistance of the TBAs. In these three health facilities, total ANC attendance in 2012 was at 4,005 while total number of deliveries in the same year was at 2,880 only. These results imply that 1,125 (28%) did not deliver at health facilities (Mzimba District Health Office, 2012). This study proposed to find out why some women in Mzimba District were not giving birth at a health facility with the assistance of a skilled birth attendant but preferred TBAs.

Objectives of the study

Broad Objective

To investigate the reasons women in Mzimba District still prefer giving birth with the assistance of TBAs despite policy change for TBAs.

Specific objectives

1. Assess knowledge of women on policy change for TBAs.
2. To identify women's beliefs towards delivery services at TBAs.
3. Assess the influence of subjective norms on place of delivery.
4. To identify barriers that prevent women from accessing delivery services at health facilities hence their preference for TBAs.

Significance of the Study

Exploring reasons women still prefer giving birth with the assistance of TBAs will help to bridge the gap in terms of how the problem can be fully resolved so that TBAs no longer conduct deliveries. Since deliveries conducted by TBAs have contributed to high maternal mortality, this study will help the district as well as the Malawi government generate information that will help them develop appropriate interventions to address the problem. The study will help decision and policy makers to effectively develop the best strategies to prevent pregnant women from delivering with the assistance of TBAs.

CHAPTER TWO

LITERATURE REVIEW

An integrative literature search was conducted to find quality studies and articles relevant to why women were still giving birth at Traditional Birth Attendants despite policy change for TBAs. According to Burns & Grove (2011), integrative reviews are conducted to identify, analyze and synthesize the results from independent studies to determine the current knowledge, that is what is known and not known in the particular area. Furthermore, Helen (2010) ascertains that literature reviews are important because they seek to summarize the literature that is available on any one topic. In Malawi, not much investigation has been done on this policy change for TBAs since it was instituted in 2007.

A computer assisted literature search was conducted through various academic databases such as Google Scholar, Pub Med and World Health Organization websites to review what is known about the study topic. In addition, manual search was done from Kamuzu College of Nursing, National Health Surveys, Maternal Health reports publications in Malawi and World Health Organization publications to ensure a comprehensive literature search. The assumption was that the literature for the last decade would provide sound scientific evidence relevant to the current best practice on policy change for TBAs. This was done to find out what had happened since the introduction of this policy change.

The main key words used for this search were: policy change for traditional birth attendants, Traditional Birth Attendants and policy change, women and traditional birth attendants, traditional birth attendants, barriers and skilled attendance at birth, attitudes of nurses at birth, millennium development goals and women preference for traditional birth attendants.

This chapter presents the reviewed literature which covered a number of related studies that had looked at reasons women preferred to deliver with the assistance of TBAs. The literature review was guided by sub-topics which included: knowledge on policy change for TBAs; socio-cultural influence; positive attitudes towards TBAs; beliefs in adequate skills of TBAs; influence of subjective norms on choice of place of delivery and barriers to deliver with skilled attendants.

Knowledge on policy change for Traditional Birth Attendants

Knowledge of women on policy change for TBAs is the basis for informed decision to use skilled birth attendants in health facilities. However, it does not always follow that possession of knowledge transforms into practice. According to Magoma et al., (2010), antenatal care visits constitute an important opportunity to inform women of the advantages of skilled delivery care. They argue that women who attend antenatal care are more likely to seek skilled delivery. The study revealed that 85% of maternal deaths were due to total lack of or partial knowledge of policy change for TBAs for both women and spouses. The results showed that health care providers failed to consistently communicate the importance of skilled delivery for all women during routine antenatal visits. Therefore, lack of adequate health education during routine antenatal care represented a missed opportunity to educate women and family members about the

importance of skilled delivery care for all women. Additionally, husbands, on one hand, were rarely encouraged to attend antenatal sessions and messages about the importance of skilled delivery care for all women were not given emphasis. On the other hand, the husbands typically served as gatekeepers of women's reproductive health. A qualitative study that was conducted in Ngorongoro district among the Maasai and Watemi women, northern Tanzania, found that women's preference to deliver with the assistance of TBAs was a result of lack of or partial knowledge of policy change for TBAs for both women and their spouses. Imparting knowledge on the policy change for TBAs is essential to reducing maternal deaths by facilitating health facility delivery. Maternal mortality is widely regarded as a key indicator of population health and of social and economic development (Wilmoth, et al., 2012).

Studies have shown that educated women are more likely to be aware of difficulties during pregnancy and as a result, are more likely to use institutional health services. This is supported by Karkee, Binns & Lee (2013) in a study in Nepal where women were more likely to deliver in a health facility if they were educated and especially if they had higher secondary or above qualification. In addition, Babalola & Fatusi (2009) in Peru and Guatemala found that women with primary level education were more likely to utilize maternal health services compared to those without any formal education. This shows that educated mothers are more likely to take advantage of health care services than uneducated mothers. Furthermore, education is likely to enhance female autonomy so that mothers develop greater confidence and capabilities to make decisions regarding their own health. Additionally, education helps to gain health information leading to higher level of health awareness, values that result in improved ability and freedom to make health related decisions. Generally, education promotes

health-seeking behaviour. This entails that educated women have more knowledge on importance of seeking skilled attendance at birth than uneducated women. As such, they are more likely to deliver in a health facility. According to National Statistical Office (2011), women (98%) with more than secondary school education attainment are more likely to deliver in a health facility than women (63%) with less or no education. Furthermore, a mother's levels of education and wealth have a positive association with the likelihood that a skilled attendant will assist her during her delivery. Therefore, education of women is vital since women would know of the consequences of delivering with the assistance of TBAs like maternal deaths, and accordingly take measures to prevent them. A study in Patani, Nigeria, by Ferdinand, Geoffrey and Christopher (2014) found that more educated women would more likely not use the delivery services of TBAs at all. On the other hand, women with no formal education or with only a primary education were more likely to use the services more often.

Socio-cultural influence for preferring delivering at TBAs

Policy makers ignore the important cultural and social roles TBAs fulfill in their local communities. The provision of skilled attendants for all birthing women cannot occur in isolation from TBAs who in themselves are also highly skilled (Shamsu-Deen, 2013). These live in the same communities as birthing women, interact with them, sharing the same culture and beliefs. Therefore, shared socio-cultural beliefs are among the reasons that influence women to deliver with the assistance of TBAs. Jia (2010) points out that birth in rural Bangladesh has a rich set of cultural beliefs and rituals, which renders any attempt to make facility birth standard a threat because it could compromise the existence of these indigenous beliefs. It needs no emphasis that eradication of indigenous beliefs eventually kills a people's culture. According to

Medical Association of Malawi (2012), TBAs are often trusted members of the community who speak the woman's language and understand her tribal culture. Their existence is not seen as a threat. Additionally, Emmanuel, Gladys & Cosmas (2013), in a study conducted in southeast Nigeria, found that there were numerous TBAs and people who strongly believed in herbal medicine provided by these TBAs. Consequently, people approved to utilize TBAs services. This suggests that women's strong adherence to the existence of beliefs and traditional practices related to pregnancy and childbirth contribute to preference to deliver at TBAs. Temesgen, et al. (2012) concur with this and state that culture is among the most important factors that act as a barrier in positive health seeking behaviour practices. In a study conducted in Mali, White, Dynes, Rubardt, Sissoko & Stephenson (2013) mentions that individual attitudes and behaviours are products of their social and cultural environments. Women hold low status and are subject to the preferences and beliefs of their husbands and elder relatives in some socio-cultural environments.

Positive attitudes towards TBAs

Traditional birth attendants' caring attitudes attract the community to choose to deliver with their assistance. This is supported by Simfukwe (2011) in a study conducted in Tanzania which found out that women still liked TBAs because they were familiar, polite, did not ask for new clothes or items necessary during child birth as often happens in health facilities. However, new clothes are needed because they are clean and would keep the baby warm. Other items like basin and razor blade are needed to prevent cross infection with other clients since a single woman uses these items during labour and delivery. This implies that women had low level of critical thinking, as they could not see the importance of the new clothes and other items needed during delivery. Furthermore, a

study by Owolabi, Glenton, Lewin & Pakenham-Walsh (2014) found that the relationship with the TBAs, according to the women, was cordial. For example, a TBA would always greet a woman warmly and ask about the health of her family members. This would be evidence of caring beyond the woman herself as it extended to her family. In contrast, skilled attendants at health facilities might not do so, the woman might perceive this as being uncaring. Additionally, TBA's roles may include doing massage and domestic chores for women. As already stated above, generally, TBAs attract clients by reputation and word-of-mouth. This concurs with findings of Babalola and Fatusi (2009) that many Nigerian women, particularly those in rural areas, rated the services of the TBAs to have been of higher quality than those of medical health care practitioners, particularly with regard to interpersonal communications and relationships. Onasoga, et al. (2012) in Nigeria, point out that the attitudes of skilled attendants towards women in labour influence their decision with subsequent pregnancies whether to give birth at health facilities or with the assistance of TBAs. Additionally, Onasoga, et al. (2012) reported that the place of birth should provide comfortable, supportive, reassuring environment for mothers and their families. This is also in line with Vyagusa, et al. (2013) study which revealed that pregnant women sometimes were disappointed because of unfriendly handling by service givers at formal health care facilities.

Beliefs in adequate skills of TBAs

In Malawi, TBAs do not have the capabilities of handling complicated deliveries such as breech. Moreover, their previous roles before the policy change allowed them to conduct only normal deliveries (Republic of Malawi, 1994). It appears they depended upon superstitious indigenous practices, which are not evidence based. Specifically, they carry out risky practices, which are perceived by women and communities, albeit

erroneously, as adequate skills of the TBAs. These include facilitating delivery by using local medication and maneuvering abnormal position to normal position. This is in line with findings by Jia (2010) in Bangladesh, that one TBA used herbal treatment to reduce labour pain and facilitate childbirth. Also, in some instances, snail shell was used to facilitate dilatation of the cervix. Additionally, some TBAs claimed an ability to handle breech births by repositioning the baby to appear head first. However, these practices are particularly risky because TBAs would waste time during an emergency situation in Bangladesh trying out these practices. Instead of making a referral early to save life, they delay and in the long run, more often that not, there is loss of life. Izugbara, Ezeh & Fotso (2009) confirm that Kenyan TBAs with formal training have been accused of frequently sliding back into their old ways of managing birth, often with disastrous consequences for the women who use their services.

Influence of subjective norms in deciding pregnant women's place of delivery

Significant others have shown to have an influence in deciding women's choice of place of delivery. Studies indicate that these play a role in either encouraging or discouraging delivery with the assistance of TBAs or skilled attendants at health facilities. According to Jia (2010), it was viewed that men had the ability to exercise control over women. Sometimes, men would not allow their wives to deliver in a facility or even to access antenatal care. This also implies that husbands were denying their wives their rights to access health facilities for delivery with skilled birth attendants. As such, these women were at high risk of maternal deaths. To address the issue of male dominance over healthcare decisions in Bangladesh, the Maternal Neonatal and Child Health programme reached out to local males to explain the programme, and persuade them to allow wives to go to facilities for birth. Another study in Nepal found that

women with more decision making power in a household were more than twice likely to deliver at a health facility compared to those with little power (Dhakal, Van Teijlingen, Raja & Dhakal, 2011). Additionally, in Malawi, the National Statistical Office (2011) revealed that 44% of currently married women reported that their husbands mainly made the decisions for their health care. The ability of women to make decisions that affect their personal circumstances is essential for their empowerment and serves as an important factor in national development. In a study conducted in Mali where strong patriarchal society exists, mothers in-law discourage their daughters in-law from seeking care from trained providers. This is because they adhere to and believe in traditional and cultural practices and see institutional care as unnecessary. They influence decision making for their daughters in-law. This suggests that the influence of mothers in-law may surpass the role of husbands (their sons) in maternal health decision making. It was suggested that interventions focusing on women or couples may be insufficient to advance women's reproductive health in patriarchal societies. Therefore, efforts need to address gender norms and consider the influence of other family members, such as mothers in-law (White, et al., 2013). Mzimba District in Malawi is a patriarchal society. Culture reinforces gender roles making it difficult for females to exercise their reproductive rights. Culture values promote gender inequality and marginalization of women in a patriarchal society. Women are usually not allowed to make decisions without the approval of a husband (Azuh, Fayomi & Ajayi, 2015).

Furthermore, 90% of women with more than a secondary education decide on their health care, either alone or jointly with their husbands. Increased empowerment of women is likely to increase their ability to seek out and use health services to meet their reproductive health goals. Furthermore, Republic of Malawi (2008) points out some of

the notable socio-cultural and economic challenges that include: persistent unequal power relations between men and women due to strong patriarchal attitudes, limited male involvement in reproductive health, high poverty level particularly amongst women; limited participation and representation of women in decision-making processes at all levels. All these factors contribute to male dominance to perpetuate women to deliver at TBAs. These significant others have power over women because of the culture of putting women in a subordinate position and the low level of education of women, hence women are not empowered to make healthful decisions.

Barriers to deliver with skilled attendants

Barriers to deliver with skilled attendants were identified from literature. These included lack of birth preparedness, financial constraints/poor socio-economic status, poor attitudes of skilled birth attendants, absence of skilled birth attendants at health facilities, negligence of skilled birth attendants, long distances to health facilities and lack of /limited physical transport.

Lack of birth preparedness creates a challenge for women to deliver with the assistance of skilled attendants at health facilities. As such, women resort to seeking the assistance of TBAs for delivery. A study in northern Tanzania revealed that planning in advance for delivery was not part of traditional practice (Magoma, Requejo, Campbell, Cousens & Filippi, 2010b). Birth preparedness is associated with being assisted by skilled birth attendants at the time of delivery. Therefore, the practice of birth preparedness should be encouraged during antenatal utilization and in the community (Feyissa & Genemo, 2014). Male involvement in decision making, which is part of birth

preparedness, increases the likelihood of women being attended to by skilled birth attendant at birth (Iliyasu, Abubakar, Galadanci & Aliyu, 2010).

Financial constraints/poor socio-economic status is also one of the barriers that prevent women from accessing skilled birth attendants at health facilities for delivery hence their preference for TBAs. This is substantiated by a study that looked into the attractive role of TBAs that is responsible for preference for their use in Oyo state in Nigeria. The study found that the population that preferred TBAs was not well to do. It was mainly rural with some urban areas and most people were poor peasant farmers, petty traders, artisans and government workers. In view of this, financial constraints also caused a problem to seek maternal health. Less than 50% delivered in government health facilities (Ayede, 2013). In contrast, a study in Democratic Republic of Congo by Aremu, Lawoko and Dalal (2012) found that women from richer households were more likely to have delivered their child at a health care facility. Additionally, use of maternal services at household level increased steadily with socio-economic status and also there was a positive relationship between economic status and delivery in medical settings (Babalola & Fatusi, 2009). Literature further points out that all over Africa, governments are introducing free healthcare for pregnant women in the rush to meet the United Nation's millennium development goal on reducing maternal deaths (Ana, 2011). This is aimed to promote skilled attendance at delivery by averting financial barriers. Malawi was reported to have a high number of absolutely poor people (Republic of Malawi, 2009b).

Denial of women's rights

Denial of women's rights acts as a barrier for women to deliver at health facilities with the assistance of skilled birth attendants. In a study conducted in Mali, it was reported that women often have only partial, if any, autonomy over their reproductive and sexual health. Husbands have a significant influence on the behaviour and actions of their wives including household members, especially mothers in-law, who also exert control over younger women (White, et al., 2013). Additionally, in a study conducted in Tamilnadu, India, it was found that family members did not allow women to deliver at health facilities as they took advantage of women's illiteracy. Increased education influences service use by increasing female decision-making power and increasing awareness of health services (Ravi & Kulasekaran, 2014). Low level of education for the women contributed to their poor decision making, hence their compliance to deliver at TBAs.

Poor attitudes of skilled birth attendants created a barrier for women to deliver with the assistance of skilled birth attendants in health facilities. Chavula (2012) revealed that poor attitudes of health care workers prevented women from delivering in health facilities in Malawi. In a study conducted in Nairobi, Kenya, it was found that skilled attendant harassment and mistreatment of women in public health facilities was common and there was little evidence that this situation would improve soon (Izugbara et al., 2009). In contrast, Kumbani, Bjune, Chirwa & Odland (2013) in Malawi, found that TBAs received pregnant mothers well during delivery. However, Shiferaw, et al., (2013) argues that there is little empirical evidence that showing respect to women during delivery, allowing autonomy to these women and providing care in time could reduce

maternal mortality in many low income countries where women preferred to deliver with TBAs.

Skilled birth attendants, on one hand, are not found in health facilities due to scarcity of staff. Shortage of these attendants increases barrier for women to deliver at health facilities hence their preference for TBAs. On the other hand, TBAs are accessible in the communities. Findings by Jia (2010) in Bangladesh revealed that the numbers of formally trained practitioners were not able to satisfy the basic needs of communities in developing countries. The formal human resource for health was at 0.47%. Traditional Birth Attendants are often the most accessible maternal health resource in rural Bangladesh. This finding is consistent with a study conducted in Nigeria by Babalola & Fatusi (2009) which found that there was poor staffing in primary health care facilities. This made it difficult to provide services for 24 hours per day. Therefore, this discouraged women in Nigeria to deliver in a health facility when labour commenced, even when they had received antenatal care services. Additionally, Although traditional birth attendants do more harm than good, Ana (2011) argues that the shortage of skilled health workers means traditional birth attendants are by default, given a chance to continue conducting deliveries. Furthermore, in a study conducted in Mali, it was found that inadequate personnel were recognized as most important barriers to receipt of maternal health care (White, et al., 2013).

Negligence of skilled birth attendants

Negligence of duty displayed by nurses when women were in labour and during delivery acted as a barrier for women to deliver with skilled birth attendants. This is supported by a report in Kenya whereby women delivered with the assistance of TBAs

with subsequent pregnancies after bad experiences or after learning from fellow women who had gone through the bad experiences from nurses. A nurse ignored to attend to a woman when she was called when the woman was in advanced labour, which ended up in the death of a newborn. Despite introduction of free delivery services, women opted to deliver with TBAs who showed attention to women during delivery (Wairimu, 2013). Additionally, while facility deliveries are preferred wherever possible Siziya, Muula & Rudatsikira (2009) have reported on low quality of care in health facilities in Malawi. This shows why women then opt for delivery with assistance of TBAs.

Long distances to health facilities and lack of affordable transport barred women from utilizing skilled birth attendants; and as such they delivered at TBAs (Magoma, et al., 2010). Additionally, Mayhew, et al. (2008), in Afghanistan, found that women who resided farther from health facilities were likely to be even more disadvantaged with respect to utilization of safe care during delivery. However, this stands in contrast to a study by Jia (2010) in Bangladesh where distance was not long. The study points out that in Bangladesh, health facilities are located within three kilometers of 90% of the households and skilled birth attendants were close to pregnant women, yet pregnant women utilized TBAs for delivery. This implies that women delivered with the assistance of TBAs because of other reasons as distance was not a problem.

Limited/lack of physical transport creates a barrier for women to access skilled attendants at health facilities. This is substantiated by a study conducted in northern Tanzania which asserts that lack of reliable transport prevented women from accessing skilled delivery (Magoma, et al., 2010). Additionally, unpredictable onset of labour coupled with difficulties to access physical transport to health facilities contributed to

challenges for women to deliver with assistance of skilled attendants at health facilities. Also, poor road network in Nigeria contributed to failure for women to deliver at health facilities with skilled attendants (Babalola & Fatusi, 2009). As such women delivered at TBAs in their communities. Also, lack of transport to a health facility is more of a challenge during the night than during the day. Jia (2010) in Bangladesh revealed that TBAs could be called at any time during the night as they lived close to pregnant women in the same community. This is highly significant because study participants would cite a delivery occurring in the middle of the night as justification for delivering at TBAs, since finding transportation was extremely difficult.

Conclusion

Literature has revealed factors that influence women to prefer delivering with the assistance of TBAs. Firstly, knowledge of women on policy change for TBAs is the basis for informed decision to use skilled birth attendants in health facilities. However, it does not always follow that possession of knowledge is transformed into practice. Education is likely to enhance female autonomy so that women develop greater confidence and capabilities to make decisions regarding their own health. Additionally, education increases access to information. Women with higher levels of educational attainment are more likely to deliver in a health facility with skilled birth attendants than women with less education or no education.

Secondly, literature points to socio-cultural influence because of trust and tradition as communities share the same culture with TBAs; positive attitudes towards TBAs and beliefs in adequate skills of TBAs as preference to deliver at TBAs.

Additionally, TBAs accessibility during labour and delivery influence women to prefer delivering with their assistance.

