

**UNIVERSITY OF MALAWI**  
**KAMUZU COLLEGE OF NURSING**  
**DISSERTATION**

**Done for the Fulfillment of Bachelors Degree in  
Nursing Education**

**Factors that Contribute to under utilization of  
Community Based Maternal Newborn Program  
by mothers of Mchiramwera village in Thyolo  
District**

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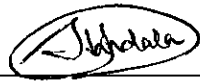
**OCTOBER 2011**

DECLARATION

I hereby declare that this research dissertation is my own work and has not been produced or submitted for any degree else where.

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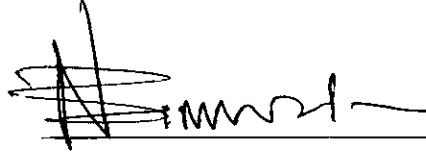


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## DEDICATION

This dissertation is dedicated to My Uncle, the Late Mr. Willard Bert Kamlaza who inspired me to become a State Registered Nurse after his Successes as one of the First Registered Nurses who went to UK Specifically in Manchester for specialization of Psychiatric Nursing. He was Awarded a Bronze Meddle for Attaining Second Position in the Final Examinations in a competition with the white nurses and also worked in Liverpool for 2 years .He was amongst the first psychiatrist to open Zomba Mental Hospital in early 1970s and in 1980, he was transferred to Lilongwe to open the psychiatric Hospital at Bottom Hospital as a Senior Consultant. His Life will be cherished for the rest of my life and also others who have been educated because of his financial assistance and guidance.

I also dedicate this finest document to my Children Yankho and Faith and Febbie my wife who missed me for almost 2 years because of this wonderful Scholarship from Global Interfaith Agency that has resulted me in completion of A Course in Degree in Nursing Education. I am proud of them due to their untiring patience and support.

## ACKNOWLEDGEMENT

I would like to thank God the Almighty for keeping me strong and guiding me through out the time I was writing this research Dissertation.

Special thanks to my supervisor Mr. Simwaka the Head of Basic Studies his patience, untiring support, guidance and constructive remarks during the time of writing research findings.

I also thank the District Health Officer and Management Team of Thyolo for allowing me to conduct the study at their institution.

I also thank the Participants who took part in the study and without them I could not have this useful information for the study results.

## LIST OF ABBREVIATIONS

MDG.....	Millennium Development Goals
HIV.....	Human Immunodeficiency Virus
CBMNC.....	Community Based Maternal and Neonatal Care
HSA.....	Health Surveillance Assistant
UNICEF.....	United Nations Children's Funds
RHU.....	Reproductive Health Unit
PMTCT.....	Prevention of Mother to Child Transmission
KMC.....	Kangaroo Mother Care
HIV.....	Human Immunodeficiency Virus
ANC.....	Antenatal Care
PNC .....	Post Natal Care
MCH.....	Maternal and Child Health

## DEFINITION OF TERMS

Antenatal Period: It is the period that starts from conception of pregnancy to labour and delivery (Oggutu.M.et al 2009 p40).

Postnatal Period: It is the time from child birth where the Uterus and other organs affected by pregnancy are returning to their non gravid state usually up to six weeks (Fraser and Cooper, 2009).

Postnatal Care: It is the provision of midwifery care to women following the birth of their baby to a period of six weeks. (Fraser and Cooper, 2009).

Neonate: It is baby who is alive within twenty eight weeks gestation (Oggutu.M.et al 2009).

Peri -natal Period. It is the period within seven day of birth of the baby. (Oggutu. M.et al 2009, P40)

Maternal Mortality: It is rate of the death of the woman who had pregnancy irrespective of gestation. It is measured by number of women who have died per hundred thousand live birth (Oguttu. M. et al 2009, p40)

Neonatal Mortality it is the rate of death of the babies within the period of twenty eight days. It is measured by number of death per thousand live births (Oguttu. M. et al. 2009).

Reproductive Health : Is the defined as a state of complete physic al, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproduction system and to its functions and process(WHO,2003).

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## ABSTRACT

Thyolo District Hospital has low attendance of women starting antenatal in their first trimester and also low attendance of women who come for postnatal checks one week after delivery. For these reasons, a study was conducted at Thyolo District Hospital focusing Mchiramwera Village to uncover the factors that prevent mothers from attending antenatal and postnatal care as expected. This area of focus attracted the attention of the researcher because it is affecting the whole programme of community Based Maternal and Neonatal Care programme..

The qualitative descriptive design was used during the study. The study setting was at Thyolo District Hospital at Maternal and child health department where mothers come with children to receive immunizations at 6 weeks postnatal .A convenience sample of 10 mothers was included. The criteria for choosing the participants of the study were those women who started their antenatal after the first trimester and also the women who did not come for postnatal checks one week after delivery. In depth interviews were conducted using an interview guide and extra notes were written on a separate sheet of paper to capture the essences.

The purposive sampling technique was used. Interview guide was used to collect data. Pilot study was done in order to test the clarity and usability of the data collecting instrument. The Key findings were as follows: There is lack of commitment to some Health Surveillance Assistants in conducting antenatal and postnatal home visit. Most women do not know exact time to start antenatal and postnatal checks because of conflicting messages. Other women believed that they had to wait for fetal movements and pregnancy to be visible before starting antenatal hence cause delay. Rooming in was found to be the cause of failure of mothers to attend postnatal checks one week after delivery. And antenatal and postnatal attendance was related to feeling of illness of the mother or baby. Recommendations have also been included for possible implementation.

## C HAPTER ONE

### 1.0 INTRODUCTION:

Globally, Maternal Mortality rate registered 422/ 100,000 in 1980 and in 2008 the maternal mortality rate was 250 / 100,000 live birth. The maternal deaths registered 342,900 in 2008. Countries such as Italy had the lowest maternal mortality rate registering 3.9/100,000. Most of the maternal deaths are coming from India, Pakistan, Ethiopia and the Democratic Republic of Congo. In the world data of 2008 shows that the third highest ranking in maternal mortality rate was Malawi showing 1047/ 100,000 live birth.( [Http/ world maternal mortality](#)).

In Sub-Saharan Africa women 515,000 women die each year of complication of pregnancy. For every woman who dies approximately 30 more women suffer from injuries related to delivery, infection and disabilities in pregnancy and child birth .And a total of 15 million women suffer due to this type of damage.( [Http/ world maternal mortality](#)).

Malawi is one of the developing countries which have a high maternal and neonatal mortality rate. Maternal mortality rate was at 807/100,000 live births (MIS 2006) and 1047/100,000 live births in 2008 registering the 3<sup>rd</sup> highest in the world. ([Http/ world maternal mortality/](#) ) a Neonatal mortality rate is at 33/1000 live birth (MIS 2006). 18,900 neonates die very year, 52 neonates die every day and 4624 mothers die every year and 13 mothers die every day.(Facilitators Manual, Community Based Maternal New Born Care, 2009 Edition)

In response to the high maternal and neonatal mortality rate Malawi introduced Community Based Maternal and Neonatal Programme in 2008 among other programmes which were existing such as safe motherhood in order to reduce maternal mortality rate and neonatal mortality by utilising trained health surveillance assistants who could bring health messages of prevention of maternal and neonatal death at the village level. Three pilot districts were chosen such as Chitipa in the northern region, Dowa in the central region and Thyolo in the southern region. (Health Surveillance Training Manual for Community Based Maternal New Born Care 2008 Edition.)

The Health surveillance assistants are supposed to conduct antenatal and postnatal home visits where the messages of attending antenatal and postnatal care are emphasized.

## **1.1 BACK GROUND INFORMATION**

In Malawi, Health surveillance assistants were previously taking part in conducting home visits for checking sanitation of the villagers and most of their time was spent in conducting immunisations of children, growth monitoring of under five children and weighing babies. Little effort was placed on care of pregnant mothers and postnatal mothers or even the neonatal care. This was largely because they were not trained for that particular job; as a result, Health Surveillance assistants were powerless because they could not answer questions pertaining to maternal and newborn care. Now more than four hundred Health Surveillance Assistants have been trained in Community Based maternal New Born Programme who are providing the services at the community level (HMIS Thyolo).