Thirdly, influence of subjective norms on women as regards place of delivery is another factor for delivering at TBAs. Fourthly, barriers to deliver with the assistance of skilled attendants were identified as lack of birth preparedness, financial constraints/poor socio-economic status, denial of women's rights, poor attitudes of skilled birth attendants, absent skilled birth attendants, inadequate skills of skilled birth attendants, long distance to a health facility, lack of physical transport and low status of women.

CHAPTER THREE

METHODOLOGY

Introduction

This section focuses on the methodology used to generate data regarding why women still preferred to give birth with the assistance of TBAs. It gives an overview of the study design, setting, target population, inclusion and exclusion criteria, sampling method, sample size, recruitment of participants, data collection methods, data management and analysis, trustworthiness of data, and ethical considerations.

Study Design

A descriptive and exploratory qualitative method was used in this study to explore reasons women were still giving births at TBAs despite policy change for TBAs. The use of qualitative methodology allowed the participants to speak freely about their personal life and experiences. Additionally, descriptive design was used for the purpose of identifying problems with current practice, making judgments, or determining what others in similar situations are doing (Burns & Grove, 2009). It is also a way of understanding the meaning of social interactions by those involved (Burns & Grove 2005).

Study Setting

The study was conducted in Mzimba District specifically at Mkoma and Manyamula Health Centres and Mzimba District Hospital. These health facilities were chosen because they are located in the catchment areas in which women still prefer to

give birth with the assistance of TBAs. The researcher chose Mzimba District because there was a possibility of having a big proportion of women that were giving birth at TBAs.

Study Population

The study populations were women of child bearing age (18-49 years) from Mzimba District who attended at least one antenatal care at Mkoma and Manyamula Health Centres and Mzimba District Hospital in 2012 but did not give birth at the health facilities. The total population of Mzimba District is approximately 1,000,987. Total projection population of women of child bearing age for the district is 230,227 (National Statistical Office, 2012). The total population for the study, which is the population for women of child bearing age in Mkoma and Manyamula Health Centres, and Mzimba District Hospital was 39,108 (National Statistical Office, 2011). The study population also included men to increase credibility of findings.

Inclusion Criteria

According to Polit and Beck (2010), inclusion criteria refer to specific characteristics that delimit the study population. For this study, the inclusion criteria were women of childbearing age who were aged 18-49 years, were able to give informed consent, attended at least one antenatal care, delivered at TBA, had antenatal card or verified antenatal care with facility ANC register and spoke either English, Tumbuka or Chichewa for ease of communication. Included were men who were married, 18 years and above, whose wives delivered at TBAs but the wives were not interviewed in this study and who spoke English, Tumbuka or Chichewa for ease of communication.

Exclusion Criteria

According to Polit and Beck (2010), exclusion criteria refer to characteristics that participants do not have. For this study, the exclusion criteria were women of childbearing age who were below 18 years and above 49 years, did not attend antenatal care, delivered at a health facility, did not have antenatal card or could not be traced in facility ANC register, could not communicate in either English, Tumbuka, Chichewa or needed an interpreter to avoid distortion of information and were unable to give informed consent.

Sampling

Purposive sampling was used to select 3 health facilities within Mzimba District where many women prefer to deliver with the assistance of TBAs. Purposive sampling was used to select both women and male participants for the study. Purposive sampling was also used to identify participants meeting the inclusion criteria of the study. According to Polit and Beck (2010), purposive sampling is a form of non probability sampling. The researcher has prior knowledge about possible participants who are knowledgeable about the issues under study.

Sample Size

Mason (2010) states that, most often, little that is new or data saturation comes out of transcripts after interviewing 20 or so people. Where data has reached saturation new data that is being collected only confirms the previously collected data. In the study the number of probable participants was estimated at 20. With good informants who are able to reflect on their experiences and communicate effectively, saturation is achieved w with a relatively small sample. However, the actual sample size may either increase or

decrease depending upon the data saturation. Therefore, the decision to stop seeking new participants was made after interviewing 19 women in the face to face interviews and six participants in each of the three focus groups in addition to five participants in one of the FGDs during pretesting when the researcher ceased learning new information (information redundancy).

Recruitment of Participants

Letters of permission authorized by the DHO as approval to carry out the research were presented to the in-charges of the participating health facilities. Two Community Health Nurses at the district hospital and two Health Surveillance Assistants (HSAs), each one from the chosen health centres were trained on identifying eligible participants for the study. Purposive sampling was used to select participants that met the inclusion criterion. The participants were told that they would be recruited on a voluntary basis. Interviews were conducted at the study area health facilities in private rooms in order to maintain audio and visual privacy as well as confidentiality. The researcher introduced herself and explained about the study, its purpose, and eligibility criteria and anonymity was ensured in the study by not writing names on the interview guide. Code numbers were used instead. Additionally, no names were mentioned during interviews. The participants were told that they had the right to refuse or consent to participate in the study and that their right to health services would not be affected by their decision. Interviews were done for only those willing to participate in the study and nobody was coerced. Those who participated in the study were given more detailed information about the study, its benefits and risks in order for them to make an informed choice as written in English and Tumbuka respectively (Appendices A and B). They were also encouraged to

ask questions and express their concerns, which were addressed by the researcher. All identified participants willingly participated in the study and they were asked to sign a consent form written in either English or Tumbuka versions respectively (Appendices C and D). Participants who could not read or write used a thumb print to consent.

Description of the interview guide

A semi-structured interview guide was used to conduct face to face interviews. The interview guide contained open ended questions and probes were employed which guided the discussions. The topic guide was entitled "Traditional Birth Attendants (TBAs) are not allowed to Assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?" The instrument composed the following sections: Section A addressing Demographic Data and this section comprised of closed ended questions; Section B comprised of knowledge of women on policy change for TBAs; Section C comprised of beliefs of women towards delivery services at TBAs; Section D comprised of subjective norms while section E comprised of barriers to deliver with skilled attendant. FGD guide was utilized for focus group discussions. The development of the focus group discussion (FGD) guide was based on the study objectives.

Data Collection

Data collection was done during the month of March 2014. Data was collected through face to face interviews and focus group discussions using a semi-structured interview and FGD guides respectively. Participants were encouraged to talk freely and to tell stories using their own words (Shosha, 2012). The interview guide contained open ended questions and probes were employed which guided the discussion. Semi structured

interviews allow participants the freedom to express their views in their own terms and also allows a two way communication (Polit & Beck, 2006). Face to face interviews lasted approximately 30 minutes while FGDs lasted one hour (Nicholas, 2010).

The interview guides were translated from English into the vernacular language of Tumbuka, which is spoken in these areas for easy communication with the respondents (Appendices E and F). The interviews were audio taped using a digital recorder. In the process of data collection, it is of paramount concern to collect accurate data (Creswell, 2012). As such, the principal investigator conducted the interviews to ensure accuracy in data collection.

The researcher also reviewed health passports and antenatal registers to verify that women attended antenatal care. The instrument composed of the following sections: Section A addressing demographic data and this section comprised closed ended questions. Information from this section was stored electronically including date of recording and participant number for ease of identification. Section B comprised knowledge of women on policy change for TBAs. Section C comprised beliefs of women towards delivery services at TBAs. Section D comprised subjective norms while section E comprised barriers to deliver with skilled attendant.

The study included focus group discussions for both women and men in the selected catchment areas (Appendices G and H). Focus group discussions are interviews with groups of about 5 to 10 people whose opinions and experiences are solicited simultaneously Polit and Beck (2010). Initially, the principal researcher planned in the proposal to conduct 3 FGDs. Three focus group discussions were conducted consisting of six people in each group. One group comprised women of childbearing age (18-49 years)

from Mkoma Health Centre catchment area. The other two groups comprised men from Mzimba District Hospital and Manyamula Health Centre catchment areas. Data collection was also done from FGD for women at Mzimba District Hospital, which comprised 5 people during pre-testing the data collection instrument. The women that participated in the FGDs were those women who delivered at TBAs but did not participate in the face to face interviews.

Triangulation aided to check cross-site consistency (Polit & Beck, 2010). Therefore, the researcher interviewed participants coming from three identified health facility catchment areas where TBAs conduct deliveries. Additionally, triangulation of data sources and methods was employed comparing information from different sources, that is, different categories of respondents (women and men) and also different methods, that is, face to face interviews and focus group discussions. Additionally, triangulation was done to increase credibility of findings (Patton & Cochran, 2002). Data triangulation of methods was employed to produce a comprehensive set of findings to ensure rigor of the reasons women were still giving birth at TBAs despite policy change for TBAs. It also provided an opportunity to evaluate the extent to which a consistent and coherent picture of the phenomenon emerges (Polit & Beck, 2010). Triangulation also aided in complementing results.

The principal researcher, who was the interviewer, guided the discussion utilizing the topic guide on “Traditional Birth Attendants (TBAs) are not allowed to Assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?” This method of data collection was chosen in addition to face to face interviews because it helped to understand knowledge on policy change for TBAs among women and men, beliefs towards delivery services at TBAs, who influence women in

deciding place of delivery in the area and barriers to deliver with skilled birth attendant at a health facility. The method is also efficient as it generates a lot of dialogue. The discussions were audio-taped using a digital recorder and also detailed notes were taken during discussions. The data were transcribed within 24 hours after completion of interviews and discussions.

Pretesting the Data Collection Instrument

Pre-testing is the administration of the data collection instrument with a small set of respondents from the population in order to identify problems with the data collection instrument and find possible solutions. Pretesting is done to evaluate the instrument's capacity to collect the desired data and to evaluate the procedures before data collection begins (Government of Canada, 2007).

Pretesting assisted the researcher to refine the questions and came up with appropriate probes and removed one of the probes. Pretesting was done at Mzimba District Hospital which is one of the health facilities where research study was done to evaluate the content of the interview guide. Experts in the field also reviewed the interview guide and their comments were incorporated. As such, pretesting avoided making the instrument complicated or inappropriate for the study. For example, on part B of the interview guide under question 16, there was a probe on ‘What is your perception on this policy change? On the other hand under question 21 there was a question on ‘Can you give your suggestions or comments if any for improving Policy Change for TBAs? Respondents were giving the same responses for the two which led the principal researcher to delete probe for question 16. Additionally, two questions number 8 and 12 which were asking about the year that participants in the face-to-face interviews attained

their highest level of education including their spouses have been excluded in the demographic data, as they are not relevant.

Data Management

The researcher transcribed verbatim the recorded interview herself in order to ensure accuracy after listening to the tape and checking that the data collected, including the written information, was relevant to the study. Each interview was transcribed in Tumbuka language which is spoken in the research study area. Data was later translated into English. Thereafter, to ensure validation of data, an independent person did the translation of data from English back into Tumbuka language. Data from the signed consent forms, interview guides, tape recorded data, field notes and transcripts were stored in lockable cupboard to ensure restricted access, confidentiality and prevent data loss. Additionally, electronic research data kept in the principal researcher's personal laptop computer was restricted for accessibility through use of password on the computer.

Data Analysis

Data analysis was done simultaneously with data collection. This allowed the refinement of the interview guide content. Data was analyzed manually using principles of thematic content analysis (Anderson, 2007). A directed approach analysis was used which started with relevant research findings that guided the initial codes. A directed content analysis uses prior research to develop the initial coding scheme prior to beginning to analyze the data. Using prior research, the researcher began by identifying key concepts as initial coding categories. Categories are patterns or themes that are directly expressed in the text or are derived from them through analysis. Data was collected primarily through interviews and open-ended questions were used, followed by

targeted questions about the predetermined categories. Additionally, the researcher used probes specifically to explore participants' knowledge on policy change for TBAs, beliefs towards delivery services at TBAs, influence of subjective norms on place of delivery and barriers to deliver with skilled births attendants. The researcher read the transcripts and highlighted all text that on the first impression appeared to represent why women delivered at TBAs despite policy change. The next step in the analysis was that the researcher coded all highlighted passages using the predetermined codes. Any text that could not be categorized with the initial coding scheme but captured the essence of the study was given a new code. Therefore, as analysis proceeded, additional codes were developed, and the initial coding scheme was revised and refined. After coding, the researcher examined the data for each category to determine whether the subcategories were needed for a category. The previous research studies aided to guide the discussion of current findings (Hsieh & Shannon, 2005). The quantitative questions which are the demographic data that includes age of participants, marital status, religion, tribe, level of education, occupation and number of children were analyzed using SPSS version 16.0 (Appendix I).

Trustworthiness of Data

Trustworthiness of data was met by five criteria in the qualitative enquiry namely; credibility, dependability, confirmability, transferability and authenticity (Polit & Beck, 2010).

Credibility

Credibility refers to confidence in the truth of the data and interpretations of them. This involves carrying out the study in a way that enhances the believability of the findings and taking steps to demonstrate credibility to external readers (Polit & Beck, 2010). Therefore, to ensure credibility, the researcher firstly, pre-tested the research instrument and evaluated the instrument's capacity to collect the desired data. This assisted the researcher to refine the instrument as stated earlier on. The interview guide for data collection was revised by research supervisors to confirm that it addressed the phenomenon under study. The researcher built a good working relationship with the participants since qualitative research based on data from narrative, requires understanding and cooperation between researcher and the participants. Member checking with participants was carried out in an ongoing way as data was being collected. This was done through deliberate probing to ensure that the principal researcher had understood participants' meanings (Polit & Beck, 2010). In addition, after each interview and focus group discussion, the researcher read out the notes during the interview and discussion respectively, for the participants to verify if the recorded information was a true reflection of the interview and discussion.

Dependability

This refers to the stability of data over time and over conditions (Polit & Beck, 2010). It is a criterion met once researchers have demonstrated the credibility of the findings. This is similar to validity in quantitative research in which there can be no validity without reliability (Streubert & Carpenter, 2011). In order to ensure dependability, the researcher questioned the same areas for all participants. Additionally,

the researcher ensured that data was not extensive and the collection was not extended over time to prevent risk of inconsistency. Also, the research supervisors checked the content of the data for consistency (Graneheim & Lundman, 2004).

Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning. This is to ensure that the data represent the information participants provided and that the interpretations of those data are not figments of the inquirer's imagination (Polit & Beck, 2010). The researcher therefore used only the participants' voice in recording findings. This was done by leaving an audit trail, which is a recording of activities over time that another individual can follow. The audit trail consists of raw data, personal notes and analyzed information. The objective will be to illustrate as clearly as possible the evidence and thought processes that led to the conclusions. The supervisors of the study also checked the data for accuracy, relevance and meaning.

Transferability

Transferability refers to the extent to which qualitative findings can be transferred to other settings or groups. The responsibility of the investigator is to provide sufficient descriptive data in the research report so that consumers can evaluate the applicability of the data to other contexts (Polit & Beck, 2010). In this study, the researcher provided a rich and vigorous presentation of the findings together with appropriate quotations which enhanced transferability.

Authenticity

Authenticity refers to the extent to which researchers fairly and faithfully show a range of different realities. It converges the feeling tone of participants' lives as they are lived (Polit & Beck, 2010). The researcher has portrayed this by recording direct quotes from participants which portray mood, feeling, experience, language and context of their experiences.

Ethical considerations

Permission to conduct the study was sought from the College of Medicine Research Ethics Committee (COMREC) through Kamuzu College of Nursing (Appendices J & K). Permission to conduct the study and to pre-test the research instrument in Mzimba district was sought by writing a letter to the District Health Officer of Mzimba District (Appendices L & M). Ethical issues that were considered when conducting the research included informed consent by ensuring that participant's information sheet was read to participants and that the participants understood the content before endorsing signatory, observed clients' rights by avoiding coercing participants to take part in the study. Participants voluntarily participated in the study and were told to be free to withdraw at anytime without giving reasons. Privacy and confidentiality were ensured by not writing names on the interview guide. Code numbers were used instead. Additionally, no names were mentioned during interviews for anonymity. The study did not have any physical harm. The probable risks included psychosocial risks in terms of long time of attending to interview. The researcher also used private rooms for interviews, and kept records under lockable cupboard. The principal investigator has also included copies of Nurses and Midwives Council of Malawi to show that the investigator is licensed with the body as such ethically worth conducting research. (Appendices N).

Additionally, a copy of a certificate of ethics approval from the COMREC has been included showing that the principal investigator was granted permission to conduct the study (Appendix O).

CHAPTER FOUR

PRESENTATION OF RESULTS

Introduction

This chapter presents the findings of the study. The aim of the study was to investigate why women in Mzimba District are still giving births at TBAs since there is a policy change for the Traditional Birth Attendants. The findings are divided into demographic data, themes and subthemes which emerged from the four study objectives. The results of both face to face interviews and focus group discussions have been presented in an integrative manner implying that they have been presented together. These results include direct quotations expressed by participants to illustrate important points from their experiences.

Demographic data

There were 19 mothers who participated in face to face interviews. Eleven of these mothers aged 18-24 years and eight of these mothers were of ages 25-34 years. There were six women who participated in the focus group discussions from Mkoma Health Centre catchment area. Three of these mothers were of ages 18-24 years and the other three mothers were of ages 35-44 years. Five women participated in the focus group discussions from Mzimba District Hospital catchment area. One of these women aged 20 years and four of these women were of ages 25-29 years. Six men participated in focus group discussions from Mzimba District Hospital catchment area and were of ages 25-45 years. Six men participated in focus group discussions from Manyamula Health Centre

catchment areas and were of ages 20-48 years. The rationale for separating women from men in the focus group discussions was to allow free expression of ideas. Focus group members are likely to effectively share information if they have certain characteristics in common (Morgan & Krueger, 1993). All study participants were married in both face to face interviews and focus group discussions. Additionally, all study participants in the face to face interviews were Christians though their denominations varied. Nine of the participants were Roman Catholics; three were from C.C.A.P while seven were from other denominations (Last, Chipangano and New Apostle). Also, 90% (n=17) of the study participants were Tumbuka by tribe and 10% (n=2) were Ngoni by tribe. All study participants ever attended school. However, the majority of the participants, 84% (n=16) attended primary school while only 16% (n=3) attended secondary school. The main source of income for the majority of the study participants, 90% (n=17) was peasant farming while only 10% (n=2) were engaged in small businesses such as selling snacks and small grocery. The majority of the participants, 90% (n=17) did not have any occupation while only 10% (n=2) had small businesses.

The majority of the participants' husbands, 79% (n=15) attained primary school as their highest level of education while only 21% (n=4) attained secondary school. The majority of the participants' husbands, 74% (n=14) did not have any occupation (unemployed) while 16% (n=3) were self employed and 10% (n=2) were privately employed. On number of children delivered, 16% (n=3) of the participants delivered 1 child each, 26% (n=5) of the participants delivered 2 children each, 21% (n=4) of the participants delivered 3 children each, 26% (n=5) of the participants delivered 4 children each, while 11% (n=2) of the participants delivered 5 children each. Summary of

demographic variables is shown in Table 4.1. The detailed analysis is shown in Appendix I.

All men and women who participated in three focus group discussions were peasant farmers except one man who was employed to graze cattle and also in one focus group discussion, all women were engaged in small businesses.

Table 4.1: Demographic Characteristics of WCBA (18-49 years) in face to face interviews

Socio-demographic Characteristics	**Frequency**	**Percentage (%)**
Age (years)		
18-24	11	58%
25-34	8	42%
Marital Status: All were married		
Religion: All were Christians		
Denomination of participants		
Roman Catholic	9	47%
CCAP	3	16%
Others	7	37%
Tribe		
Tumbuka	17	90%
Ngoni	2	10%
School attendance: All attended school		
Highest level of education of participants		
Primary	16	84%
Secondary	3	16%
Main source of income for the participants		
Peasant farming	17	90%

Business	2	10%
Occupation of the participants		
None	17	90%
Business	2	10%
Highest Level of education attained by participant's husband		
Primary	15	79%
Secondary	4	21%
Occupation of participant's husband		
Unemployed	14	74%
Self employed	3	16%
Privately employed	2	10%
Number of children participant delivered		
1	3	16%
2	5	26%
3	4	21%
4	5	26%
5	2	11%

Qualitative findings

Three main themes emerged from the qualitative data: Awareness on policy change for TBAs, Women's lack of decision making power and Barriers to deliver with skilled attendants.

Awareness on policy change for TBAs

Awareness on policy change for TBAs had three sub-themes namely: adequate awareness on policy change; lack of awareness on policy change; and source of information on policy change.

Adequate awareness on policy change

The majority of the participants demonstrated awareness of the policy change for TBAs. The data revealed that most women had adequate awareness of the policy change for TBAs and this was demonstrated when they correctly explained the policy change and explained the risk of delivering with the assistance of a TBA. Additionally, participants explained the benefits of delivering with the assistance of a skilled attendant. One participant from Mzimba District Hospital catchment area in the face-to-face interviews stated;

The policy says pregnant women should not deliver with the assistance of TBAs but should deliver at health facilities with the assistance of skilled attendants. They informed us because it was observed that many new born babies and their mothers were dying because of delivering with the assistance of TBAs (P18).

Likewise, most participants in the focus group discussions for men were aware of the policy change for TBAs and one participant from Mzimba District Hospital catchment area said; "TBAs are supposed to phone a health facility so that pregnant women should be picked to a health facility when these women report to them. ……..TBAs are supposed to encourage pregnant women to deliver at a health facility" (P13, FGD).

Participants also demonstrated awareness on policy change for TBAs when they included the benefits of delivering with skilled attendants. One participant from Mzimba District Hospital catchment area in the focus group discussion for females stated:

> There is a policy change for TBAs which states that pregnant women should deliver at a health facility and not at TBAs. This is because a TBA cannot know if a woman is anaemic while at a health facility they can know and a woman can be transfused..... Skilled attendant operates if a woman fails to deliver (P2, FGD).

Another participant from Mzimba District Hospital catchment area in the focus group discussion for females said:

> Now, I feel I should no longer deliver with the assistance of a TBA but I should deliver at a health facility with the assistance of skilled attendant because..... A TBA cannot put up an intravenous infusion if a woman is dehydrated while a skilled attendant can put up the infusion at a health facility and also can call for an ambulance for referral. A skilled attendant will be able to diagnose a problem and assist me. A TBA cannot assist me in case of a problem because she does not have resources (P1, FGD).

Lack of awareness on policy change for TBAs

Some participants demonstrated lack of awareness on the policy change for TBAs. The data revealed that some women lacked awareness on policy change for TBAs. The lack of awareness was demonstrated when the participants indicated that they did not know anything about the policy change. One participant from Manyamula Health Centre catchment area in the face to face interviews aged 21 years had this to say: “I do not know anything. I have never heard about it” (P4).

Some participants incorrectly explained the policy change. One participant from Manyamula Health Centre catchment area in the face-to-face interviews aged 25 years and only did primary education said:

> Policy change for TBAs states that a pregnant woman should go and deliver at a health facility though she does not have somebody to escort her to a health facility. A woman should go and deliver with the assistance of a TBA if she cannot be able to proceed to a health facility for delivery (P9).

Similarly, some participants in the focus group discussions for males incorrectly explained the policy change for TBAs. One participant from Manyamula Health Centre catchment area stated:

> TBA policy change states that TBAs should have a clean delivery area just like at a health facility to prevent diseases. A TBA should build a separate house for conducting deliveries only. Women should not deliver in a TBA's house where she lives (P6, FGD 41 years old).

Likewise, a participant from Mkoma Health Centre catchment area in the focus group discussions for females had this to say; "TBAs are supposed to conduct deliveries. In case, a pregnant woman fails to deliver, a TBA is supposed to refer the woman to a hospital……." (P21, FGD 36 years old).

Source of information on policy change

Several sources of information on policy change for TBAs emerged from the data. Most of the participants indicated that their sources of information about the change of

policy for TBAs were: skilled attendants during health talks at antenatal clinics; Health Surveillance Assistants during antenatal clinics at the health facilities and in the communities, mass media, village headmen during village meetings, pregnant women who spread the information after a visit to a health facility. Some participants indicated that they heard about the policy change from unknown people who were discussing about the policy within the communities. The following quotes illustrate the participants' expression of sources of information on policy change. One participant from Mkoma Health Centre catchment area in the focus group discussions for women stated; "I heard during health education at a health facility when I went for antenatal care. I was told by a skilled attendant" (P18, FGD). Another participant from Mzimba District Hospital catchment area said; "I knew that a TBA should not conduct deliveries through health education conducted by HSAs in our communities" (P17). One participant from Mzimba District Hospital catchment area in the focus group discussions for men stated; "We hear from radio that women should deliver at a health facility. Village headmen informed me that pregnant women should deliver at a health facility. Pregnant women informed us" (P15, FGD). Another participant from Mzimba District Hospital catchment area said; "I was informed that TBAs had been stopped from conducting deliveries. I heard it from unknown people who were discussing about it" (P3).

Women's lack of decision making power

Women's lack in decision making power influenced by socio-cultural beliefs and culture influenced them to deliver with the assistance of TBAs. The subthemes that emerged from the results were Beliefs towards delivery services at TBAs, culture, denial of women's rights, positive attitudes towards TBAs, beliefs in adequate skills of TBAs and Subjective norms.

Beliefs towards delivery services at TBAs

The majority of participants in both face-to-face interviews and FGDs said that women preferred to deliver with the assistance of TBAs because of socio-cultural influence. This signified women's lack of decision-making power as they were influenced by what culture prescribes. Most participants believed that if a pregnant woman or husband had extra marital relationship, or a pregnant woman had been bewitched, the woman would fail to deliver normally. Therefore, a woman had to deliver with the assistance of a TBA who gave local medicine that assisted a woman to deliver normally. Participants believed skilled attendants could not assist such a woman during labour hence she might die. This signified participants trust in TBAs. One participant from Manyamula Health Centre catchment area in the focus group discussions for men had this to say:

> Sometimes, women fail to deliver normally because of '*mapinga*' so when these women go to a TBA, they are assisted to deliver normally that is why pregnant women prefer to deliver at a TBA. As such women utilize both health facilities for antenatal care and TBAs services for delivery. *'Mapinga'* is failure for a pregnant woman to give birth to a baby, which is caused by either a husband or wife committing adultery when the wife is pregnant. In such a case, a TBA gives local medicine to the pregnant woman to assist her to deliver (P6, FGD 41 years old).

Likewise, one participant from Manyamula Health Centre catchment area in the face-to-face interviews aged 22 years and only did primary education said:

According to our tradition, a pregnant woman develops a condition called '*mapinga*' if the husband has sexual relationship with other women while she is pregnant. Health workers do not know this condition. As such, a woman fails to deliver and dies while pregnant. The woman experiences rising fundus during time of labour and delivery (P12).

Another participant from Manyamula Health Centre catchment area in the face-to-face interviews aged 21 years and only did primary education stated; "A woman who has been bewitched so that she fails to deliver, is assisted by TBAs since skilled attendants fail to assist such a woman. A TBA provides local medicine to drink which assists her to deliver normally" (P4).

It is part of tradition for women to deliver at TBAs. It is believed that women should deliver with the assistance of TBAs. One participant from Manyamula Health Centre catchment area in the focus group discussions for men had this to say:

> This issue that TBAs should not conduct deliveries has come recently. Delivering at TBAs started sometime back and many children have been born at TBAs. As such, we are just following the same tradition. This becomes a challenge to us. How can we stop what our parents have been doing? We are just continuing in every generation. Moreover, three quarters of mothers in my area deliver at TBAs (P7, FGD 48 years old).

Culture

Women had also to obey their spouses to deliver at TBAs as main decision makers, according to Tumbuka culture. One participant from Manyamula Health Centre

catchment area in the face-to-face interviews aged 25 years and only did primary education stated; “A man decides place of delivery for a woman because of culture. Women follow the culture of Tumbuka whereby a husband makes decisions. A woman who does not obey the decisions made by a husband underrates him” (P9).

Denial of women’s rights

Denial of women’s rights was one of the major barriers for women to deliver with the assistance of skilled birth attendants at health facilities. However, this was due to women’s lack in decision-making power. One participant from Mzimba District Hospital catchment area in the face-to-face interviews aged 24 years and only did primary education said:

> The wife tells the husband that she is in labour and that she wants to go and deliver at a health facility. The husband responds by telling the wife that she should deliver at a TBA, despite informing him that pregnant women should no longer deliver with the assistance of TBAs. As such, the woman just follows the husband’s instruction (P19).

The face to face finding concurred with focus group discussions finding where denial of women’s rights was one of the major barriers for women to deliver with the assistance of skilled birth attendants. One participant from Mzimba District Hospital catchment area in the focus group discussions for men had this to say; “The challenge in families is that the husband wants a woman to continue with household chores though the woman is due to go to a health facility for delivery” (P17, FGD 25 years old). Similarly, another participant from Mzimba District Hospital catchment area in the focus group discussions for women stated:

> The challenge in families to deliver with the assistance of skilled attendant is that husbands discourage their wives to go to a health facility for delivery. They say, you are just wasting time for useless things when a woman wants to go and wait for delivery at a health facility. The husband further says, we should go and work. This discourages a woman and she obeys the husband. This is because husbands are not involved during antenatal care as such they do not learn from health talks provided at health facilities (P2, FGD 28 years old).

Positive attitudes towards TBAs

Few participants in both face-to-face interviews and FGDs responded that women delivered with the assistance of TBAs because of good care they received from TBAs. These included good reception, which included warm welcome by smiling at women. TBAs provided food to women in labour such as porridge, massaged and did hold women's back during delivery. However, the potential risks of delivering with the assistance of TBAs outweighed the benefits women experienced with TBAs. This implied that women lacked decision-making power contributed by low level of education, which led to illiteracy. One participant from Manyamula Health Centre catchment area in the face to face interviews aged 23 years and only did primary education had this to say; "The care of a TBA is good. Reception is very good unlike at a health facility. A TBA supports a woman's back during labour. A TBA gives porridge to a woman after delivery unlike at a health facility" (P5). Another participant from Mzimba District Hospital catchment area in the focus group discussions for women had this to say; "We decide to deliver with TBAs because TBAs massage a woman's back and hold the back during

labour and delivery. Skilled attendants hold women's back at health facilities only at the time of pushing the baby" (P1, FGD 29 years old).

Participants also said TBAs do not demand birth preparedness materials during time of delivery as compared to a health facility delivery. Therefore, this made women prefer to give birth with the assistance of TBAs. One participant from Manyamula Health Centre catchment area in the face-to-face interviews aged 23 years and only did primary education said; "TBAs do not require bringing these materials that are demanded at a health facility during delivery such as clothes (zitenje), shawl and basin. A woman just goes to deliver without any of these materials" (P5). Additionally, one participant from Mkoma Health Centre catchment area in the focus group discussions for women had this to say; "A TBA teaches us to bring the materials. Since we do not have money to buy the materials, the TBAs do assist us with some of these materials hence our preference to deliver with their assistance" (P22, FGD 35 years old).

Beliefs in adequate skills of TBAs

Some participants in both focus group discussions and face-to-face interviews believed that TBAs had adequate skills of maneuvering abnormal lie of a foetus to normal position before 9 months of gestation. This made women to deliver with the assistance of TBAs. However, their beliefs reflected illiteracy. Women lacked decision-making power as they were influenced by mothers in-law to go to a TBA who was believed to change abnormal lie of foetus to normal position, which predisposed women to potential risk of rupture of a uterus. Demographic data revealed low level of education for both women and men, which contributed to beliefs in adequate skills of TBAs. Furthermore, low level of education was reflected by women's lack of knowledge that a

foetus can change into any position before 9 months of pregnancy even without maneuvering it. As such, participants believed that a TBA was able to correct abnormal position of a foetus, which was believed to be evidenced by a skilled attendant during subsequent visit at antenatal clinic. One participant from Manyamula Health Centre catchment area in the focus group discussions for men had this to say:

> When a pregnant woman goes for antenatal care at a health facility, and she is told that there is abnormal lie, the mother-in-law instructs her to go to a TBA. She is given local medicine, which makes the foetus to lie normally. When the woman goes again for antenatal care at a health facility, she is told that the foetus is in normal position (P10, FGD 26 years old).

Another participant from Manyamula Health Centre catchment area in the focus group discussions for men added; "When a pregnant woman goes for antenatal care at a health facility and she is told that the foetus lies in transverse, the TBA according to her science performs external maneuvers till the foetus lies normally" (P6, FGD 41 years old).

A TBA accelerates slow progress of labour. One participant from Mzimba District Hospital catchment area in the face to face interviews aged 25 years and did secondary education had this to say; "A TBA assists by providing local medication to a pregnant woman in labour when there is delay in progress of labour. The local medicines facilitate delivery of a baby" (P18).

Participants believed that a TBA has adequate skills to examine a woman in labour just like a skilled attendant. One participant from Manyamula Health Centre catchment area in the face-to-face interviews aged 23 years and only did primary education stated:

> I will tell other women that delivering at health facilities with the assistance of skilled attendants and delivering with the assistance of TBAs is just the same. This is because a TBA examines a woman in labour just like a skilled attendant at a health facility and she knows whether it is time for bearing down or not just like at health facilities since she follows what she was taught by the government (P6).

Subjective norms

It was noted from the results that subjective norms influenced pregnant women in deciding choice of place of delivery. The majority of the participants in the focus group discussions explained that women preferred to deliver with the assistance of TBAs because of the influence of mothers in-law. This signified women's lack of decision-making power as they could not refute significant others influence to deliver with the assistance of TBAs. Additionally, it reflected that women had limited control over their own reproductive health decisions. The preferences and opinions of mothers in-law influenced the maternal health behaviours of their daughters in-law. This was followed by self decision-making by women, influence of husbands and TBAs. Mothers in-law, husbands including some fathers in-law exercise power over married women in the district. Generally, it was also noted in most of the participants' narrations that lack of birth preparedness evidenced by financial challenges and failure to walk contributed. One

of the participants from Mzimba District Hospital catchment area in the focus group discussions for men said; “The mother in law…….influenced her to deliver at a TBA because it was during the night” (P13, FGD 45 years old). Another participant from Manyamula Health Centre catchment area in the focus group discussions for men narrated; “The mother in-law decided to take the woman to a TBA because of lack of money to use for transport to take the woman to deliver at a health facility” (P8, FGD 20 years old).

The focus group discussions finding concurred with face-to-face interviews findings as most participants responded that mother’s in-law influenced women to deliver with the assistance of TBAs. One participant from Manyamula Health Centre catchment area in the face to face interviews aged 18 years and did secondary education narrated this:

> My mother in-law influenced me to deliver with the assistance of a TBA. This is because I did not have money for transport to go and wait for health facility delivery. Furthermore, my mother in-law said all daughters in-law deliver at home, but I failed to deliver at home that is why I had to go and deliver at a TBA. Women do not have power when they are married and come to stay in the husband’s home (P7).

Some participants expressed that husbands influenced women to deliver with the assistance of TBAs because they exercise power over married women in the district. One participant from Manyamula Health Centre catchment area in the face-to-face interviews aged 23 years stated; “The husband influences a wife and says, you should deliver with

the assistance of a TBA, not at a health facility! This is because the husband has the powers and not the wife" (P5).

Some participants responded that they delivered with the assistance of TBAs because of the influence of the TBAs. One participant from Mzimba District Hospital catchment area in the face to face interviews aged 29 years had this to say; "The grandmother of my husband influences women to deliver with her assistance because she was trained on health issues at a health facility since she is a TBA" (P16).

On the other hand, some participants made self-decision to deliver with the assistance of a TBA because of lack of birth preparedness evidenced by failure to walk when they were in labour. One participant from Mkoma Health Centre catchment area in the focus group discussions for women had this to say; "I decided to deliver at a TBA because I could not manage to go to a health facility as I failed to walk" (P22, FGD 35 years old).

On the other hand, participants mentioned village headman, skilled attendants, HSAs and Health Volunteer as people who influenced mothers to deliver with the assistance of skilled attendants and not TBAs. This is because they did not want women to die. One participant from Mzimba District Hospital catchment area in the focus group discussions for women stated; "Village headman X influences people in deciding pregnant women's choice of place of delivery. The village headman tells people that women should deliver at a health facility. This is because the village headman does not want women to die" (P1, FGD 29 years old).

Barriers to deliver with skilled attendants

Results show that there were barriers for pregnant women to deliver with the assistance of skilled birth attendants at health facilities. The sub themes that had emerged were challenges in families, challenges in health facilities and challenges in the community. Additionally, participants gave suggestions/comments for improving policy change for TBAs. Women will continue giving births at TBAs unless these challenges have been addressed.

Challenges in families

Results revealed that challenges encountered in families included lack of birth preparedness as one of the major barriers for women to deliver with the assistance of skilled birth attendants at health facilities. One participant from Mkoma Health Centre catchment area in the face-to-face interviews aged 27 years and only did primary education said; “It is a mistake delivering at TBAs. However, I delivered at a TBA because I was unable to prepare all those materials we are taught at a health facility such as basin, plastic paper……..” (P11).

This finding from face to face interviews concurred with a finding from focus group discussion where lack of birth preparedness was one of the major barriers for women to deliver with the assistance of skilled birth attendants. One participant from Mzimba District Hospital catchment area in focus group discussions for men had this to say; “The challenge is that we do not have money to buy materials needed for birth preparedness such as basin, shawl and clothes (zitenje). As such, a pregnant woman fails to go and deliver at a hospital” (P16, FGD 38 years old). Another participant from Mkoma Health Centre catchment area in the focus group discussions for women said; “The husband does not buy the following materials; basin, clothes (zitenje) plastic paper

and razor blade. As such, a woman fails to deliver at a health facility" (P21, FGD 36 years old).

Results revealed that financial constraints/poor socio-economic status was another major barrier for women to deliver with the assistance of skilled birth attendants at health facilities. One participant from Manyamula Health Centre catchment area in the face-to-face interviews aged 25 years and only did primary education said; "The challenge is lack of finances to pay for transport to a health facility. The distance to a health facility is long" (P9).

The face-to-face finding concurred with focus group discussions finding where financial constraints/poor socio-economic was one of the major barriers for women to deliver with the assistance of skilled birth attendants. One participant from Manyamula Health Centre catchment area in the focus group discussions for men stated; "The challenge is lack of money that is why we take pregnant women to deliver at a TBA, because it is near. Money is needed to buy food, shawl, basin, clothes (zitenje) and plastic paper" (P11, FGD 23 years old). Another male participant from Mzimba District Hospital catchment area had this to say; "There is a problem of poverty. We do not have money to assist for transport of the woman that is why we take her to deliver at a TBA" (P14, FGD 32 years old).

Participants complained of teaching them to buy all new materials for birth preparedness, which acted as a barrier for women to deliver with assistance of skilled attendants. However, new clothes for the newborn provide warmth and prevent infections. A basin and razor blade are used by an individual woman for bathing and cutting cord of a baby respectively which helps to prevent cross infections during

delivery. One participant from Manyamula Health Centre catchment area in the focus group discussions for men said:

> Sometimes, labour starts unexpectedly. The problem at a health facility is that skilled attendants want us to buy all new materials such as clothes (zitenje), shawl, basin, hat, and napkins. An old cloth (chitenje) is not welcome. He laughed. A shawl that was bought and used for another baby is not welcome (P10, FGD 26 years old).

Challenges in health facilities

Results revealed that challenges encountered in health facilities included disrespect/poor attitudes of skilled birth attendants which acted as one of the major barriers for women to deliver with the assistance of skilled birth attendants. Most participants in the focus group discussions complained of the negative behaviour of skilled attendants. One participant from Manyamula Health Centre catchment area in the focus group discussion for men stated:

> The challenge is that at a health facility, skilled attendants leave a woman alone in labour ward when time is due to deliver her baby. They tell a woman that time is not yet due to deliver. The skilled attendant leaves labour ward for his/her house and just waits there. As such, a woman who is chosen as chairperson among the women or guardians to the woman in labour conducts delivery. When the skilled attendant comes back to assist delivery and finds a baby is born, he/she becomes angry towards the guardian. Consequently, when these women who delivered at a health facility assisted by a chairperson or guardian come back home, they tell

other women. The result is that other women say, they cannot go to deliver at a health facility and they choose to deliver at a TBA (P8, FGD 20 years old).

Participants experienced negative attitudes of nurses and women had self-delivery at health facilities, which prompted them to deliver with the assistance of TBAs for subsequent pregnancies. One participant from Manyamula Health Centre catchment area in the face to face interviews aged 25 years had this to say:

> The other challenge is that skilled attendants shout at women if they failed to go and wait for health facility delivery but reports while in labour. Reception is not good. Skilled attendants say, we already told you that every pregnant woman should come and wait for health facility delivery at 9 months but you deliberately choose not to come. Go away and your husband should assist you during delivery. A woman waits outside labour ward till she delivers there. People go to skilled attendant's house and tell him/her that the woman……. has delivered a baby. The skilled attendant shouts at a woman who has delivered and says, you villagers, you are like that. You are used to unhygienic practices (muli kuzyowela ukazuzi) (munazolowela uve) that is why you have delivered there. This is why a woman fails to deliver at a health facility. It happened to me. I was in labour and came to labour ward by foot from my home. The skilled attendant was informed by my guardian. The skilled attendant asked, where did labour pains start? The response was, labour pains started at her home. The skilled attendant said, you should sit down there with her. I sat

down outside labour ward. Another skilled attendant came and entered labour ward. This time I just opened the door of labour ward and entered. The skilled attendant asked me and said, who told you to enter labour ward? You are going to deliver right there on the floor, so I delivered a baby by myself on the floor. It was then when the skilled attendant started to assist me (P9).