The trained Health Surveillance Assistants go into the community and conduct antenatal and postnatal home visits where messages of importance of starting attending antenatal care early within first trimester and also attending postnatal checks at one week after delivery are emphasized. Despite the continuing efforts by health Surveillance Assistants on home visits, statistics shows that 5% of women start attending antenatal care within first trimester. This means that 95% of women are at greater risk of developing obstetric complications or medical conditions due to lack of early detection, through proper screening or laboratory test for example syphilis is detected by VDRL test and if the woman has undetected syphilis may end up in abortion or intrauterine death. The data at HIMS department of Thyolo indicates that only 10% of women go for postnatal care at one week after delivery. This also means that 90 % of women may be at risk of having undetected postnatal condition such as sepsis. Therefore in this study the researcher is going to investigate the reasons for reduced numbers of antenatal mothers starting antenatal care within first trimester and also reduced numbers of women attending one week postnatal checks despite Health Surveillance Assistants stressing importance of early antenatal care and attending of one week postnatal checks during the counselling sessions as they conduct antenatal and postnatal home visits in their respective catchment areas.

## **1.2 STATEMENT OF THE PROBLEM**

Although Health surveillance assistants are conducting antenatal and postnatal home visits at least three times on every mother there is still evidence that Thyolo District Hospital data of 2010 showed low attendance of pregnant women during their first trimester and also low

attendance of postnatal mothers one week after delivery. This resulted in undetected conditions in the mother during antenatal period such as abortions, or premature delivery or intrauterine death. And also postnatal period the mothers had sepsis or postpartum haemorrhage while babies had neonatal sepsis. Consequently avoidable maternal death or neonatal death occurred. Therefore it is against this back ground that a study needs to be carried out to uncover issues that affect these women utilisation of Community Based Maternal New Born Programme.

### **1.3 SIGNIFICANCE OF THE STUDY**

This study is very important because the study findings will act as the basis in decision making and the problems that are affecting the mothers will have solutions. In order to improve care for mothers during their antenatal, intranatal and postnatal period there is needed to describe problems that affect these women. This study will solicit views from postnatal mothers who had undergone through the process of pregnancy labour and delivery. Therefore their problems will easily be identified. When their problems will be identified then greater understanding of the problems will help to find solutions for the problems thereby improving utilisation of community based Programme. For example policies will be formulated to address factors that affect utilisation of community based maternal newborn care programme.

### **1.4 BROAD OBJECTIVE**

To explore factors that contributes to under-utilisation of community Based Maternal Newborn Programme by mothers.

### **1.5 SPECIFIC OBJECTIVES**

- 1 To determine perception of mothers on the impact of involving Health Surveillance Assistants in conducting antenatal and postnatal home visits.
- 2 To describe Cultural practices that affect mothers attending first antenatal care within first trimester irrespective of Health Surveillance Information Education and Counselling (IEC).
- 3 To investigate on cultural practices that affect mothers in attending postnatal care within first week of delivery irrespective of Health Surveillance IEC on postnatal checks.
4. To identify ways of improving utilisation of community based maternal care programme by mothers in Mchiramwera village in Thyolo District.

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

Literature review has revealed that there are some research studies that have been conducted in relation to the topic under study both internationally and nationally. Most of the studies were conducted in developing countries including Malawi.

#### 2.1 Studies done on Perception of mothers on Maternal and New born health Package

The study done Peter w. at el (2008) whose aim was to find out if the internationally recommended practices were acceptable and could be demanded by the target community. The findings were that communities associated the need for antenatal care attendance with feeling ill, and postnatal care was non-existent. The health system barriers were financial burden, lack of male involvement, lack of waiting shelters at health clinics. The study also revealed that men are key barriers to birth preparedness because women rely on them for decisions and support including finances for pregnancy related care. It was also found that the danger signs were just treated with herbs and only seek medical care when the condition became worse. The other findings were that the women could not go for delivery to skilled birth attendants due to lack of transportation, in accessible health unit and were closed at night and the health workers were rude, corrupt, and could absent themselves. The study found out that home visits conducted by community volunteers were acceptable and helpful but desired special qualities of community volunteers who would visit home such as being a woman , who is permanent resident in the area ; literate, and well behaved, and respected in the community.