Another participant complained that nurses displayed their poor attitudes by leaving young women alone in labour ward while going for lunch break. One participant from Mzimba District Hospital catchment area in the focus group discussions for men stated:

> The major problem is that when we have sent a young woman below 18 years to a hospital, skilled attendants do not care…….When time is 12: 00 o'clock pm, all nurses leave for lunch. Nurses say, we are going for lunch. You do not know that a pregnant woman can start labouring anytime, so we see that this is a problem there at the hospital (P12, FGD 40 years old).

Similarly, participants complained that skilled attendants displayed their poor attitudes by not showing attention for women in labour. One participant from Mzimba District Hospital catchment area in the focus group discussions for men stated:

> What I dislike in this policy change for TBAs is that sometimes when a pregnant woman is in labour at a health facility, there is no attention, and no encouragement. A pregnant woman in labour is just alone on a bed, lying unhappily. Skilled attendants say, we are the ones who are going to

assist the woman. The woman is just afraid…..so this does not please us. People should be near her to comfort her. There is nobody on her bedside to comfort her (P12, FGD 40 years old).

Participants also complained that nurses displayed their poor attitudes by chasing away a birth companion who was suckling a baby when she was the only guardian to a woman in labour. This made women to deliver at TBAs with subsequent pregnancies. However, this was possibly done to prevent infection to the baby and the newborn. One participant from Mkoma Health Centre catchment area in the focus group discussions for women stated:

> The other reason is that at health facilities, they chase away a female guardian who is suckling her baby. Sometimes, the mother in-law is sick, and the woman suckling a baby is the only guardian available. As such we just go to deliver at TBAs since the mother in-law cannot manage to be a guardian….. (P21, FGD 36 years old).

Additionally participants complained that nurses displayed their negative attitudes by threatening women who failed to push their babies that they will cut their abdomen (operate on them). This made women decide to deliver at TBAs with subsequent pregnancies. One participant from Mzimba District Hospital catchment area in the focus group discussion for men had this to say; “Sometimes nurses show their anger to woman during delivery by saying “You are lazy in pushing, we are going to cut your abdomen, and so the woman says Ee! This is what nurses say threatening woman. Eya! Nadi (Surely)” (P17, FGD 25 years old).

Skilled attendants refused to discharge women who delivered in a health facility, mainly from the catchment areas of the two health centres, the sites of the study till new materials were bought. However, one participant from Mzimba District Hospital catchment area in the focus group discussions for men had a positive view of the misinformation, narrated:

> What I like in this policy change for TBAs is that when a pregnant woman delivers at a TBA, we do not remember to buy a basin, shawl, socks and hat. The baby should be covered using clean materials; therefore this pleases us. Skilled attendants tell us that you should buy all these materials, which are needed that is when your wife will be discharged from the health facility (P14, FGD 32 years old).

Results revealed that stranger feeling were some of the barriers for women to deliver with the assistance of skilled attendants. Pregnant women feared skilled attendants at a hospital when they were admitted. They could not feel free. They felt as if skilled attendants would beat them. This made women decide to deliver at TBAs. One participant from Mzimba District Hospital catchment area in the focus group discussions for men stated; “Pregnant women fear skilled attendants at a hospital when they have been admitted. They do not feel free. They feel as if the skilled attendants will beat them” (P17, FGD 25 years old). Another participant from Mzimba District Hospital catchment area in the focus group discussion for men added:

> It is because the pregnant woman has never seen the skilled attendants before. EE! To her they are strangers. The woman also fears that she

might be done operation since she does not want operation. This is what the women are afraid of (P12, FGD 40 years old).

Results revealed that absent skilled birth attendants were some of the barriers for women to deliver at health facilities. These skilled attendants could not be found, especially at the two health centres, the sites of this study. As such, women returned and delivered at TBAs. One participant from Mkoma Health Centre catchment area in the focus group discussions for women stated:

> The challenge to deliver with skilled attendants at a health facility is that sometimes, skilled attendants are not available at Mkoma Health Centre. The skilled attendants are changed so frequently such that when we go to deliver, we find that the other nurse has not yet come. As such, we just go back and deliver at TBAs (P19, FGD 23 years old).

Similarly, another participant complained of the absence of skilled birth attendants at health facilities which made women to return and deliver at TBAs. One participant from Manyamula Health Centre catchment area in the focus group discussions for men stated:

> Skilled attendants working in health facilities in villages work from morning till 12:00 pm and they knock off. When we go…….in labour to a health facility in the afternoon, only to be told that the skilled attendant is on a jolly walk and we are told to search for him/her. After failing to find the skilled attendant, we then just decide to go to a TBA… (P11, FGD 23 years old).

Negligence of skilled birth attendants during examination of women in labour was reported as some of the barriers which discouraged women to deliver at health facilities. Skilled birth attendants were unable to diagnose women in active phase of labour. As such, these women delivered alone. This demotivated women. As a result, these women delivered with the assistance of TBAs with subsequent pregnancies. One participant from Mzimba District Hospital catchment area in the face-to-face interviews aged 24 years said:

> There are challenges at health facilities. Nurses at a health facility tell us when we report that we are in labour to wait and tell us to come at another time for re-examination when actually there are signs of advanced labour. The nurses tell us that we are not in active labour, only to find a baby is born (P19).

Likewise, another participant expressed the negligence of skilled attendants who sent women in labour back home and they delivered on the way home. This shows that there was negligence in examination of women in labour. Learning from their experiences, other women decided to deliver with the assistance of TBAs. One participant from Manyamula Health Centre catchment area in the face to face interviews aged 18 years and did secondary education had this to say:

> There is a challenge at a health facility. Skilled attendants send women back home when they report in labour. My two sisters in-law were sent back three times when they reported in labour at a health facility. As a result, a baby was born on the way home from a health facility the third time they were sent back (P7).

Challenges in the community

Results revealed that most participants in the focus group discussions mentioned long distance as one of the major barriers for women in the community to deliver at health facilities with assistance of skilled attendants. Women in labour were unable to walk a long distance. One participant from Mkoma Health Centre catchment area in the focus group discussions for women said; “The distance to Mkoma Health Centre is long, so it becomes difficult for us to walk. As such, we just decide to go and deliver at a TBA” (P21, FGD 36 years old). Similarly, another participant from Mkoma Health Centre catchment area in the focus group discussions for women stated; “The distance to the health facility is long as such a pregnant woman in labour fails to walk” (P19, FGD 23 years old). Another participant from Mzimba District Hospital catchment area in the focus group discussions for men said; “The challenge in the community to deliver with skilled attendants is long distance” (P12, FGD 40 years old).

This finding concurred with finding from face to face interviews where participants responded that distance to a health facility is long hence pregnant women failed to walk. As such, they delivered at TBAs. One participant from Manyamula Health Centre catchment area in the face to face interviews aged 25 years sighed and said; “I started off to deliver at a health facility but I failed to walk on the way so that is why I delivered with the assistance of a TBA. The distance to a health facility is long” (P9).

Results revealed lack of physical transportation especially during the night as some of the barriers that made women fail to deliver at health facilities with assistance of skilled attendants. One participant from Manyamula Health Centre catchment area in the face to face interviews aged 23 years said; “There is a challenge of transport since

vehicles are rarely found to take a pregnant woman to a health facility though money may be available to pay for transport. Unavailability of transport is more a challenge during the night" (P6).

Some participants in the focus group discussions indicated that illiteracy was a barrier for women to deliver with skilled attendants at health facilities. One participant from Mzimba District Hospital catchment area in the focus group discussions for men had this to say; "Ee! The other reason is that there is a lot of ignorance in our villages" (P12, FGD 40 years old).

Participants' suggestions/comments for improving adherence to policy change for TBAs

Suggestions/comments for policy makers in the Ministry of Health Organization

It was noted from most of the participants' comments that they were in support of the policy change for TBAs since it would help to reduce maternal deaths. One participant from Mzimba District Hospital catchment area in the focus group discussions for men stated; "TBAs should completely stop conducting deliveries because they do not assist women…….many women can just end up dying" (P16, FGD 38 years old). Another participant from Mzimba District Hospital catchment area in the focus group discussions for women said; "We should deliver at a health facility because numbers of women dying are reduced" (P4, FGD 28 years old).

On the other hand, some participants expressed of need to comply with the policy change because they were denied health services once they delivered at TBAs. One participant from Manyamula Health Centre catchment area in the face to face interviews aged 22 years had said; "The policy should be followed as per the government decision.

This should be so since a baby born with a problem is not assisted at a health facility because the woman delivered at a TBA" (P12).

However, some participants were against the policy change and stated that TBAs should continue conducting deliveries. One participant from Manyamula Health Centre catchment area in the face to face interviews aged 25 years and only did primary education said; "I feel a house should be built for a TBA for conducting deliveries for those women who are unable to walk to a health facility rather than delivering in their personal houses" (P9).

Some participants suggested that the government should procure bicycle ambulances for the community for transporting pregnant women from their homes, TBAs or village headman to a health facility. One participant from Mzimba District Hospital catchment area in the focus group discussions for men had this to say:

> My suggestion is that the government should provide bicycle ambulances which should stay at TBAs or village headman so that they should be used to wheel women to a hospital. The woman should be collected either at a TBA or wherever she might be because a TBA can be far like at Milala (P14, FGD 32 years old).

Comments for improving policy change for TBAs in the community

Some participants commented that they should increase their farm outputs by farming more so that they should be able to sell farm products and use money to buy birth preparedness materials. One participant from Mkoma Health Centre catchment area in the focus group discussions for women said:

……we need to garden more so that we find money to buy these materials needed when we go for delivery such as basin, clothes (zitenje), plastic paper, and razor blade. We shall deliver at a health facility if we find these materials. If we do not find the materials, we shall continue delivering at TBAs (P22, FGD 35 years old).

Suggestions/comments for improving the policy in health delivery services

Some participants suggested that other health facilities should be built to reduce the physical distance. One participant from Manyamula Health Centre catchment area in the face-to-face interviews aged 25 years and only did primary education said; "My suggestion is that another health facility should be built at Mchelela Health Post where we should be delivering. Manyamula Health Centre is far. It is a long distance to walk to this health facility" (P9).

This suggestion concurred with a suggestion from focus group discussion. One participant from Mkoma Health Centre catchment area in the focus group discussions for women stated; "My suggestion is that the government should build a health facility at Chasefu since distances to health facilities are long including the distance to Mkoma Health Centre" (P21, FGD 36 years old).

Some participants suggested that the government should provide ambulances to collect women in labour from their homes to health facilities. One participant from Mzimba District Hospital catchment area in the face-to-face interviews aged 25 years and did secondary education said:

My suggestion is that when a woman is in labour, an ambulance call should be made to the hospital to come and collect a woman from her

house for hospital delivery. During the night, it is a challenge as a woman cannot walk (P18).

This suggestion concurred with a suggestion from focus group discussion. One participant from Mzimba District Hospital catchment area in the focus group discussions for men said; “My suggestion is that there should be a special vehicle at the district hospital assigned to collect pregnant women only when a call is made” (P17, FGD 25 years old).

Some participants commented that nurses should be available at health facilities so that women receive delivery services. One participant from Mkoma Health Centre catchment area in the focus group discussions for women stated “I suggest that at Mkoma Health Centre, skilled attendants should be citizens (permanent) and not mobile. They should not be changed so frequently. This is because we face challenges as we do not find them during delivery” (Skilled attendants should not work on relief duties as pregnant women experienced a gap when the other skilled attendant had delayed to report for relief duties) (P19, FGD 23 years old).

Some participants commented that nurses should demonstrate positive attitudes towards women during labour and delivery. One participant from Mzimba District Hospital catchment area in the focus group discussions for men had this to say:

AA, my comment is that when a pregnant woman goes to deliver at the hospital, nurses should quickly attend to her. Nurses should not shout at a woman but they should talk to her to make her laugh. The second comment is that a relative to the woman should be at the bedside to be observing her so that the woman should not be afraid. What happens is

that nurses tell all relatives to go out of the delivery room (P17, FGD 25 years old).

Conclusion

This chapter has presented the findings to the study. It has revealed that participants had awareness on policy change for TBAs. Despite awareness on the policy, women preferred to deliver with the assistance of TBAs. This was due to women's lack in decision making power despite socio-cultural beliefs. Additionally, there were barriers for pregnant women in families to deliver with assistance of skilled birth attendants that included lack of birth preparedness and financial constraints/poor socio-economic status. Barriers were also encountered in health facilities that included disrespect/poor attitudes of skilled birth attendants, stranger feeling with skilled attendants, absent skilled birth attendants and negligence of skilled birth attendants. Barriers were also encountered in the community that included long distance to a health facility, lack of physical transport and women's or men's illiteracy.

However, other participants demonstrated lack of awareness on the policy change for TBAs hence delivered with the assistance of TBAs. Participants also gave comments and suggestions on areas for improving policy change for TBAs at the Ministry of Health. It was pointed out that TBAs should completely stop conducting deliveries to prevent maternal deaths. The government should provide transport to collect women in labour from homes, TBAs and village headmen to a health facility. In the community, participants suggested that they should increase farm outputs so that they sell and buy birth preparedness materials. In health facilities, participants suggested that the government should construct other health facilities to reduce the physical distance.

Nurses should demonstrate good attitudes and attention to women in labour. On the other hand, some participants were against the policy change and demanded that TBAs should continue conducting deliveries. Women will continue giving births at TBAs unless these challenges have been addressed.

CHAPTER FIVE

DISCUSSION OF RESULTS

Introduction

This chapter presents a discussion of the results of the study. The study participants were from catchment areas of Manyamula and Mkoma Health Centres and Mzimba District Hospital. The discussion will focus on the demographic data as well as the themes and sub-themes that emerged from the results. It would also include study recommendations and areas for further studies.

Demographic data

Age of participants

The study results revealed that most of the female participants were 18-24 years while a few were 35-44 years. Literature indicates that by age, women between 35-49 years are most likely to deliver at home (National Statistical Office, 2011). However, this study has revealed that most of the women who delivered with the assistance of TBAs were between 18-24 years which is contrary to the findings of the National Statistical Office. This implies that there are more women who prefer to deliver with the assistance of TBAs in these study catchment areas. Furthermore, literature indicates that delivering with the assistance of TBAs is associated with increased maternal deaths (Shamsu-Deen, 2013). Malawi wants to achieve the Millennium Development Goals (MDGs) 5 and 6 (Bourguignon, et al., 2010). Therefore, women in these study areas are at higher risk of maternal deaths. This finding suggests scaling up awareness campaigns to empower

women so they could use skilled birth attendant at a health facility. Additionally, it requires a multi-pronged or multi-sectoral approach at community level that includes support from NGO's in addressing this issue. Health system levels also need to be addressed. The ages of male participants were between 20-48 years.

Marital Status of participants

The results indicated that all study participants were married. Marital status influences type of support that the participant could receive in preparation for and during labour and delivery. In Malawi, most decisions about health care are made by husbands (National Statistical Office, 2004). The contributing factor is culture. The Tumbuka and Ngoni tribes adopt patriarchy families whereby the husband is the head, has authority over the wife and is the main decision maker. This is in line with the findings by Casimir, Emmanuel, & Okpara (2013) that the majority of African women are still burdened by cultural ignorance. This creates enormous disempowerment in the homes and villages thereby preventing freedom of women from taking part in the decision-making processes. In the same way the husband influenced the wife or mothers in-law influenced their daughters in-law to deliver with the assistance of TBAs in these study areas. Therefore, it was necessary to provide policy change for TBAs messages to a couple during antenatal care so that the husband could support the woman to have institutional delivery with a skilled attendant.

Religion of participants

The study results further revealed that all study participants in the study were Christians though their denominations varied. Surprisingly, none of these denominations stop their members from health facility delivery like Apostolic faith. This therefore,

implies that it is not religious dominance that determines the women's decision making to deliver with the assistance of TBAs. This further illustrates that there are more women who prefer to deliver with the assistance of TBAs evidenced by women from these denominations which do not stop their members from health facility delivery.

Tribe of participants

The study results indicated that most of the participants were Tumbuka by tribe and a few were Ngoni. The Tumbuka and Ngoni are patrilineal tribes. The existence of patrilineal system suggests that men have the most dominant social status. Such a position may have negative implications on the women. This is in agreement with a study conducted by Mushibwe (2013) which elaborates that Tumbuka women's experiences and beliefs reflect socio-cultural traditional norms. These norms tend to limit gender equality and oblige women to accept and justify male domination at the expense of their own status and to regard consequent inequalities as normal. In Malawi, traditionally, in these families, decision-making is made by a husband because it is believed that he has the powers and authority. Additionally, mothers in-law make decisions and bypasses the daughters in-law. Therefore, this implies that women delivered at TBAs because most of them could not make decisions for health facility delivery. Also, another study conducted by Tiessen (2005) points out that cultural norms and attitudes in Malawi are believed to increase the likelihood of HIV transmission. This is because they perpetuate gender inequalities which reinforce women's subordinate position in society. In this study, women could just obey and follow the culture of the husbands and deliver at TBAs though it poses a great risk of contracting HIV since TBAs do not have the appropriate resources to prevent HIV transmission. Republic of Malawi (2013) states that Malawi

aims at achieving zero new HIV infections. Therefore, community health nurses should address this problem by continued teaching to families and communities to adhere to the policy change for TBAs.

Educational Level of participants

The study results also indicated that all the participants in the face-to-face interviews in this study had attended school. However, the majority attended primary school and a few went through secondary school. This also applied to spouses of these participants. The educational level of these participants and their spouses was low. Low education negatively affected the spouses of decisions making by encouraging women to deliver at TBAs. Additionally, low education deprived the participants both women and their spouses of finances as they could not be employed for better jobs. Consequently, this affected their ability to seek delivery with skilled birth attendants. They could not meet transport costs or buy materials necessary for delivery. Additionally, it appeared as if participants did not value their health because they continued delivering with the assistance of TBAs. This is in spite of their stating that delivering at TBAs was risky because it was associated with maternal deaths.

The results concurred with National Statistical Office (2011) in which it was reported that women with higher levels of educational attainment were more likely to deliver in a health facility than women with less education. This is in line with a study done in Nyandarua south district in Kenya where they found that mothers with higher level of education (more than secondary education) delivered with assistance of skilled birth attendants. Whereas, mothers with low level of education (primary education) delivered at TBAs (Wanjira, Mwangi, Mathenge, Mbugua & Ng'ang'a, 2011). Education

level can therefore be related to the level of exposure to the right information with regard to delivery. In this study, by extention, the low level of education affected thinking capabilities of the participants. They could not make informed decisions since women were disempowered. Education helps to take personal responsibility for one's own health. Educated mothers are more likely to break away from traditions and better able to use available health services for their health. As such, people need to be educated to value their health, so that they can make better choices which translate into better decisions.

Moreover, one of the participants stated that there was a lot of ignorance in the communities. Most female participants even misinterpreted obstructed labour when they experienced rising fundus and when the baby could not descend during labour. They saw it as having been caused by either a husband or wife having extra marital relationship**.** Among the signs of obstructed labour include no progress of descent of the presenting part for 3 hours and rising fundus (Republic of Malawi, 2009c)**.** Similarly, Harun et al. (2012) in Kenya found that, among the Maasai women, the majority of them were ignorant due to low level of education. They could not utilize skilled birth attendants even though the majority of these women lived within 30 minutes walk to a health facility.

Main source of income of study participants

The study results also revealed that the main source of income for most of the participants was peasant farming and a few women had small businesses. Most women in the face-to-face interviews and their spouses were not employed. However, some of the spouses were self employed and privately employed. In addition, one man was employed to graze cattle. This implies that all study participants were poor since their socio-

economic status was low. According to Republic of Malawi (2012a), the national poverty rate in Malawi was 50.7% in 2011 indicating that almost half of the population was poor. This poor population had total consumption below MK 37, 002 per person per year. This consumption is below the poverty lines in Malawi. Worse still, 25% of the population in Malawi in the same year was deemed very poor with total consumption less than MK 22, 956 per person per year. This consumption is for food and non food. This explains the financial challenges they faced to meet cost of transport for women and to buy birth preparedness materials. As such, health facility delivery was more likely to be unaffordable. This current study has shown similar results with a study conducted in Masasi district, Tanzania where the majority of women were farmers who preferred delivering with TBAs (Pfeiffer & Mwaipopo, 2013). In that study, financial challenges posed a barrier to deliver at health facilities hence they preferred TBAs. Employment has been viewed as one source of empowerment for women given that they exercise control over their income. It is, however, difficult to measure employment status because even though some women work, it is on family farms, in family businesses, or in the informal sector; and such work is often not perceived as employment by the women and men themselves (National Statistical Office, 2011). Therefore, if a woman is not employed, they are not empowered economically as such they are abused by their husbands and significant others on the preference of place of delivery hence, they deliver with the assistance of TBAs. Therefore, the community health nurse should advocate for economic empowerment for these women with other organizations in order for women to make birth preparations so as to comply with the policy change for TBAs.