Ability to walk long distances, good tempered knowledgeable, punctual, good listener experienced in parenting properly married and a kind hearted person. The study done by Dr Joshua in Malawi in 2007 revealed that female HSAs were more preferred than male HSA s because the male HSAs could abuse the new roles and have affairs with the women in the village.

## **2.2 Knowledge of mothers in Community Based Maternal and Newborn Health Care Package**

Several studies have investigated mothers' knowledge on Community Based Maternal Newborn Care. The study done by Dr Joshua; A. (2007) showed that women were able to mention the maternal and neonatal care that is provided at the health facility such as conducting physical examination, weighing the baby, checking of blood pressure and examining the baby and the mother. The women were also able to mention most of the danger signs but few danger signs were originating from beliefs such as husband having sexual relations with other women the neonate to be sick and also menstruating women adding salt into the relish was viewed as the origin of some negative consequences in postnatal mothers and newborns.

## **2.3 Common Practices of Mothers during Antenatal and Postnatal Period**

A study by Peter W. etal (2008) that antenatal attendance was rare and those who fell ill the ones who were supposed to attend antenatal care. The community relied on herbs because they believed that they made the bones to be flexible at the time of delivery thus help to prevent the risk of caesarean section.

In a study done by Peter Waiswa in 2008 in Uganda showed that the postnatal mothers used to bath babies just after birth of the baby. This was done because their babies were believed to be born dirty with a bad smell and as such needed to be bathed immediately after birth .The communities had their cord care practices such as applying baby powder, spirit, herbs, soapy water and salty water because they believed to help cord to dry and heal faster. The baby whose cord had not fallen was traditionally kept inside the house. Postnatal care was found to be non existent. Therefore postnatal care as part of maternal and new born care was considered to be something new.

Another study done by Dr Joshua in Malawi in 2007 before the Community based maternal New born was established in Malawi in 2008 the findings on postnatal care practices was that majority of women that delivered at the hospital had to seek postnatal care. This group of women were going back to the hospital for follow up after 3 days. And women who delivered at home or TBA they were taking the child to the hospital for check up and most of them had to seek postnatal care if the child or mother presented with some problem.

On bathing of the baby there were some variations and 50% of the respondents said that they were giving bath to the baby soon after birth. Others said they gave a bath when the baby was

one week old and others said they gave bath to the baby after the period of rooming in which was from 3 – 14 days. The first bathing involved bathing the baby in warm water that contained some herbs.

On breast feeding practices, exclusive breast feeding was known to the majority. It was also found that breast feeding on first milk (colostrums) was believed to cause illness on the newborn. And when the mother had stayed for 2 days or more away from the baby she was instructed to stop breastfeeding as the milk was believed to have gone bad. Therefore it is necessary to know if there is behaviour change of postnatal mothers after the HSAs had been conducting antenatal and postnatal home visits.

#### **2.4 Summary of Literature review.**

The studies have revealed that Mothers associated antenatal care attendance with feeling ill, and postnatal care was non existent. The mothers viewed health system barriers such as financial burden, lack of male involvement, and lack of waiting shelters at the clinics. The study also revealed that female Health Surveillance Assistants were more preferred than male Health Surveillance Assistants.

In India women are vulnerable to complications in the postnatal period because of lack of knowledge and effective care while in Uganda cultural practices affect care of the new born babies for instance babies are bathed immediately after birth because they believe to be born dirty. Therefore associating antenatal care and illness of the mother, financial burden, lack of shelter, lack of knowledge about postnatal care and cultural practices can affect utilisation of Community Maternal New Born Programme by mot

## CHAPTER THREE

### 3.0 CONCEPTUAL FRAMEWORK

#### 3.1 HEALTH BELIEF MODEL

Health belief model is one of the first theories of the health behaviours. In the 1950s, Rosenstock proposed a health belief model intended to predict which individuals would or would not use preventive measures such as screening for early detection of cancer. Becker modified the health belief model and included components such as individual perceptions, modifying factors, and variables likely to affect initiating action. The health belief model is based on motivational theory. Rosenstock (1974) assumed that good health is an objective common to all people. Becker (1974) added positive health motivation as a consideration. Pender (1975) modified the health belief model by adding two further considerations: the importance of health as perceived by individual and perceived control.