The ages of male participants were between 20-48 years. According to National Statistical Office (2011), 82% of men aged 15-49 years, are currently employed, though

in this current study most men were peasant farmers. Similarly, in a study conducted in Ethiopia, it was observed that women whose husbands occupation were farmers and labourers were less likely to choose health institution for delivery compared to women whose husbands were government employees (Mezmur, Desalegn & Semahegn, 2013). High status occupations are associated with greater wealth and ability to pay costs.

Number of children delivered

The study results indicate that all the participants had less than 6 children each. The likelihood of a skilled attendant delivering a birth decreases with increasing birth order from 80% for first order births to 64% for births of order 6 or more (National Statistical Office, 2011). Likewise, studies in Pakistan and Nepal showed that lower parity women were more likely to deliver in health facilities and use skilled birth attendants than high parity (Sharma, Poudyal, Devkota, & Singh, 2014). Therefore, this shows that preference of women to deliver at TBAs is higher in these current study catchment areas as evidenced by women of lower parity/parity below 6 delivered at TBAs.

Awareness of policy change for TBAs

The results revealed that most women who participated in this study were aware of the policy change for TBAs. Likewise, most men were aware of the policy change for TBAs. Participants' awareness was demonstrated when they correctly explained the policy change and explained the risk of delivering with the assistance of a TBA. Additionally, participants explained the benefits of delivering with the assistance of skilled attendants such as performing operation and skilled attendants have adequate resources to diagnose a problem. Women's and spouses' awareness on policy change for

TBAs enhances awareness of risk for seeking delivery with the assistance of a TBA such as maternal deaths. Despite awareness, pregnant women did not follow what they were taught. Likewise, spouses did not follow what they were taught as their wives delivered at TBAs. Similarly, a study conducted in Haramaya Woreda, Ethiopia, the majority of women participants had information about the benefit of giving birth at health institution but preferred to deliver at TBAs (Mezmur, et al., 2013). This stands in contrast to a study documented by Feyissa and Genemo (2014) which found that in north-west Ethiopia, awareness about health facilities made women to deliver with assistance of skilled professionals. In the current study, community health nurses, therefore, should mobilize communities to practices which adhere to the policy change for TBAs. This should be done by continued teaching to the communities.

Sources of information on policy change for TBAs

Several sources of information about policy change for TBAs were identified from the data. The major sources were skilled birth attendants, Health Surveillance Assistants, the mass media such as the radio; village headmen, and fellow women who received the information from antenatal clinics. Additionally, some women obtained information from people whom they did not know but heard them discussing the policy change for TBAs. This shows that the informal channel is also a powerful source of health information. The managers of health facilities should take advantage of this source and find ways of using it to its full potential as it has the likely hood of disseminating policy information to change habits to save lives.

Lack of awareness on policy change for TBAs

The results for this study also revealed that some women lacked awareness on policy change for TBAs. The lack of awareness was demonstrated when the participants indicated that they did not know anything about the policy change and incorrectly explained the policy change. A study in Nabi Nagar, India found that women preferred delivering with the assistance of TBAs mainly because of lack of knowledge (Khan, Mehnaz, Khalique, Ansari & Siddiqui, 2009). Similarly, some men lacked knowledge on the policy change for TBAs. This implies that though women went for antenatal care, there was a gap in the administration of health talk messages by omitting the policy change for TBAs. However, the contributing factor to inadequately explaining the policy change could be low level of education of the participants. This finding concurs with a study conducted in Ethiopia where it was found that some women did not have knowledge on benefits of health facility delivery hence preferred to deliver at TBAs. It needs no emphasis therefore, that health education is required by community nurses to better inform the community about the benefits of this policy change for TBAs (Mezmur, et al., 2013). The researcher recommends refresher courses for health care givers so that they are empowered to give comprehensive health education to the community and motivate it to best practices of delivering with the assistance of skilled attendants.

Factors that influence women to deliver with the assistance of TBAs

The participants mentioned several reasons that made women to give birth with the assistance of TBAs. These were mainly due to women's lack of decision making power. These included; beliefs towards delivery services at TBAs, cultural influence,

positive attitudes towards TBAs, beliefs in adequate skills of TBA and influence of subjective norms.

Women's lack of decision making power

The results revealed that culturally, most participants believed that if a pregnant woman or husband had extra marital relationship, the woman failed to deliver normally. The woman experienced rising fundus during time of labour and delivery. Therefore, the solution was believed to be a woman delivering with the assistance of a TBA who gave local medicine to facilitate normal delivery. However, this signified women's lack of decision making power to deliver at health facilities in the face of cultural demand to deliver with the assistance of TBA. Participants believed skilled attendants could not assist such a woman during labour, hence she could die. This signified participants trust in TBAs. These findings are similar to a study in Nigeria whereby TBAs attributed obstructed labour to infidelity on the part of the woman. As such, women did not often use the services of health facilities despite living close to these facilities. It is such socio-cultural beliefs that made the TBAs keep on conducting deliveries and took advantage of the ignorance of these women (Mboho, Eyo & Agbaje, 2012). There is need for continued teaching on the policy change and discourage cultural beliefs which are not evidenced based.

Likewise, communities believed that women are sometimes bewitched so that they fail to deliver normally. Similarly, a study conducted in Malawi by Kanjo (2011) revealed that there was a belief that a woman who was due for labour failed to start labour pains because of being bewitched. As such, the women looked for remedies to save their lives by consulting TBAs. These TBAs provided local medicine for women to

take which they believed helped women to deliver normally. Traditionally, communities felt skilled attendants could not assist such a woman who had been bewitched. They believed it was beyond the capacity of the skilled attendants and this perpetuated the active role of TBAs to assist in deliveries.

Additionally, in the present study, participants reported that it was part of tradition for women to deliver with the assistance of TBAs. This concurs with a study conducted in Nabi Nagar, India (Khan, et al., 2009). Furthermore, men are main decision makers in Tumbuka and Ngoni culture so they influence women to deliver with the assistance of TBAs. Women had to obey their spouses to deliver at TBAs. This finding also concurs with findings among Ogu people in Lagos state, Nigeria whereby male domination in decision making influenced women to deliver at TBAs as they are a patriarchy society (Emmanuel & Abimbola, 2012). This explicitly shows that socio-cultural factors play a role in decision making for choice of place of delivery. One would expect that communities would encourage delivery at a health facility. On the contrary, they accept and approve their culture and maintain it for identity. The prevailing socio-cultural beliefs have a strong impact on the behaviour of women to prefer delivering with the assistance of TBAs. However, this calls for a need to empower women to make healthful decisions of delivering at health facilities rather than abiding by culture or influence of significant others. This can be done through continued education on the risks of delivering with assistance of TBAs.

Also, women's preference to deliver with the assistance of TBAs was because of their cultural beliefs in local medication for facilitating delivery administered by TBAs. This is similar to results of a study in Uganda whereby TBAs administered local herbs on

mothers during birth which were perceived to cause labour contractions. However, these herbs are toxic (Nyakaisiki, 2012). These drugs which were taken orally could cause rupture of the uterus which could lead to maternal deaths. The drugs which were inserted in the vagina to quicken contractions or expel the placenta very fast could possibly predispose women to pelvic infection and cervical cancer. Addressing this issue becomes a challenge when the whole community strongly approves of use of the herbal medicine on women by TBA. For instance, a study conducted in south east Nigeria found that people strongly believed in herbal medicine and approved to utilize TBA services (Emmanuel, Gladys & Cosmas, 2013). This, therefore, shades light addressing the issue has to be done holistically, with the communities in perspective. This is because the communities in which these women live reinforce and encourage women's preference to deliver with the assistance of TBAs. Culture appears to play a very important role in influencing delivery with the assistance of TBAs (Aqil, 2012). This explains why TBAs still assist many women during delivery in sub-Saharan Africa countries (Kayombo, 2013). Nevertheless, there is hope in Malawi since the Road Map for Community Health Nursing and Midwifery Services aims at empowering communities to ensure continuity of care between the household and health care facility. As such, TBAs need orientation for their new roles (Republic of Malawi, 2011). Additionally, other community members, Non Governmental Organizations, Community Based Organizations (CBOs) and CHNs should address these cultural beliefs through community sensitization.

Positive attitudes towards TBAs

The results for this study revealed that women's preference in delivering with the assistance of TBAs was also because of caring attitude shown by TBAs. These included

good reception, which incorporated warm welcome by smiling at women, providing food such as porridge to women during labour and delivery. Additionally, TBAs massaged back of women and physically supported women's back during labour and delivery. In Nigeria, it was revealed that women delivered at TBAs because of their uniform attractive roles such as massaging the back of women, sitting close, accessibility, accommodating other relatives Ayede (2013). However, the potential risks of delivering with the assistance of TBAs outweighed the benefits women experienced with TBAs. The women could not do a cost benefit analysis. This implied that women lacked decision making power contributed by low level of education. The other reason is that TBAs did not demand birth preparedness materials during time of delivery as compared to a health facility delivery. Otherwise, a TBA understood that women were poor hence she provided some of these materials to some women during delivery. It would appear participants' negative view of birth preparedness materials demanded at health facilities reflected illiteracy. Skilled attendants demand birth preparedness materials such as clothes during delivery for warmth. Additionally, the other materials such as basin and razor blade help in infection prevention as they are not shared with other mothers. TBAs will still continue to practice despite their services carrying high risks of complications simply because they are friendly. This implies that skilled birth attendants need to adapt to user friendly health services to attract women to prefer skilled attendance at birth and avoid delivering at TBAs.

Beliefs in adequate skills of TBAs

The current study results reveal that participants also believed in adequate skills of TBAs as preference for women to deliver with the assistance of TBAs. These skills

included; TBA's ability to correct the abnormal lie which was evidenced by a skilled attendant during subsequent visit at antenatal clinic: TBA accelerating slow progress of labour by providing local medicine to a woman to take to facilitate delivery of a baby. TBA had examining skills to examine a woman in labour just like a skilled attendant. However, participants' beliefs reflected illiteracy because of low level of education. Women lacked decision making power as they were influenced by mothers in-law to go to a TBA. This was because they changed abnormal lie of foetus to normal position which predisposed women to potential risk of rupture of a uterus. These risky practices performed by TBAs in this study are in line with findings in India documented by Kathiresan, Soundappan & Amarjeet (2013) which targets 100% institutional deliveries. The government's view is to put to an end harmful practice, following major policy changes for TBAs. Additionally, the current study findings agree with what Choguya (2014) documented for the preference of women to deliver with TBAs in Zimbabwe. It was indicated that TBAs might have knowledge of special herbs known to be important for cervical dilation and believed to be necessary in precipitating labour during delivery. In contrast, a study in Fiji found that Fijian women preferred hospital delivery because there was no one left (no TBA) who knew how to reposition a baby who was in the wrong position as it was done in the past. All TBAs had died. This lack of traditional knowledge made the women scared to give births in the villages. Therefore, many observed this lack of knowledge as a positive, as it might not be safe to manually change the position of the baby (Heick, 2013). However, in Malawi, though these TBAs are still available, there is need to discourage these harmful practices through active engagement of local leaders to continually inform communities that women should deliver at health facilities.

Subjective norms

The current study results revealed that the majority of the participants preferred to deliver with the assistance of TBAs because of the influence of mothers in-laws. This was followed by self decision making by women, influence of husbands and TBAs. Mothers in-law and husbands exercise power over married women. This signified women's lack of decision making power as they could not refute significant others influence to deliver with the assistance of TBAs. A study in Chiapas, Mexico states that decision-making power resided with the husbands or mothers in-law for women to deliver at TBAs (Tucker, et al., 2013). These findings are also consistent with those of a study in Kenya by Wanjira, Mwangi, Mathenge, Mbugua & Ng'ang'a (2011) whereby most mothers did not plan on the delivery place prior to the delivery with majority of them being decided for by their husbands. Additionally, this is similar to findings among the Maasai in Tanzania whereby decision making process was mainly made by husbands, hence the majority of these women delivered at TBAs (Roggeveen, et al., 2013). The results showed that decision makers or husbands have a role to play in determining the place of delivery.

Generally, it was also noted in most of the participants' narrations that lack of birth preparedness evidenced by financial challenges and failure to walk long distances to a health facility contributed to delivering at TBAs. This also applied to women who made decisions by themselves to deliver at TBAs. It appears that, it is vital to interview TBAs as to why they attract women to deliver with their assistance, despite this policy change. According to National Statistical Office (2004), women who were more empowered were generally somewhat more likely to receive health care during delivery. However, in another study by Iliyasu, Abubakar, Galadanci & Aliyu (2010), it was found that in a

patriarchal society like northern Nigeria, pregnancy and childbirth were often regarded as exclusively women's affairs. This may also apply in this study as the most decision makers were mothers in-law influencing women to deliver at TBAs. In contrast, participants mentioned village headman, HSAs and Health Volunteer as people who influenced mothers to deliver with the assistance of skilled attendants and not TBAs. The place of delivery is of great significance to the reduction of maternal mortality if assisted by skilled attendants rather than the assistance of TBAs. This calls for community health nurses to intensify male involvement to meet birth preparedness. Men will be able to understand the potential risks women face because of delivering at TBAs. The men will most likely make birth preparations for their wives to deliver with skilled attendance. Additionally, men will bypass the influence of their wives' mothers in-laws demanding delivery at TBAs.

Barriers to deliver with skilled attendants

The study findings revealed that there were barriers from families, at health facilities and in the community to deliver with the assistance of skilled birth attendants. The major barriers stated were; lack of birth preparedness, financial constraints/poor socio-economic status, disrespect/poor attitude of skilled birth attendants, long distance to a health facility, and denial of women's rights. Others included; lack of physical transport, negligence of skilled birth attendants, absenteeism of skilled birth attendants at health facilities and skilled attendants denied women discharge from health facilities till they bought new materials demanded during birth preparedness. Unless these challenges are addressed, women will continue giving births at TBAs. Skilled birth attendance is vital in improving maternal health.

Challenges in families

Lack of birth preparedness

This study result reveal that lack of birth preparedness plans was mainly due to poverty as participants did not have the finances to buy materials required at health facilities during delivery. Birth preparedness is an important factor which can influence mothers' choice of delivery place. Similarly, a study in Mpigu District, Uganda, it was found that women were poor and husbands always gave women little money when it was time for delivery. As such, women failed to buy birth preparedness materials hence their preference to deliver with the assistance of TBAs. However, Uganda banned TBA's services in 2009 (Nyakaisiki, 2012). It was also noted that health workers gave wrong information which prevented mothers to have health facility delivery but to prefer TBAs. This was mainly pointed out from catchment areas of the two health centers, the sites of this study. Participants complained that women were denied to be discharged at health facilities after delivery, unless they bought new materials that were required during birth preparedness. This, therefore, instead of encouraging women to seek skilled attendant to assist them, further demotivated women hence their preference to deliver at TBAs where there were no such demands.

Financial constraints/poor socio-economic status

In this study, it was revealed that families were financially challenged hence participants could not afford to pay transport for women to deliver at a health facility. Families were poor. Similarly, studies conducted in Kenya and Ethiopia found that economic barriers such as financial constraints to pay for transport caused a barrier to deliver at a hospital hence most women were assisted by TBAs (Mwangome, Holding,

Songola & Bomu, 2012: Roro, Hassen, Lemma, Gebreyesus, & Afework, 2014). Therefore, community health nurses need to advocate for organizations which can empower families economically so that they engage in income generating activities in their communities. This would relieve poverty constraint as the money would be used for transport and buying birth preparedness materials. Burkina Faso adopted national health policy change in 2007 whereby TBAs encouraged mothers to deliver with skilled birth attendants. In Djibo district in Burkina Faso, it was found that accessibility to skilled birth attendant remained a challenge though its national health policy subsidized 60% to 80% delivery costs with an aim of improving financial accessibility (Belaid & Ridde, 2012). However, in Malawi, with the introduction of service level agreements with Christian Health Association of Malawi, it was anticipated that access to delivery services for women would increase (Government of Malawi, 2011). The agreement eliminates user fee for pregnant mothers for maternal services which includes free delivery services. It is surprising to note that despite the exemption of fees, women preferred delivering with the assistance of TBAs in these study catchment areas. This clearly shows that fees were not the barrier which prevented women from delivering with the assistance of skilled attendant.

Denial of women's rights

The current study revealed that husbands denied women's rights by stopping their wives from going for health facility delivery. Husbands valued household chores and other works performed by their wives rather than taking them to a health facility for delivery to avoid risks of delivering at TBAs such as maternal deaths. This is consistent with a study by Titaley, et al. (2010) whereby women preferred to deliver with the

assistance of TBAs so that they could manage their daily household chores. Similarly, in Mpigi District, Uganda it was found that gender inequality such as domination of decision making process by men infringed on the rights of women to a safe delivery. Women delivered at TBAs despite policy change for TBAs (Nyakaisiki, 2012). The contributing factor was lack of male involvement during birth preparedness plans as pointed out by one of the participants. The community health nurse should therefore empower women to be responsible for their own health by making self decision to have health facility delivery with skilled attendance. Community health nurses should address this problem by continued teaching in the communities to adhere to the policy change for TBAs.

Challenges in health facilities

Disrespect/poor attitudes of skilled birth attendants

The current study results revealed disrespect/poor attitude of skilled birth attendants as a barrier for women to deliver at health facilities. These included lack of attention for women in labour by skilled attendants, deliveries conducted by guardians with some women experiencing self delivery on the floor, shouting at women including telling them that they were unhygienic and refusing women suckling babies to be birth companions in labour ward. It would appear skilled attendants refused women suckling babies in labour ward to be birth companions because they wanted to avoid risks of the baby acquiring infections as well as avoiding the baby passing infection to the newborn. This finding agrees with a study conducted in Chikhwawa District in Malawi whereby skilled attendants from Mwanza health facilities displayed their negative attitudes by chasing away mothers from Chikhwawa District who went to Mwanza health facilities to

deliver. Women chose to deliver at Mwanza health facilities because it was closer than Chikhwawa health facilities. Still more, they had to walk long distances. Nurses from Mwanza health facilities chased away these women because they did not want to attend to women from another district. As such, women were left to give birth under a tree or in a toilet with the assistance of guardians. Worse still, everybody around including men observed the birth due to lack of privacy. As such, women preferred to deliver at TBAs (Kambala, Morse, Masangwi & Mitunda, 2011). However, nurses' acts demonstrated violation of patients' rights. Patients' rights include treating them with kindness, consideration, respect and dignity without any form of discrimination (Nurses & Midwives Council of Malawi, 2002). Therefore, women who experienced mistreatment with skilled birth attendants during delivery were dissatisfied with their services. As such, they tended to deliver with TBAs with subsequent pregnancies.

In the same way, a study in Bayelsa State, Nigeria, revealed that negative attitudes of midwives such as abuse, neglect, rudeness, refusal to offer assistance influenced women to deliver with the assistance of TBAs with subsequent pregnancies (Onasoga et al., 2012). Likewise, Lane, Mansouri & Marotta (2013) found that women experienced challenges with skilled attendants at hospitals. These included; not allowing family members in labour ward, midwives shouting at women and shamed them for inadequate hygiene. Similarly, in Gujarat, India, it was found that women were in labour room during delivery with unfamiliar persons such as nurses and doctors or other attendants. Families and friends were not allowed (Sharma, Giri, Christensson, Kv & Johansson, 2013). This was in to contrast of their positive experiences at TBAs. This is similar to findings in Kenya that skilled birth attendants were abusive to women transferred from TBAs to hospitals following policy promoting skilled birth attendance (Dietsch, 2010).

In contrast, in Somaliland, pregnant women reported being more confident about accessing facility based maternity care owing to the improved attitudes of the skilled birth attendants who were reported to be more supportive than they had been previously. Consequently, delivering at a facility became a routine following the change in the TBA role (Pyone, Adaji, Madaj, Woldetsadik & Van den Broek, 2014a). It is suggested that Continuing Professional Development (CPD) in Mzimba district should include re-training skilled birth attendants in interpersonal communication skills to enhance respect and relationships appropriate towards the women and guardians.

Additionally, women in labour had stranger feeling towards nurses and felt as if nurses would beat them. Also, women feared that they would be operated which made these women to deliver at TBAs with subsequent pregnancies. This was possibly because there was poor interpersonal communication between the women and nurses. It would appear establishing good rapport would prevent the stranger feeling of unfamiliarity and fear of operation.