#### INDIVIDUAL PERCEPTIONS

##### **Individual perceptions include:**

1. **The importance of health to the person.** Behaviour that indicates health is perceived as something of value and includes providing special foods and vitamins to keep children well, having dental check ups, and participating in screening tests for cervical cancer, breast cancer, and cardiovascular disorders.

##### **Perceived control.**

People who perceive that they have control over their own health are more likely to use preventive services than people who feel powerless. People

2. Who are internally controlled, view them as less vulnerable to ill-health. Control over health can relate to such behaviours such as not smoking, maintaining an appropriate weight, using seat belts or obtaining immunizations such as influenza.

3. **Perceived threat** of a specific disease. For example, a man who perceives that many people around him have influenza is more likely to modify his behaviour than a man who perceives that most of the people with influenza live in another city.
4. **Perceived susceptibility**. A family of a certain disorder, such as diabetes or heart disease, may make the individual feel he or she is at risk.
5. **Perceived seriousness**. The question here is: In the perception of the individual, does the illness cause death or have serious consequences?
6. **Perceived benefits** of preventive action. For example, many individuals correctly perceive that not smoking may have beneficial outcomes.
7. **Perceived value of early detection**. This perception can motivate the person to have screening tests and regular physical or dental examinations.

### **Modifying Factors**

Factors that modify a person's perception include:

1. **Demographic variables** such as age, sex, and race. An infant for example does not perceive the importance of a health diet; an adolescent may perceive peer approval as more important than family approval and participate as a consequence in hazardous activities or adopt unhealthy eating and sleeping patterns.
2. **Interpersonal variables**. These include concern of significant others, family pattern of health care (e.g. the member of a family may have dental examinations every 6 months), and interactions with health professionals who are likely to provide information and encourage preventive behaviour.
3. **Situational variables**. These include the cultural acceptance of specific health related behaviours. For example, in some cultures it is considered inappropriate to seek medical advice unless one is seriously ill. Societal norms also influence behaviour .For example, a group may convey disapproval when a person drives an automobile after drinking alcohol. Another situational factor that modifies that modifies behaviour is information from non-personal sources, such as newspapers or television broadcasts, which can affect health behaviour positively or negative

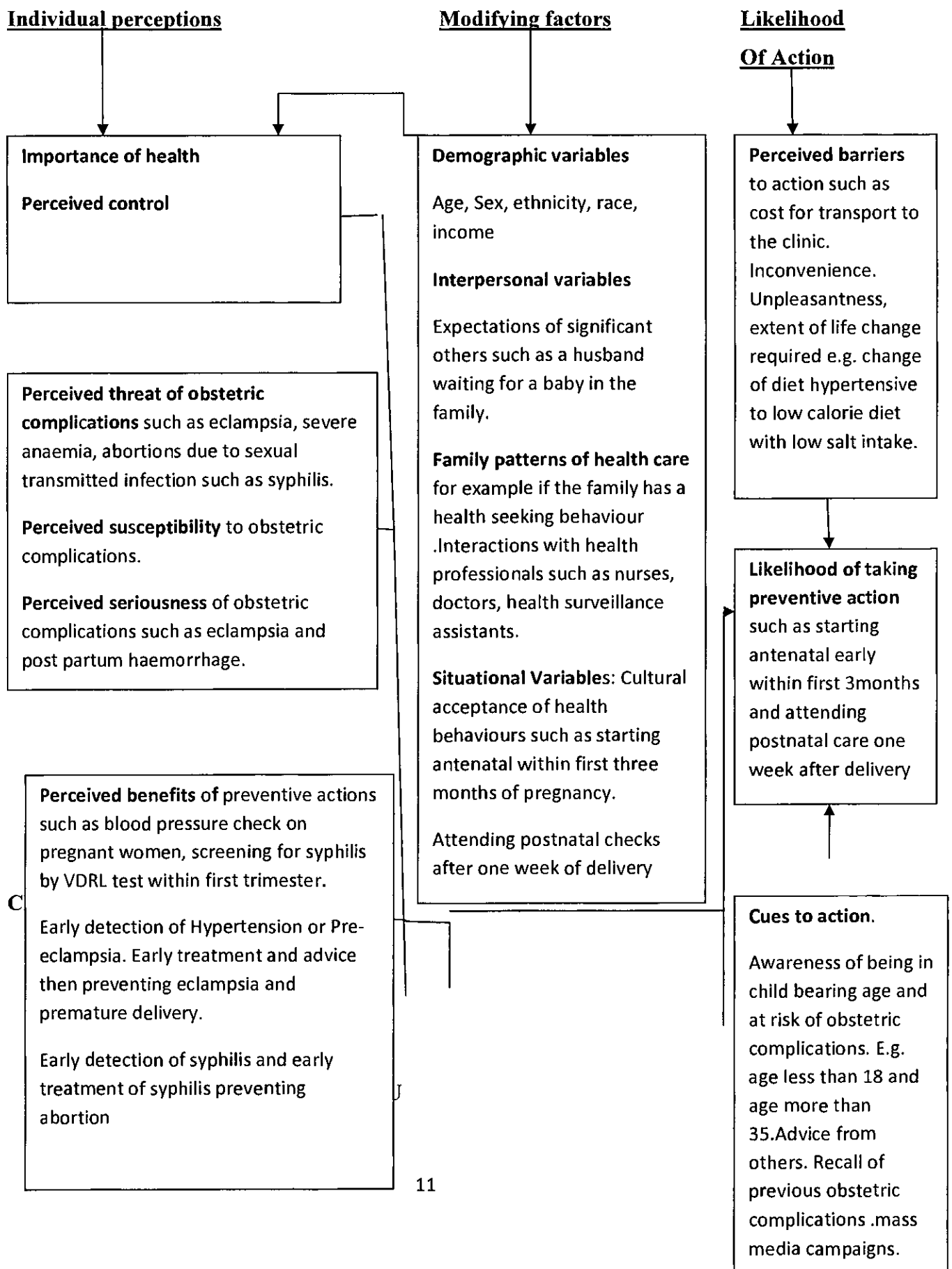
#### **4 Likelihood of Action**

Perceived barriers to action can include cost, inconvenience, unpleasantness, and life-style changes. By contrast, certain cues may trigger action. Such cues may be external or internal e.g., a birthday may make a person realize that he or she is now at greater risk of developing a particular disease. If cues are too strong, anxiety can inhibit action rather than encourage it.

Health belief model is a good model for addressing problem behaviours that evoke health concerns for example high risk sexual behaviour and possibility of contracting HIV.

Health Belief Model is a popular applied in nursing, especially in issues focusing on patient compliance and preventive health care practices. Health Belief Model addresses the relationship between a person's beliefs and behaviours. It provides a way to understanding and predicting how clients will behave in relation to their health and how they will comply with healthcare therapies.

### 3.2 APPLICATION OF PENDER'S MODIFICATION OF BELIEF MODEL TO THE RESEARCH STUDY



## CHAPTER FOUR

### METHODOLOGY

#### 4. O Introduction

This section discusses research design, study setting, population sample, and sampling procedure, Instruments used in data collection, data collection, data analysis, and ethical consideration.

##### 4.1.0 Research Design

Research Design is a blue print for the conduct of the research that maximizes the control over factor that could interfere with the studies desired outcome (Burns and Grove, 2005) For the purpose of this study, a descriptive qualitative design was used to investigate the factors that affect utilisation of community based maternal and neonatal care programme by mothers. This approach was important because qualitative research emphasises the dynamic holistic and individual aspect of human, knowledge, skills and perceptions. This helped to gain more insight into the factors that affect utilisation of community based maternal and neonatal care programme. Mothers who come for immunisations of their children at six weeks were included and these mothers had started attending antenatal after their first trimester and did not attend one week postnatal check.