Absent skilled birth attendants at health facilities

This study also revealed that absenteeism of skilled birth attendants were a challenge for women to deliver with skilled attendants at health facilities. They could not be found at health facilities especially at the two health centres, the sites of this study. As such, women returned and delivered at TBAs. The rationale for the skilled attendants' absenteeism was frequent changing, so women could find that another skilled attendant had not yet come when they went for delivery. Women meant these skilled attendants worked on relief duties at Mkoma Health Centre as there was no permanent nurse at the health facility. Pregnant women experienced a gap when the other skilled attendant had

delayed to report for relief duties. Additionally, it appears skilled birth attendants do not work normal duties in the afternoon, specifically, in the two health centres as evidenced by participant's narration. This illustrates negligence. The primary role of the Nurses and Midwives Council of Malawi of protecting the public from malpractice, misconduct, negligence or abuse by any of the nursing and midwifery practitioners registered and licensed under the Act should be honored. As such, the council should monitor professional conduct and impose disciplinary measures to practitioners who are found guilty of negligent of duties, conducting themselves unprofessionally and engaging in malpractice (Nurses & Midwives Council of Malawi, 2005) .Moreover, Nurses & Midwives Council of Malawi (2002) explains that a nurse should at all times maintain standards of professional conduct which reflect credit upon the professional image. As such, judgment skills and attitudes of a nurse must demonstrate the promotion of quality care. Additionally, it is therefore, suggested that the district health management team should address this matter by putting corrective measures. Therefore, supervision needs to be intensified for the skilled birth attendants so as to enhance professionalism.

Similarly, Harun, Shelmith & Muia (2012) found that among the Maasai women in Kenya, the persistent utilization of TBA services was attributed to among others availability of these TBAs and poor access to skilled birth attendants despite policy change in 2007 which promoted skilled birth attendance. In another study in India, it is documented that there is no health provider willing to be available 24 hours a day to assist women during delivery specifically in remote areas. Furthermore, it is stated that coverage by skilled birth attendants remain low in many countries due to insufficient numbers of these attendants and inappropriate deployment of existing personnel (Sharma, Walia & Saini, 2010). A study in Krong Kep, Cambodia revealed that unavailability of

health care staff in rural areas prevent women from delivering in a health facility (Montesanti, 2011). Titaley, et al. (2010) mentions that occurrence of absenteeism by skilled birth attendants in rural health facilities forced women to deliver with assistance of TBAs. Republic of Malawi (2012) affirmed that the main contributing factors to the high maternal morbidity and mortality ratio in Malawi included shortage of staff and weak human resource management, limited availability and utilization of maternal health services.

Negligence of skilled birth attendants

This study revealed that skilled birth attendants showed negligence in assessing women in labour to determine if a woman was really in labour. As such, women experienced self-delivery either in labour ward or on the way back home after they had been sent back home as the skilled birth attendants concluded that they were not in labour. Women therefore, were demotivated as they did not meet their expectations from trained skilled attendants and, as such, preferred to deliver at TBAs. Similarly, in a study by Kruger, Olsen, Mighay & Ali (2011) in Tanzania, it was found that women perceived quality of care of skilled birth attendants as poor. As a result, they could not give birth at a hospital, even at those geographically close sites.

Challenges in the community

Long distance to a health facility

The results for this study indicated that long distance created a barrier for women to deliver at health facilities with skilled attendants. As such, they preferred TBAs since they were easily accessible. Women failed to walk the long distances while in labour.

Additionally, financial challenges prevented them from paying for transport to a health facility. Therefore, it is viewed that leaving close to either a TBA or health facility is an indication for selecting delivery care services. This is supported by a study in Tanzania which found that although health facilities were available in most of the rural areas, it was still difficult to utilize the services because of long distance (Roggeveen, et al., 2013: Esena & Sappor, 2013: Pyone, Adaji, Madaj, Woldetsadik & Van den Broek, 2014b) and unaffordable cost of transport to pay for the long distances (Simfukwe, 2011). In this light, Government of Malawi (2011) states that to improve access to health services, the Ministry of Health and stakeholders will construct health facilities so that the majority of Malawians live within an 8 kilometers radius of a health facility. However, this is not within a walking distance. Furthermore, a study in Gambia as documented by Okonofua & Ogu (2014) indicated that despite rural women awareness of the benefits of delivery in health care institutions with skilled providers, the majority of the women delivered with TBAs. This was due to, among other factors, personal constraints, lack of transportation. Additionally, it was suggested that provision of transport would likely be effective in increasing the proportion of women delivering with skilled birth attendants. This is similar to the suggestions that were provided by the participants in this study that there should be provision of ambulances to collect mothers in labour from their homes and that the government should procure bicycle ambulances for transporting women to a health facility.

Lack of physical transport

This study revealed lack of physical transportation in the community especially during the night as some of the barriers that made women fail to deliver at health

facilities with assistance of skilled birth attendants. This concurs with a study by Feyissa & Genemo (2014) which affirmed that physical distance was one of the major constraints that prevented community members from accessing and utilizing institutional delivery. It was noted that vehicles for transportation were not available in the community though distances were long to a health facility. This prevented women from delivering with assistance of skilled birth attendants. Walking is the main form of transportation in rural Africa as a result of lack of motor vehicle for transport services. There is poor public transport system. Furthermore, this current study and that of Mwangome, et al. (2012) agree that, in many instances, even if mothers can afford to pay transport, the vehicle may not be available at the time they needed it. Therefore, this was viewed as an underlying issue for delivery at TBAs and barrier for health facility delivery with skilled birth attendants.

Suggestions/comments for improving policy change for TBAs

Suggestions for policy makers in the Ministry of Health Organization

The results for this study indicated that most of the participants were in support of the policy change for TBAs. They were in support of the policy since it would help to reduce maternal and newborn deaths. While on one hand, some participants expressed need to comply with the policy change because they were denied health services once they delivered at TBAs, on the other hand, some participants insisted that TBAs should continue conducting deliveries. Additionally, participants said a house should be built for a TBA for conducting deliveries for those women who were unable to walk to a health facility rather than delivering in TBAs personal houses.

Some participants suggested that the government should procure bicycle ambulances for the community for transporting pregnant women from their homes, TBAs or village headman to a health facility. Additionally, this bicycle ambulance should stay at TBA or village headman. It should also be used to transport women who have failed to deliver at TBA to a health facility. This is in line with a study by Titaley, et al. (2010) in Indonesia which found that the services of skilled birth attendants, were perceived important by community members only during obstetric complications. However, in support of the literature review, it has already been stated that TBAs do not bring positive change of reducing maternal mortality. Therefore, TBAs should not continue conducting deliveries. This research supports that otherwise; TBAs should adhere to their new roles of encouraging and referring clients to deliver with the assistance of skilled birth attendants at a health facility. In addition, community health nurses should educate women and men on the benefits of assistance of women at birth with skilled birth attendants to foster utilization.

However, in a study conducted in Tanzania, it was suggested to offer free transportation from home to a health facility for pregnant women to increase institutional deliveries with skilled attendance at birth. Consequently, the number of deliveries increased greatly at a hospital since this strategy was introduced (Kruger, et al., 2011).

Suggestions in the community

The results for the present study revealed that some participants said that they would increase their farm outputs which they would sell and use the finances to buy birth preparedness materials. Participants failed to deliver at health facilities because they did not have these materials and chose to deliver at TBAs. In Sierra Leone, women still

preferred to deliver assisted by TBAs despite government discouragement and provision of free facility delivery service in 2010 in government health facilities. As such, it was suggested to reinforce community level by-laws to prevent TBAs from conducting deliveries (Giovanna, 2013). Some adhere to by-laws such as in Mchinji District (Malawi Government, 2012). However, some districts in Malawi have by-laws. Some adhere to by-laws such as in Mchinji District (Malawi Government, 2012). Others do not.

Suggestions for improving policy change for TBAs in health delivery services

Some participants suggested that health facilities should be built at Mchelela Health Post and Chasefu to reduce the physical distance between their homes and the suggested health facilities. This suggestion is good as it will help to bring the delivery services with skilled birth attendants closer to the communities to enhance their utilization. This is in line with what worked in India and Bangladesh whereby skilled health personnel were deployed close to communities. This was associated with an increase in skilled attendance at birth (Vieira, et al., 2012). It is suggested to build health centres and deploy skilled birth attendants at health centres within walking distances for women in Malawi. It is hoped that this would increase skilled attendance at birth.

The results for the current study indicated that participants suggested that nurses should be available at health facilities to provide delivery services. Additionally, participants commented that nurses should demonstrate positive attitudes towards women in labour by quick attention, talking to women warmly and allowing a birth companion in labour ward. This concurs with suggestions that were made in a study conducted in Tanzania that there was need to change skilled providers' attitudes and practices to foster delivery with skilled attendants (Magoma, et al., 2010b).

Recommendations of the study

A number of issues have been identified from this study that could be useful in preventing childbirth with the assistance of TBAs. Therefore, the following are the recommendations;

Ministry of Health should collaborate with other stakeholders such as Ministry of Transport and Public Works to promote vehicular access through improved physical access by construction of roads. This was raised by participants that availability of physical transport was a challenge to reach a health facility. This would enable women in labour who had money to pay for transport to access health facilities and enhance health facility delivery especially at night when physical transport was a challenge. The physical barrier would therefore be eliminated that prevent women from accessing health facility delivery.

Ministry of Health should collaborate with Ministry of Education, Science and Technology to campaign for improved education so as to improve literacy. Consequently, the communities will be better informed of health issues. They will understand the risk of delivering with the assistance of TBAs since they will be more knowledgeable. The knowledge will also aid to eliminate beliefs towards delivery services at TBAs which are risky. Additionally, they will obtain opportunities for job employment to eliminate their financial challenges.

Ministry of Health should collaborate with organizations to come up with poverty alleviation strategies. For instance, these can assist in income generating activities (IGAs) to improve socio-economic status of the communities as the participants expressed that they were poor. Generated money would be used to buy birth preparedness materials and

pay transport costs to health facilities. Therefore, such poverty alleviation strategies would contribute to improving access and utilization of skilled birth attendants at births by preventing financial barrier.

Ministry of Health should collaborate with Ministry of Gender, Children, Disability and Social Welfare to empower women on decision making. This would limit gender inequalities. Subjective norms would therefore not influence women to deliver at TBAs. Consequently, implementing the policy change for TBAs will be effective.

Community Health Nurses should intensify community mobilization sensitizing communities to gain knowledge on the policy change for TBAs. This will prevent women from delivering with the assistance of TBAs and at the same time enhance health facility delivery assisted by skilled birth attendants. Campaigns should be enhanced against cultural practices that are risky that promote women to deliver at TBAs. These include gender inequalities whereby men or mothers in-law are main decision makers on place of delivery. Additionally, beliefs in taking local medication to facilitate delivery should be discouraged.

Community health nursing managers should mobilize resources so that community groups of both men and women should be oriented on the policy change for TBAs so that they should be imparting this knowledge to community members in their respective areas. As such, community health managers should advocate in the District Implementation Plan (DIP) for such a programme. Communities will therefore be empowered with knowledge for them to understand risks of delivering at TBAs.

Skilled birth attendants should be deployed on a permanent basis in health centres so as to enhance accessibility by pregnant women in labour as it was raised by participants that they were changed very frequently. Women could not find a skilled birth attendant when they went for delivery after the other attendant had completed her/his relief duties and had left. This would eliminate the barrier that prevented women from delivering with the assistance of skilled births attendants.

Nursing Research (Areas for further study)

A study should be done to investigate preference of women on home deliveries not assisted by TBAs in the district since this current study concentrated on deliveries conducted by TBAs only. The study should be done because some participants stated that they delivered with the assistance of TBAs after failing to deliver at their homes. They wanted to deliver at their homes just like other daughters in-law did because they were coerced by their mothers in-law to do so.

Another study could be done to find out TBAs' practices on the new roles assigned to them since in this current study, they were not interviewed.

Limitations/constraints of the study

The results may not be generalized to the whole country because the study was conducted in one district only and the participants were purposively sampled. However, the study findings may help decision and policy makers to effectively develop the best strategies to prevent pregnant women from delivering with the assistance of TBAs. Consequently, this will lower maternal mortality and improve maternal health.

Conclusion

This study has provided insight into why women prefer delivering with the assistance of TBAs at catchment areas of Mkoma and Manyamula Health Centres and Mzimba District Hospital despite policy change for TBAs. The several reasons mentioned were lack of awareness of participants on policy change for TBAs, women's lack of decision making power influenced by beliefs, culture, low level of education and influence of subjective norms. Included were barriers that participants mentioned. These included challenges in families such as lack of birth preparedness, financial constraints and denial of women's rights. Challenges in health facilities women experienced included disrespect/poor attitude of skilled birth attendants, absenteeism of skilled birth attendants at health facilities and negligence of skilled birth attendants. Challenges in the community that hindered women to deliver with skilled attendants included long distances to health facilities, lack of physical transport and women's or men's low level of education.

The study has also revealed comments and suggestions made by participants on this policy. Most participants were in support of the policy since they believed it would help to reduce maternal deaths. However, some participants were against the policy because of the barriers they encountered.

It is suggested that multi-sectoral collaboration should be functional after formulation of policies for easy implementation of this policy change for TBAs. Barriers pointed out by participants should be eliminated to make the policy practical. However, community mobilization should be enhanced on this policy so that communities adhere to

the policy. This will consequently reduce maternal mortality and strive to meet the millennium development goal number 5.

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Appendices

Appendix A: Participants Information Sheet in English

STUDY TITLE: Traditional Birth Attendants (TBAs) are not allowed to assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?

You are being invited to take part in a research study on "Traditional Birth Attendants (TBAs) are not allowed to Assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?" Before you decide to participate in the study, it is important to understand why the research is being conducted and what it will involve. Please ask if there is anything not clear or if you would like more information. Participation is voluntary.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of the study is to investigate on "Traditional Birth Attendants (TBAs) are not allowed to Assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?" Findings from this study are expected to help bridge the gap in terms of how the problem can be fully resolved so that TBAs no longer play these old roles but concentrate on their new roles. Since deliveries conducted by TBAs have contributed to high maternal mortality, this study will help the district as well as the Malawi government generate information that will help them develop appropriate interventions to address the problem. The study will help decision and policy makers to effectively develop the best strategies to prevent pregnant women from delivering with the assistance of TBAs.

DO I HAVE TO TAKE PART?

Participation in this study is voluntary. You are free to take part or not or to withdraw at any time you feel like without giving reasons. Your refusal to take part in the study will not affect the quality of health care that you are going to receive. If you agree to take part, you will be asked to sign a consent form. Information about you will be confidential and no one will identify who answered which question as no names will be written on the interview guide. Code numbers will be used instead. In addition, no names will be

mentioned during the interviews to ensure anonymity. The interview responses will be destroyed at the end of the study.

WHAT WILL HAPPEN TO ME IF I TAKE PART?

You will be asked some questions about your seeking or your wife's seeking delivery with the assistance of a TBA. Your responses will be written on paper or will be tape recorded.

WHAT ARE THE POSSIBLE RISKS FOR TAKING PART?

There are no physical risks associated with the study. The probable risks include the psychosocial risks in terms of long time of attending to the interview.

WHAT ARE THE POSSIBLE BENEFITS FOR TAKING PART?

There are no immediate benefits to you but in future the findings of the study are expected to improve midwifery practice to attract mothers to deliver with the assistance of skilled birth attendants.

IF SOMETHING GOES WRONG WHAT WILL HAPPEN?

Complaints concerning how you have been treated during the course of the study you may call Dr. Lucy Kululanga my research supervisor on 0888 851 381or Kamuzu College of Nursing on 01 751 622 and talk to Dr. Alfred Maluwa the research director.

CONTACTS FOR FURTHER INFORMATION

If you need further information or you are worried, about any aspect of the study, please contact Ms. Atisiya Clara Mwase on 088 193 3786 or Dr Mkwinda Nyasulu on 0999 410 484.

OR

The COMREC Secretariat

College of Medicine

Private Bag 360

Blantyre 3

Malawi

Telephone number 01 871 911

Appendix B: Participants Information Sheet in Tumbuka

CHIKALATA CHA CHIMANYISKO CHAKAFUKUFUKU MU CHITUMBUKA

Chidumbirano cha Kafukufuku: Wazamba wali kukanizgika kubabizga bamama kwene kasi nchifukwa uli bamama mu boma la Mzimba wachali kubabila kuwazamba?

Vya kukhumbikwa kuwelenga

Mukuchemeka kuti mutolepo lwande mu kafukufuku wa kuti: Wazamba wali kukanizgika kubabizga bamama kwene kasi nchifukwa uli bamama mu boma la Mzimba wachali kubabila kuwazamba? Pambele mundaghaneghane kuti munjile mukafukufuku uyu, nchakukhumbikwa kuti mupulikiske chilato cha kafukufuku uyu na vyose ivyo vikukhumbikwa kuti muchite. Mufumbe mafumbo pala panyake mwaleka kupulikiska panje pala mukukhumba kuti tisazgirepo vinyake vyakuyowoya. Mukuchichizgika yayi kutolapo lwande mukafukufuku uyu, kweneso muli na wanangwa wakukakana panje kutolapo lwande mwa khumbilo linu.

Kasi chilato cha kafukufuku uyu nchi vichi?

Chilato cha kafukufuku uyu nchakuti timanye vifukwa ivyo bamama wachali kubabila kwa wa zamba muboma la Mzimba apo wazamba wali kukanizgika kubabizga bamama. Ivyo tisangenge mukafukufuku uyu viwovwirenge kumazga suzgo ili mwantheula wazamba wagwirenge nchito zawozasono pela. Kubabizga wazamba kukukuzga unandi wa bamama awo wakufwa chifukwa chakubaba. Mwantheula kafukufuku uyu wawovwirenge boma la Mzimba na la Malawi kusanga nthowa zakumazgira suzgo ili. Wawovwirengeso awo wakupanga malango kukhazikiska nthowa ziweme chomene zakuti bamama waleke kukababila kwa wazamba.

Kasi ndingatolapo lwande pa kafukufuku uyu?

Muli na wanangwa wakutolapo lwande panji kuleka. Muli na wanangwa wakulekezga panthowa pala mwa njira mukafukufuku uyu kwambula kuyowoya vifukwa kweneso pawengeve kukana kumuwovwirani ku chipatala. Pala muzomerenge kutolapo lwande mukafukufuku uyu, mukwenela kusimikizga pakusayina papepala. Mazgolo yinu yasungikenge mwachibisi, mwantheula palije uyo wamanyenge kuti ndimwe mukazgola mafumbo awo tifumbenge chifukwa pawengevi kulemba zina linu papepala. Tigwiriskenge nchito manambala mumalo mwa zina linu. Mapepala ya mafumbo na mazgolo yose yazamuwocheka pala kafukufuku wamalapo.

Kasi chichitikenge nchivichi pala natolapo lwande?

Pala mwazomela kutolapo lwande mufumbikenge mafumbo ya kukwaskana na vifukwa ivyo muchali kubabila kwa wa zamba panje wanakazi winu wachali kubabila kwa

wazamba apo dango lilikusintha. Mukupempheka kuzgola mafumbo mwa unenesko. Ivyo muzgolenge vilembekenge pa pepala kweniso tijambulenge mazgo yinu na kusunga makola.

Kasi masuzgo awo yangasangika pa kutolapo lwande ni ngani?

Palije suzgo ilo musanganenge nalo chifukwa cha kafukufuku uyu kupatula kuti mungatola nyengo yitali kuzgola mafumbo chifukwa yangakhumba kughanaghana chomene.

Kasi uwemi wa kafukufuku uyu ni vichi?

Palije kwa nyengo yasono chiweme pakutolapo lwande mukafukufuku uyu kwene kunthazi wawovwirenge kuti pazasangike dango mwantheula bamama wakakopeke kubabila kuchipatala kuti nyifwa za uchembele ziwe zichoko.

Pala mungawa na fumbo paji panyake mundapulikiske

Mungamanya kuyimbila foni mama Atisiya Clara Mwase pankhani iyi ya kafukufuku. Nambala yawo ni 088 193 3786 panje mama awo wakuwadangilila a Dokotala Lucy Kululanga. Nambala yawo ni 0888 851 381.

Pala pasangika vya kusuzga na kafukufuku kasi pachitike vichi?

Pala pangasangika suzgo lili lose na kafukufuku, mungayowoya suzgo linu pakuyimba kwa Dokotala Betty Mkwinda Nyasulu pa nambala ya 0999 410 484. Mungayimbaso ku sukulu ya manesi na wa zamba ku Kamuzu College of Nursing pa foni iyi 01 751 622 nakuyowoya na a Dokotala Alfred Maluwa mudangilili wakafukufuku uyu.