##### 4.1.1 Study Setting

The study was conducted at Thyolo District Hospital because data showed reduced attendees of antenatal care within the first trimester and also there are reduced attendees of mothers for one week postnatal care. The pilot study was done at Thyolo District focusing clients from Bvumbwe research.

##### 4.1.2 Sampling

Sampling is the process of selecting a number of individuals for the study in such a way that the individuals represent the larger group from which they are selected (Polit & Hungler, 2001).The samples were obtained through purposive sampling. This is some times referred to as selection of participants who are available in the right place at the right time, at the right time of the investigators purpose. Ten postnatal mothers who were within six weeks postnatal

period were selected. The women were recruited from maternal and Child health Clinic at Thyolo District Hospital who come from Mchiramwera village.

#### **4.1.3 Data collecting Instruments**

The interview guide was used as a data collecting tool it was developed in English and was translated to Chichewa for easy communication with the clients. The interview guide consisted of demographic data at Section A and Open ended questions at section B. The questions covered the specific objectives of the study. All the required numbers of interview guide were made available for every participant before the study.

#### **4.1.4 Pilot Study**

An interview guide will be pretested as a pilot study to two participants from Bvumbwe area in order to get a better feel of the process of the interview in terms of time on each participant, and understanding of the questions.

#### **4.1.5 Data Collection**

Mothers were found at Thyolo District Hospital specifically at Maternal and Child Health clinic for mothers who had come to start immunizations of their infants .The researcher submitted the consent form attached after introducing himself and the nature of the study. The in depth interview was used for data collection. This comprised of a section on demographic data and section of open ended questions because explanations to answers were made in a wider range. The interview guide was developed in English and then was translated into Chichewa Language for easy communication with the mothers. .

The researcher collected information from 2 postnatal mothers from Bvumbwe Research area as a pilot study to pre-test the tool in order to know the clarity of the interview guide to the participants. There after, information was collected from 10 postnatal mothers from Mchiramwera area at Thyolo District Hospital. During in depth interview the participants were allowed to express their views in their own words. The participants were asked to respond to questions as they came. The demographic data was entered in the forms and other responses from in depth interview were recorded on a separate sheet of paper.

#### **4.1.6 Data analysis**

Data analysis was done manually. Analysing of the demographic data and responses from in depth interview was analysed using content analysis .after Content analysis is a procedure for analysis of written communication in a systematic and objective manner (Polit&Hungler, 2005).

The demographic and narrative data was then subjected to coding. The code numbers were created by the researcher. The steps in data analysis were followed. Firstly there was ordering and organizing of the collected material .Secondly re- reading of data was done in order to sense the meaning. Thirdly, there was breaking of the material into manageable pieces. Fourthly building, comparing contrasting categories was done. Fifth step was searching for relationships and grouping categories together. The six steps will be recognising and describing patterns, themes and typologies. Lastly there was interpreting and searching for meaning. Summaries of findings for demographic data and analysed responses of participants form open ended questions made in narrative form.

#### **4.1.7 Ethical consideration**

Permission to conduct the study was obtained from the College Research and Publication Committee and the District Health Office in Thyolo in order to obtain approval to collect data at the hospital. An informed consent was sought from each participant after thorough and detailed explanation of aims and objectives of the study. (Polit and Hungler (2005) states that informed consent ensures that the researcher obtained voluntary participation of the participants after informing them that that there are no risks and no benefits to them as individuals. Therefore participants were explained that there were no immediate benefits to them from the results of the study. But later on the study results shall assist pregnant mothers and postnatal mothers to improve care and prevent maternal and neonatal deaths. This was done to ensure that participants made voluntary choice to take part in the study .The participants were assured that there were no risks related to the study .The right to privacy and dignity was maintained. The participants were assured that the information that was collected would be kept in strict custody and be used for the purpose of this research study. Confidentiality was achieved by face to face interview in a private place on one to one basis. Anonymity was observed where by individual identity of participants was not being linked to the information provided and the public would not have access to the information. Therefore names were avoided and instead code numbers were used (LoBiondo-Wood 2007 p288).The

volunteers were given the right to protection from discomfort and both physically and psychologically. The participants were informed of their right to withdraw at any time or point of Study. The data collected was put in an envelop and sealed. Only the principal researcher was to have access to data.