Mungamanyaso kuyowoya suzgo linu pa nambala iyi:

COMREC Secretariat

College of Medicine

Private Bag 360

Blantyre 3

Malawi

Telephone number 01 871 911

Appendix C: Consent Form in English

Please read and sign this form if you have agreed to take part in this study

Traditional Birth Attendants (TBAs) are not allowed to assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?

1. I have read and (or have had another person read to me) the attached information sheet for this study and have understood its purpose.
2. I agree to voluntarily participate in the study, be interviewed and respond to the best of my knowledge. I understand that I am free to withdraw at any time without giving reasons and that this will not influence the healthcare given to me.
3. I know that I do not have to suffer any harm during the research process and that the information that I will give the researcher will not be used against me in future.
4. I understand that my information will be kept confidential and will only be accessed by the researcher or persons directly concerned with this study.
5. I understand that there will not be any financial or material gifts for my participation in this study.
6. I know how to contact the researcher if I need to.

I voluntarily agree to take part

....

Participant's Name Signature/Thumb Print Date

....

Name of the interviewer Signature Date

Thank you for your participation in the research

Appendix D: Consent Form in Tumbuka

CHIKALATA CHA KUZOMELEZGA

Sayinani chikalata ichi pala mwazomelezga kutolapo lwande mu kafukufuku uyu

Chidumbirano cha kafukufuku: Wazamba wali kukanizgika kubabizga bamama kwene kasi nchifukwa uli bamama mu boma la Mzimba wachali kubabila kuwazamba?

1. Ndazomelezga kutolapo lwande pakafukufuku uyu kwambula kuchichizgika, kufumbika mafumbo na kuzgola mafumbo na umo nkhumanyira. Napulikiska kuti nili mwanangwa kuleka nyengo ili yose kwambula kuyowoya vifukwa. Kweneso kuleka kwane kutondeskenge yayi wa kuchipatala kunipa wovwiri wa ku chipatala.
2. Nkhumanya kuti nkhwenela kusanga suzgo yayi pakutolapo lwande mu kafukufuku uyu.
3. Ivyo niyowoyenge mukafukufuku uyu vizakuniwelela yayi.
4. Napulikiska kuti vyose ivyo niyowoyenge mu kafukufuku uyu visungikenge mwachisisi ndipo vigwiriskikengi nchito na awo wakupanga kafukufuku uyu pela na awo wakukhwaskana na udangilili wa kafukufuku uyu.
5. Napulikiska kuti palije kupoka ndalama panji katundu waliyose mu kafukufuku uyu.
6. Nkhumanya umo ningasangira awo wa kuchitiska kafukufuku uyu pala wangakhumbikwa.

Ndazomelezga kutolapo lwande mukafukufuku uyu.

.....	.....	.....
Zina la uyo watolengepo lwande	Dazi	Siginechele/Chidindo
.....	.....	.....
Zina la wakufumba mafumbo	Dazi	Siginechele

Yewo pakutolapo lwande mu kafukufuku uyu

Appendix E: Face to Face Interview Guide English Version

Interview guide for: Traditional Birth Attendants (TBAs) are not allowed to assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?

Participant number.....

Health facility number.....

Date.....

SECTION A: Demographic Data

Question Number	**Question**	**Possible Answers and their Codes**
1	How old are you?	18-24……...1 25-34……..…2 35-44…….…...3 45-49…….…...4
2	What is your marital status?	Single……1 Married…….2 Divorced……..…….....3 Widow…….....4 Separated…….....5 Others (Specify)…….……..6

3	What is your religion?	Christian……..1 Muslim……....2 Traditional…….…..3 No religion……..4 Other (specify)……5
4	If you are a Christian which denomination do you belong to?	Roman Catholic……...…1 Anglican……2 C.C.A.P…….…..…….3 Pentecostal……...4 Seventh Day Adventist……5 Others (Specify)……..……...6
5	Which tribe do you belong to?	Chewa…….……..…1 Tumbuka…….……..…2 Lomwe……..…3 Yao…….……..4 Ngoni…….…….……..5 Mang'anja……6 Other (specify)……..…7
6	Have you ever	Yes…….……1

	attended school?	No…….……..2
7	What is the highest level of education you attended?	Primary……..……..1 Secondary……..……..2 Tertiary……..……..3 Literacy school……..……..4
8	What is your main source of income?	Employment…….……..…..1 Business……2 Farming……..…….….3 Other (specify)……..……..4
9	What is your occupation?	None……..……1 Accountant…….....2 Policewoman……3 Nurse……4 Business lady….....5 Teacher……..…..6 Student…….....7 Farmer……..8 Others (Specify)….....9

10	If married what is the highest level of education your husband attained?	Primary……1 Secondary……2 Tertially……...3 Literacy school……4
11	What is the occupation of your husband?	Government employed…….……1 Privately employed……...2 Self employed……..3 Unemployed…….4 Student…….5
12	How many children do you have?	1…….……1 2…….……2 3…….……3 4…….4 5…….5 6……...More than 5

Knowledge on Policy Change for TBAs

Question:

13. Can you tell me about what you know on Policy Change for TBAs?

Probes

- How did you know?
- Who informed you?
- Why do you think they informed you?
- What do you like about it?
- Why?
- What do you dislike about it?
- Why?

Beliefs towards Delivery Services at TBAs

Question:

14. Can you explain your perception about utilizing TBA for delivery?

Probes

- What made you decide to deliver with the assistance of TBA despite policy change for TBAs?
- What are your feelings now after delivery at TBA?
- What would you share then with other women about delivering at TBAs?

Subjective Norms

Question:

15. Can you explain who influences people in deciding pregnant women's choice of place of delivery in this area?

Probes

- Why is it so?
- Who influenced you to deliver at TBA?
- Why was it so?

Barriers to deliver with Skilled Attendant

Question:

16. Can you explain the challenges if any, from the community to deliver with skilled attendant?

17. Can you explain the challenges if any, at health facilities to deliver with skilled attendant?

18. Can you explain the challenges if any, in your families, to deliver with skilled attendant?

Question:

19. Can you give your suggestions or comments if any for improving Policy Change for TBAs?

Probes

- Any suggestions for policy makers in the Ministry of Health Organization?
- Any suggestions in the community?
- Any suggestions in health delivery services?

Appendix F: Face to Face Interview Guide Tumbuka Version

Mafumbo ya kafukufuku wa kuti: Wazamba wali kukanizgika kubabizga bamama kwene kasi nchifukwa uli bamama mu boma la Mzimba wachali kubabila kuwazamba?

Nambala ya wakuzgola mafumbo.....

Nambala ya chipatala.....

Dazi.....

.....

Chigawa chakwamba: Mbiri Yinu

Nambala la Fumbo	**Fumbo**	**Mazgolo na Nambala**
1	Muli na vyaka vilinga?	18-24……...1 25-34……..…2 35-44…….…....3 45-49…….…....4
2	Kasi muli kutengwa/ Jiyowoyani za Kukhwaskana na nthengwa?	Ndindatengwe……1 Nilikutengwa……..2 Nthengwa ili kumala……..…….....3 Chokolo…….....4 Tilikupatukana…….....5 Chinyake…….……6

3	Chisopo chinu ni vichi?	Mkhristu……..1 Musilamu……....2 Chawapapi…….……..3 Nkhusopa ayi…….4 Chinyake…….5
4	Pala muli Mkhrisitu, mukusopa tchalitchi wuli?	Roman Catholic……...…1 Anglican……2 C.C.A.P…….…..…….3 Pentecostal……...4 Seventh Day Adventist……5 Chinyake……..…….....6
5	Mtundu winu ni vichi?	Chewa…….……..…1 Tumbuka…….……..…2 Lomwe…….…3 Yao…….……..4 Ngoni…….…….……..5 Mang'anja……6 Linyake…….……7
6	Muli	Enya…….……1

	kusambirapo sukulu?	Yayi…….……..2
7	Sukulu mulikulekezgha mphani?	Pulayimale……..……..1 Sekondale……..……2 Koleji……..……3 Sukulu ya kwacha……..……4
8	Kasi ni nchito uli iyo chomene mukusangira ndalama?	Kulembeka nthito……..…..1 Bizinesi……2 Ulimi……..…….……..3 Inyake……..…….4
9	Mukugwira ntchito uli?	Palije……..……1 Kusunga ndalama…….....2 Yawupolisi…….3 Nesi……4 Bizinesi….....5 Msambizi……..….6 Mwana wa sukulu…….....7 Mlimi……..8 Panji nchito uli.....9

10	Pala muli kutengwa, mfumu winu wali kulekezga mphani sukulu?	Pulayimale……..1 Sekondale……2 Koleji…….....3 Sukulu ya kwacha……4
11	Mfumu winu wakugwira ntchito uli?	Walikulembeka ya boma…….……1 Wakugwira ku pulayiveti……2 Wakugwira nchito yake…..……..3 Walipa nchito yayi……...4 Wali pa sukulu…….5
12	Mulikubabapo kalinga?	1…….……1 2…….……2 3…….……3 4…….4 5…….5 Kujumpha kankhondi …….6

Chigawa chachiwiri: Kamanyiro ka Bamama kukhwaskana na kusinthika kwa dango la wazamba

Fumbo:

13. Kasi munganiphalila vichi ivyo mukumanya kukhwaskana na kusinthika kwa dango la wazamba?

Probes

- Kasi mukamanya uli?
- Wakamuphalilani mbanjani?
- Kasi mukuwona kuti nchifukwa uli wakamuphalilani?
- Kasi icho chikumukondweskani mudango ili nchivichi?
- Nchifukwa uli icho mwayowoya chikumukondweskani?
- Kasi chilipo icho chikuleka kumukondweskani mudango ili?
- Nchifukwa uli chikuleka kumukondweskani?

Chigawa chachitatu: Vigomezgo kukhwaskana na kubabila ku wazamba

Fumbo:

14. Kasi munganiphalila vichi kukhwaskana na wovwiri wa wazamba pa ivyo vikumughanaghaniskani kukababila kwa wazamba?

Probes

- Kasi mungayowoya nchivichi icho chikamughanaghaniskani kukababila kwa wazamba nanga uli dango lilikusinthika?
- Kasi sono maghanoghano yinu yali uli na umo mulikubabila kwa wazamba?
- Kasi bamama wanyinu mungawaphalila vichi za kukhwaskana na kubabila kwa wazamba?

Chigawa chachinayi: Wadangilili awo wakugamula

Fumbo:

15. Kasi mbanjani awo wakudangilila kugamula malo awo mama wanthumbo wamubabila

mudela linu?

Probes

- Nchifukwa uli?
- Kasi mbanjani awo wakagamula kuti mukababile kwa wazamba?
- Nchifukwa uli?

Chigawa chachinkhonde: Ivyo vikutondekeska kukababila ku chipatala nawakusambizgika wakuchipatala

Fumbo:

16. Kasi ni masuzgo uli pala yalipo yakukhwaskana na kuchikaya ayo yakumutondeskani kukababizgika na wakusambizgika wa kuchipatala?

17. Kasi ni masuzgo uli pala yalipo yakukhwaskana na kuchipatala ayo yakumutondeskani kukababizgika na wakusambizgika wa kuchipatala?

18. Kasi ni masuzgo uli pala yalipo yakukhwaskana na munyumba yinu ayo yakumutondeskani kukababizgika na wakusambizgika wa kuchipatala?

19.Kasi masachizgo yinu panje ndemanga yinu ni vichi kukhwaskana nakusinhika kwa dango la wazamba kuti dango linozgekeso pala nkhwakwenelela?

Probes

Kasi masachizgo yinu nivichi kukhwaskana na awo walikupanga dango mu nduna ya zaumoyo?

- Kasi masachizgo yinu nivichi kukhwaskana na dango ili muchikaya?
- Kasi masachizgo yinu nivichi kukhwaskana na dango ili ku chipatala?

Appendix G: Focus Group Discussion Guide English Version

Interview Guide on: Traditional Birth Attendants (TBAs) are not allowed to assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?

Name of group being interviewed……..…

Date……

Time discussion started……..

Time discussion ended…….

Welcome

I thank you for coming and agreeing to assist me with my research. My name is Atisiya Clara Mwase and my research assistant is Agness Mkonda. I am a student at Kamuzu College of Nursing. I am conducting a research which is part of the requirements for the partial fulfillment of Master of Science Degree Programme in Community Health Nursing which I am pursuing. The College of Medicine Research and Ethics Committee has approved the research proposal. I am conducting a study titled: "Traditional Birth Attendants (TBAs) are not allowed to assist Childbirth but why are Women in Mzimba District Still Giving Birth with the Assistance of (TBAs)?" The study will help decision and policy makers to effectively develop the best strategies to prevent pregnant women from delivering with the assistance of TBAs. This will consequently reduce maternal morbidity and mortality.

The focus group discussion will last approximately 60minutes. I will ask you a number of questions which you should feel free to respond or not. There is no right or wrong answer to these questions. I value your opinions and knowledge to this topic as such I will tape record the discussions so that I can revisit responses. If this tape recording is a discomfort to you, let me know so that I just write down your responses on paper. The research assistant (note taker) will be taking notes to help me remember what you said during the discussion.

Introduction

I would like to start by asking each one of you to introduce yourselves. Please tell us your name

or the name you would like to be addressed during the discussion, and if you would like your age and your previous work experience if any. After introducing yourselves, please feel free to speak whenever you have something to say. However, you should listen to others in the group and value their comments when they are speaking. Additionally, you are all allowed to speak.

Can I start Yes/No?

Questions to guide the discussion

Knowledge on policy change for TBAs

Question:

Can you tell me about what you know on Policy Change for TBAs?

Probes

- How did you know?
- Who informed you?

- Why do you think they informed you?
- What do you like about it?
- Why?
- What do you dislike about it?
- Why?

Beliefs towards delivery services at TBAs

Question:

Can you explain your perception about utilizing TBAs for delivery?

Probes

- What makes women decide to deliver with the assistance of TBAs despite policy change for TBAs?
- What are your feelings now after delivery at TBA or after your wife has delivered at TBA?
- What would you share then with other women about delivering at TBA or after your wife has delivered at TBA?

Subjective Norms

Question:

Can you explain who influences people in deciding pregnant women's choice of place of delivery in this area?

Probes

- Why is it so?
- Who influenced you or your wife to deliver at TBA?
- Why was it so?

Barriers to deliver with skilled attendant

I would like to know if there are any barriers to deliver with skilled attendant as per policy requirement.

Question:

- Can you explain the challenges if any, from the community to deliver with skilled attendant?
- Can you explain the challenges if any, at health facilities to deliver with skilled attendant?
- Can you explain the challenges if any, in your families, to deliver with skilled attendant?

Concluding Question

Finally, I would like you to give your suggestions or comments for improving Policy Change for TBAs.

- Any suggestions for policy makers in the Ministry of Health Organization?
- Any suggestions in the community?
- Any suggestions in health delivery services?

Closing Remarks

This will include thanking the people for their time spent, ideas, suggestions and comments made during the discussion which will assist the researcher to come up with a write up after going through the information. The participants will be told that dissemination of findings will be made to local and international conferences, seminars and meetings with relevant stakeholders. In addition, the findings will be disseminated through journal. Copies of the final dissertation will be submitted to the Ministry of Health (Reproductive Health Unit) and respective health facilities, COMREC secretariat, College of Medicine Library, and Kamuzu College of Nursing Library. Finally, they will be told that their information will assist to improve on Policy Change for TBAs consequently, reduce maternal mortality.

Appendix H: Focus Group Discussion Guide Tumbuka Version

Mafumbo ya kafukufuku wa kuti: Wazamba wali kukanizgika kubabizga bamama kwene kasi nchifukwa uli bamama mu boma la Mzimba wachali kubabila kuwazamba?

Zina La Gulu Ilo Lifumbikenge

Mafumbo……

Dazi……

Nyengo yakwambira kufumba mafumbo……..…

Nyengo yakumalira kufumba mafumbo……

Tamupokelelani

Nkhumuwongani chifukwa chakwiza kwinu nakuzomelezga kuzakaniwovwila pakutolapo lwande mukafukufuku uyu. Zina lane ni Atisiya Clara Mwase ndipo wakwovwirana nane mba Agness Mkonda. Ine nkhusambira pa sukulu ya manesi na wazamba ya Kamuzu College of Nursing. Nkhupanga kafukufuku icho nchimoza chakwenelela kukwaniliska pa masambilo ya pachanya ayo nkhusambila ya manesi yakukhwaskana na kupwelelela wanthu muchikaya (Master of Science Degree in Community Health Nursing).

Gulu la kuwonelela kafukufuku na malamulo la pa sukulu ya madokotala ya pachanya (College of Medicine Research and Ethics Committee) lili kunizomelezga kuchita kafukufuku uyu. Zina la kafukufuku uyu ni “Wazamba wali kukanizgika kubabizga bamama kwene kasi nchifukwa uli bamama mu boma la Mzimba wachali kubabila kuwazamba? Kafukufuku uyu wawovwirenge awo wakupanga malango kusanga nthowa ziweme chomene zakovwira bamama kuti waleke kukababila kwa wazamba kwene wakababilenge ku chipatatala. Mwantheula viwovwilenge kuchepeska nyifwa za bamama.

Vidumbirano vithu vitolenge pafupifupi mphindi 60. Nimufumbeninge mafumbo ndipo muwe wakumasuka kuyowoya kweneso mungaleka kuzgola fumbo. Palije kutola zgolo kuti ili ndilo la unenesko panje ili ndakubudika. Mazgolo na masachizo yinu yachindikikenge mwantheula ni jambulenge vidumbilano kuti nane nkhawelelemo pa kupulikizga. Pala kujambula mumasukenge

nako yayi, muyowoye mwantheula nilembenge waka papepala mazgolo yinu. Wakovwirana nane mukafukufuku uyu walembengeso pa lwande lakumujambulani kuti nikumbukile ivyo mwayowoya muvidumbirano.

Mazgo ya kwamba

Pakwamba nkhumupemphani kuti waliyose wajiyowoye kuti timanyane. Mujiyowoye zina linu, panje zina ilo mukukhumba kuti timuchemeninge, vyaka vinu na ntchito iyo mulikugwirapo. Pala mwamala kujiyowoya mbwenu muwe wakumasuka kuyowoya mazgolo yinu muvidumbirano ivi. Kwene tipulikizgenge pala munyithu wakuyowoya kulongola kumupa nchindi. Kweneso waliyose ngwakuzomelezgeka kuti wayowoyepo.

Kasi sono ningayamba kufumba mafumbo? Enya/Yayi

Mafumbo ayo yatilongozgenge

Kamanyiro ka Bamama Kukhwaskana na Kusinthika kwa Dango la Wazamba

Fumbo: Kasi munganiphalila vichi ivyo mukumanya kukhwaskana na kusinthika kwa dango la wazamba?

Probes

- Kasi mukamanya uli?
- Wakamuphalilani mbanjani?
- Kasi mukuwona kuti nchifukwa uli wakamuphalilani?
- Kasi icho chikumukondweskani mudango ili nchivichi?
- Nchifukwa uli icho mwayowoya chikumukondweskani?
- Kasi chilipo icho chikuleka kumukondweskani mudango ili?
- Nchifukwa uli chikuleka kumukondweskani?

Vigomezgo kukhwaskana na kubabila ku wazamba

Fumbo: Kasi munganiphalila vichi kukhwaskana na wovwiri wa wazamba mukawanawanilo kinu?

Probes

- Kasi nchivichi icho chikupangiska mama kukababila kwa wazamba nanga uli dango lilikusinthika?
- Kasi sono maghanoghano yinu yali uli na umo mulikubabila kwa wazamba panje na umo mwanakazi winu wali kubabila kwa wazamba?
- Kasi bamama wanyinu mungawaphalila vichi za kukhwaskana na kubabila kwa wazamba panje na umo wanakazi winu wali kubabila kwa wazamba?

Wadangilili awo wakugamula

Fumbo: Kasi mbanjani awo wakudangilila kugamula malo awo mama wanthumbo wamubabila mudela linu?

Probes

- Nchifukwa uli?
- Kasi mbanjani awo wakagamula kuti mukababile kwa wazamba panje mwanakazi winu wakababile kwa wazamba?
- Nchifukwa uli?

Ivyo vikutondekeska kukababila ku chipatala nawakusambizgika wakuchipatala

Sono nkhukhumba kumanya pala vilipo ivyo vikutondeska mama kukababila ku chipatala kulondezga kusintha kwa dango.

- **Fumbo**: Kasi ni masuzgo uli pala yalipo yakukhwaskana na kuchikaya ayo yakamutondeskani panje yakamutondeska mama kukababizgika na wakusambizgika wa kuchipatala?
- Kasi ni masuzgo uli pala yalipo yakukhwaskana na kuchipatala ayo yakamutondeskani panji yakamutondeska mama kukababizgika na wakusambizgika wa kuchipatala?
- Kasi ni masuzgo uli pala yalipo yakukhwaskana na munyumba yinu ayo yakamutondeskani panje yakamutondeska mama kukababizgika na wakusambizgika wa kuchipatala?

Mafumbo yaumalilo

- Kasi masachizgo yinu panje ndemanga yinu ni vichi kukhwaskana nakusinhika kwa dango la wazamba kuti dango linozgekeso pala nkhwakwenelela?

Probes

- Kasi masachizgo yinu nivichi kukhwaskana na awo walikupanga dango mu unduna wa zaumoyo?
- Kasi masachizgo yinu nivichi kukhwaskana na dango ili muchikaya?
- Kasi masachizgo yinu nivichi kukhwaskana na dango ili ku chipatala?

Mazgo yakujalila

Nkhumuwongani chifukwa cha nyengo iyi mwajipeleka, mfundo zinu, masachizgo yinu na ndemanga zinu muvidumbilano ivi, ivyo viniwovwilenge kulemba za kafukufuku uyu pala nane nawelelamo muvyose ivyo vyayowoyeka na kulembeka. Ivyo nilembenge muvidumbilano ivi vyamuyowoyeka ku misonkhano ichokoichoko na ikuluikulu kwa wanthu awo wakukhwaskika.

Kweneso vidumbilano ivi vyamulembeka kuti vikawelengekenge. Ivyo nilembenge vinyake

vyamupelekeka ku Unduna wa zaumoyo kweneso kuvipatala ivyo kwachitika kafukufuku uyu, ku COMREC secretariat, ku koleji yapachanya ya madokotala na kusukulu ya manesi na wazamba yapachanya. Mfundo zinu ziwovwilenge kunozga dango la kusinthika la wazamba mwantheula viwovwilengeso kuchepeska nyifwa za bamama.

Appendix I: Demographic characteristics of WCBA 18-49 years face to face interviews

Age of Participant

	Frequency	Percent	Valid Percent	Cumulative Percent
18-24	11	57.9	57.9	57.9
25-34	8	42.1	42.1	100.0
Total	19	100.0	100.0	

Marital Status of Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Married	19	100.0	100.0	100.0

Religion of Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Christian	19	100.0	100.0	100.0

Denomination of Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Roman Catholic	9	47.4	47.4	47.4
C.C.A.P	3	15.8	15.8	63.2
Other	7	36.8	36.8	100.0
Total	19	100.0	100.0	

Tribe of Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Tumbuka	17	89.5	89.5	89.5
Ngoni	2	10.5	10.5	100.0
Total	19	100.0	100.0	

Has the Participant attended school

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	19	100.0	100.0	100.0

Highest Level of Education of the Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Primary	16	84.2	84.2	84.2
Secondary	3	15.8	15.8	100.0
Total	19	100.0	100.0	

Main source of income for the Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Business	2	10.5	10.5	10.5
Farming	17	89.5	89.5	100.0
Total	19	100.0	100.0	

Occupation of the Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
None	17	89.5	89.5	89.5
Business Lady	2	10.5	10.5	100.0
Total	19	100.0	100.0	

Highest level of education attained by Participant's husband

	Frequency	Percent	Valid Percent	Cumulative Percent
Primary	15	78.9	78.9	78.9
Secondary	4	21.1	21.1	100.0
Total	19	100.0	100.0	

Occupation of Participants husband

	Frequency	Percent	Valid Percent	Cumulative Percent
Privately employed	2	10.5	10.5	10.5
Self employed	3	15.8	15.8	26.3
Unemployed	14	73.7	73.7	100.0
Total	19	100.0	100.0	

Number of children the participant delivered

	Frequency	Percent	Valid Percent	Cumulative Percent
1	3	15.8	15.8	15.8
2	5	26.3	26.3	42.1
3	4	21.1	21.1	63.2
4	5	26.3	26.3	89.5
5	2	10.5	10.5	100.0
Total	19	100.0	100.0	

Appendix J: Request for Approval

Kamuzu College of Nursing (Lilongwe Campus)

P/B 1

Lilongwe

29th October, 2013

The Chairperson

College of Medicine Research and Ethics Committee

Private Bag 360

Blantyre

Dear Sir,

SUBMISSION OF RESEARCH PROPOSAL FOR APPROVAL

I am a Master of Science in Community Health Nursing student at Kamuzu College of Nursing. I am expected to conduct research as a requirement for the fulfilment of the course. I have developed a research proposal titled **"policy change for TBAs: why are women in mzimba south district still preferring giving birth at the TBAs?"** I therefore, submit my research proposal for your approval.

Yours faithfully,

Atisiya Clara Mwase (Ms).

Appendix K: Letter of Introduction

University of Malawi
KAMUZU COLLEGE OF NURSING

PRINCIPAL
DR. A. MALATA, DipNur, MRM
B.Sc.MN, Ph.D.

P/BAG 1, LILONGWE, MALAWI
TELEPHONE: 265 (0) 1751 622/200
TELEGRAMS: NURSING
FAX: (0) 756 424
EMAIL: Principal@kcn.unima.mw
Website: www.kcn.unima.mw

Our Ref.:

30th October 2013

The Chairperson,
COMREC
Private Bag 360,
Chichiri
BLANTYRE 3.

Dear Sir

RE: SUPPORT LETTER FOR ATISIYA CLARA MWASE

Atisiya Clara Mwase is a student at KCN pursuing a Masters Degree in Community Health Nursing. As a requirement for the fulfilment of a masters degree, she is required to submit a thesis. I am therefore writing to support the submission of her proposal tittled: "***Exploring why some women still prefer giving birth at Traditional Birth Attendants in Mzimba South District despite policy change for TBAs.***"

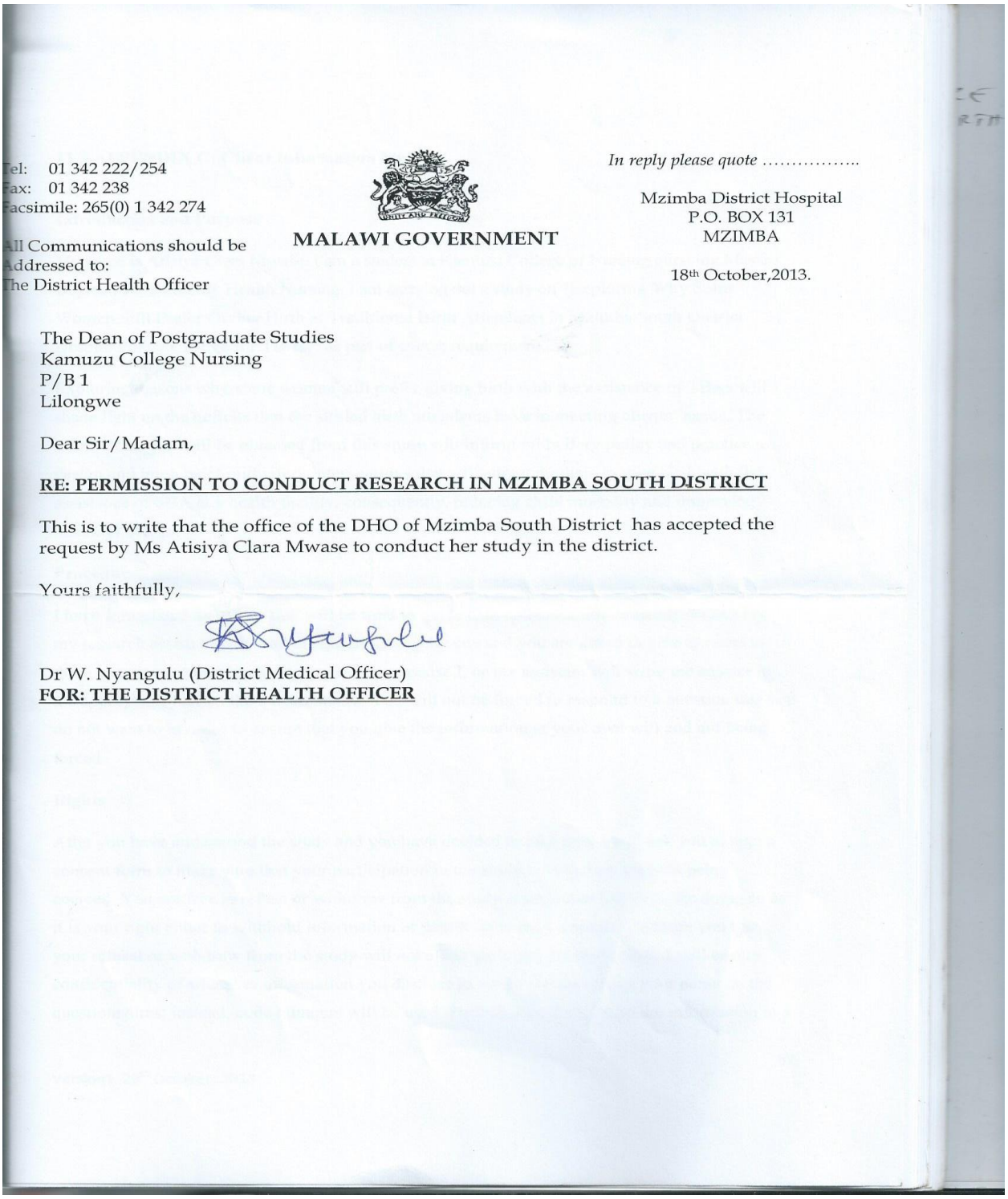
Atisiya Clara Mwase has worked with her supervisors and the proposal is now ready for submission.

Thanking you in advance for considering her proposal.

Yours faithfully,

Betty Mkwinda Nyasulu, PhD.
SUPERVISOR AND SENIOR LECTURER

Appendix L: Letter of permission to conduct study in Mzimba District



Tel: 01 342 222/254
Fax: 01 342 238
Facsimile: 265(0) 1 342 274

All Communications should be Addressed to:
The District Health Officer

MALAWI GOVERNMENT

In reply please quote ……..

Mzimba District Hospital
P.O. BOX 131
MZIMBA

18th October,2013.

The Dean of Postgraduate Studies
Kamuzu College Nursing
P/B 1
Lilongwe

Dear Sir/Madam,

RE: PERMISSION TO CONDUCT RESEARCH IN MZIMBA SOUTH DISTRICT

This is to write that the office of the DHO of Mzimba South District has accepted the request by Ms Atisiya Clara Mwase to conduct her study in the district.

Yours faithfully,

Dr W. Nyangulu (District Medical Officer)
FOR: THE DISTRICT HEALTH OFFICER

Appendix M: Letter of permission to pre-test the Research Instrument

Tel: 01 342 222/254
Fax: 01 342 238
Facsimile: 265(0) 1 342 274

All Communications should be Addressed to:
The District Health Officer

MALAWI GOVERNMENT

In reply please quote .....

Mzimba District Hospital
P.O. BOX 131
MZIMBA

13th November, 2013.

The Dean of Postgraduate Studies
Kamuzu College of Nursing
Private Bag 1
Lilongwe

Dear Sir/Madam,

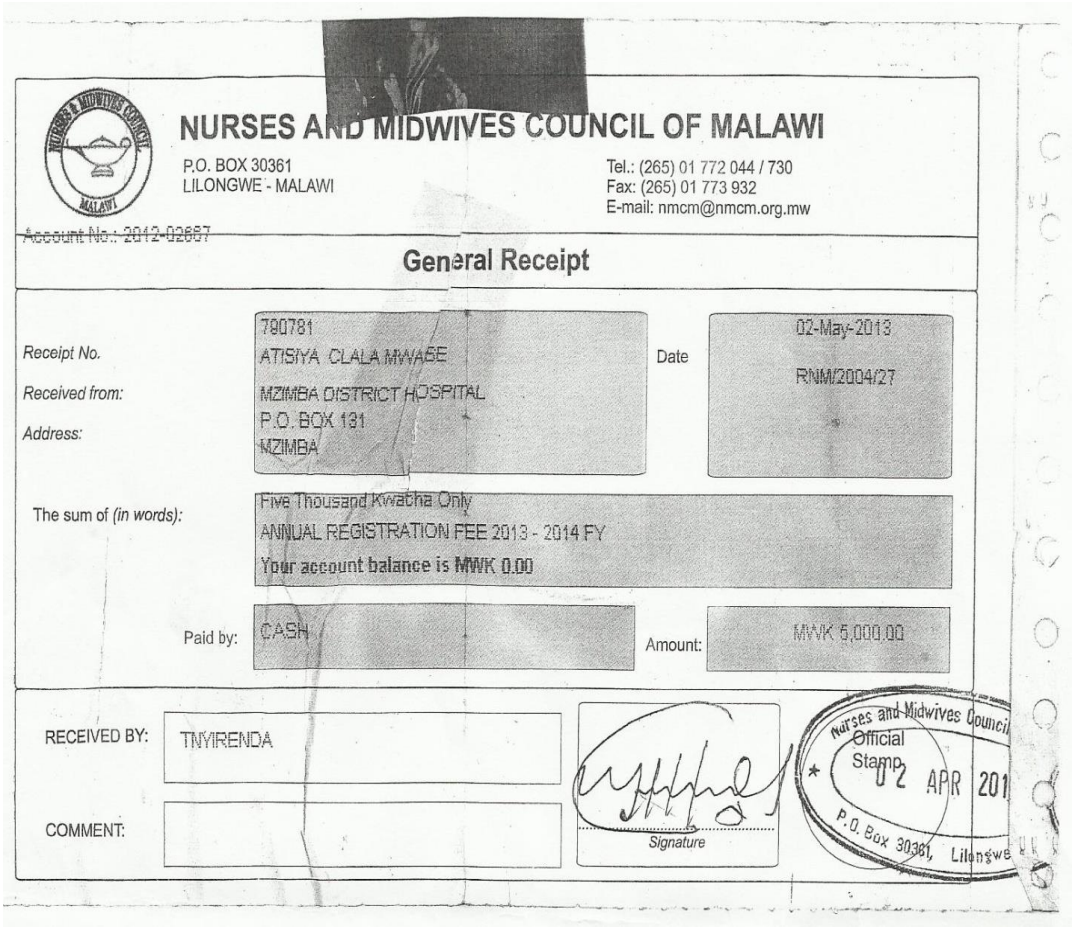
PERMISSION TO CONDUCT A RESERCH STUDY TO PRETEST THE RESEARCH INSTRUMENT

This is to write that the office of the DHO of Mzimba South District has accepted the request by Ms Atisiya Clara Mwase to pretest the research instrument.

Yours faithfully,

Dr A. Mbewe
DISTRICT HEALTH OFFICE

Appendix N: Copies of Nurses & Midwives Council Registration for Principal Investigator



NURSES AND MIDWIVES COUNCIL OF MALAWI

P.O. BOX 30361
LILONGWE - MALAWI

Tel.: (265) 01 772 044 / 730
Fax: (265) 01 773 932
E-mail: nmcm@nmcm.org.mw

Account No.: 2012-02687

General Receipt

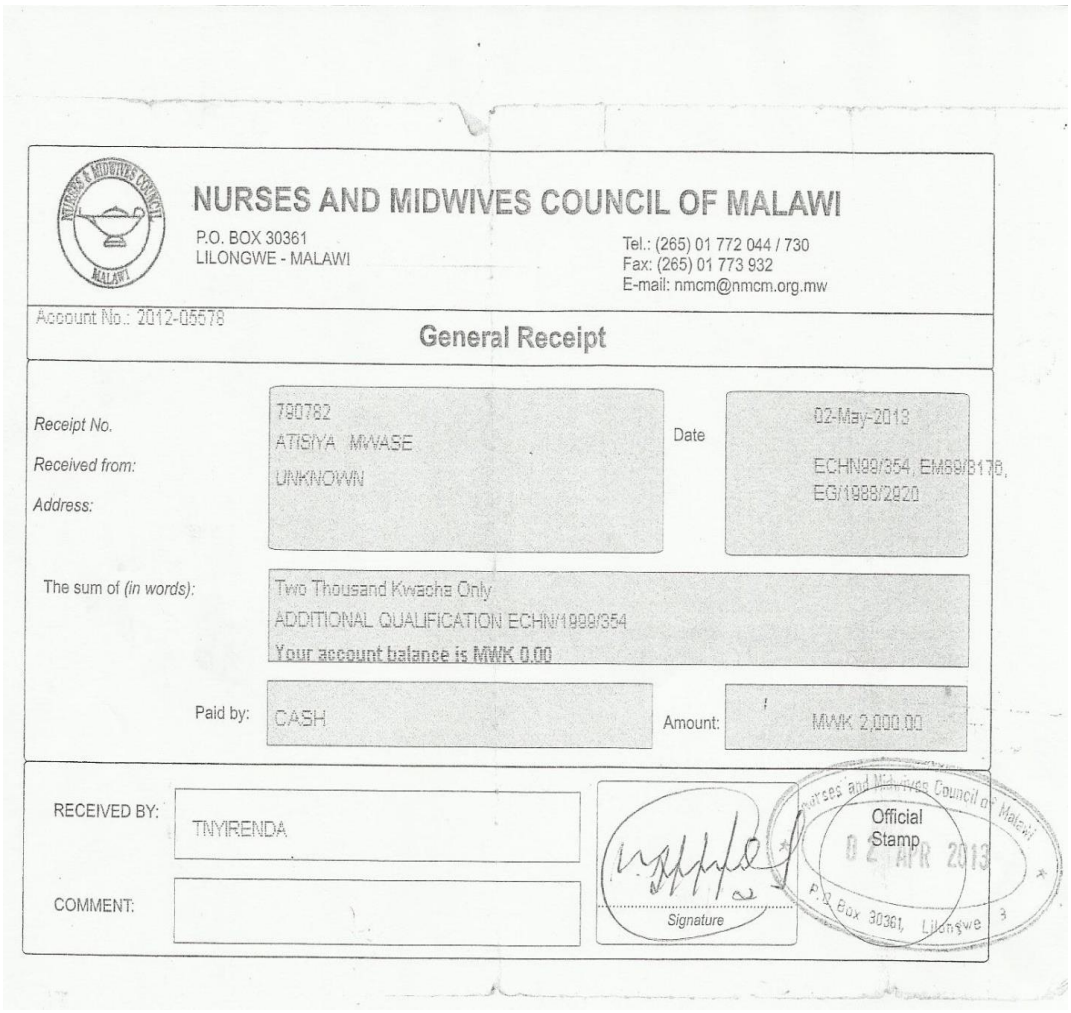
Receipt No.	780781	Date	02-May-2013
Received from:	ATISIYA CLALA MWABE		RNM/2004/27
Address:	MZIMBA DISTRICT HOSPITAL P.O. BOX 131 MZIMBA		
The sum of *(in words)*:	Five Thousand Kwacha Only ANNUAL REGISTRATION FEE 2013 - 2014 FY Your account balance is MWK 0.00		
Paid by:	CASH	Amount:	MWK 5,000.00

RECEIVED BY: TNYIRENDA

COMMENT:

Signature

Nurses and Midwives Council Official Stamp
02 APR 201
P.O. Box 30361, Lilongwe



NURSES AND MIDWIVES COUNCIL OF MALAWI

P.O. BOX 30361
LILONGWE - MALAWI

Tel.: (265) 01 772 044 / 730
Fax: (265) 01 773 932
E-mail: nmcm@nmcm.org.mw

Account No.: 2012-05578

General Receipt

Receipt No.	780782	Date	02-May-2013
Received from:	ATISIYA MWASE		ECHN99/354, EM89/3178, EG/1988/2920
Address:	UNKNOWN		
The sum of *(in words)*:	Two Thousand Kwacha Only ADDITIONAL QUALIFICATION ECHN/1999/354 Your account balance is MWK 0.00		
Paid by:	CASH	Amount:	MWK 2,000.00

RECEIVED BY: TNYIRENDA

COMMENT:

Signature

Official Stamp

Nurses and Midwives Council of Malawi
02 APR 2013
P.O. Box 30361, Lilongwe 3

Appendix O: Certificate of Ethics Approval from the 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.12/13/1502 – Policy change for the TBAs: why are women in Mzimba District still giving births at TBAs? by Ms Atisiya C. Mwase

On 21st February 2014

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. V. Mwapasa - Chairperson (COMREC)

Approved by College of Medicine
21 FEB 2014
(COMREC) Research and Ethics Committee

21/02/2014
Date

REQUIREMENTS FOR ALL COMREC APPROVED RESEARCH PROTOCOLS

1. Pay the research overhead fees as required by the College of Medicine for all approved studies.

2. You should note that the COMREC Sub-Committee on Research Participants' Safety will monitor the conduct of the approved protocol and any deviation from the approved protocol may result in your study being stopped.

3. You will provide an interim report in the course of the study and an end of study report.

4. You are required to obtain a continuation approval after 12 months from the date of approval.

5. All investigators who are Medical Practitioners must be fully registered with the Medical Council of Malawi.