#### **4.1.8 Limitation of the study**

There were constraining factors that were faced during time of the study. Time for the research was limited because the study was being conducted with other courses running concurrently. Therefore a small sample of 10 mothers was chosen and interviewed.

Since the study was only confined to one location, the results may not be generalized to the whole population of Thyolo.

#### **4.1.9 Dissemination of Results**

Results of the study were disseminated in the following ways.

A copy of bound dissertation was put at the following Libraries: Kamuzu College of Nursing Lilongwe and Blantyre Campus and was presented to the Management of Thyolo District Hospital.

## CHAPTER FIVE

### 5.0 FINDINGS OF THE STUDY

#### 5.1.0 Demographic Characteristics of the Participants

##### 5.1.1 Age of Participants.

Most of the participants 5 of them had their ages within the ranges of 25 to 36years and 3 of them had their ranges of 18 to 25 years and 2 of the participants had their ranges between 36 to 45years.

##### 5.1.2 Marital status of the participants.

8 of the women were married and 2 of the women were divorced

##### 5.1.3 No of children

5 women had greater than 4 children and 3 women had 2 children each 1 woman had 3 children and 1 woman had 1 child.

##### 5.1.4 Tribe

8 women were Lomwe, 1 woman was Tumbuka, and 1 woman was Yao.

##### 5.1.5 Denomination

3 women were catholic members, 2 women were CCAP members, 2 women were Church of Christ Members 1 was Baptist church Member 1 was Hand OF God member and 1 was New Apostle member.

##### 5.1.6 Educational Level

6 women had reached primary school, 1 attended Junior Certificate (J.C), 1 attended Malawi School Certificate of Education (MSCE) and 2 women did not attend any school.

##### 5.1.7 Occupation of Participants

6 of the participants got their income through farming, 3 of the participants got their income by doing business and 1 participant was doing Tea plucking at Conforzi Tea Estate.

### **5.1.8 Perception of Mothers on the impact of involving the Health Surveillance Assistants in conducting antenatal and Postnatal Home Visits.**

Most of the women said that Health Surveillance Assistants are doing a good job in conducting home visits because they give the women advises on how they can take care of themselves during antenatal period and also during postnatal period . They also give advices on how to take care of the babies. The Health Surveillance Assistants also tells them to start antenatal when they are pregnant but do not stress the specific time when antenatal should start as a result most of the mothers start antenatal at different time period usually at 4 months or 5 months. The most of the mothers perceived that female Health Surveillances were better than the male Health Surveillance Assistants in providing the Community Based Maternal New Born Health Services because of the fact that they are women and have undergone the process of pregnancy, delivery and postnatal period and their advices could be evidence based as a result they are rich with information. This is quite different with the male Health Surveillance assistants who can only tell them what they were taught for this program. However a few mothers recommended some male Health Surveillance Assistants who were very committed to this program because they were conducting frequent and timely antenatal and postnatal home visits to the mothers while some of the female Health Surveillance were not very committed

### **5.1.9 Cultural practices that Affect mothers in attending antenatal Care within the first trimester.**

Culturally most women know that they can comfortably explain to other people such as the health worker that they are pregnant if the baby in the uterus starts movements and this is the time when the pregnancy is within 5 to 6 months and sometime they feel its better to go to the hospital when the pregnancy can easily be seen by the nurses or doctors. Going to the clinic before the woman starts feeling fetal movements is viewed as an early suggestion because what is in the abdomen can be something else other than the baby. It is believed that the uterus can sometimes carry only the water without a fetus. Therefore waiting to confirm for presence of live baby is critical at a village level. Women at the village back bite each other if a woman has chosen to go to the antenatal clinic early before the pregnancy is easily seen. The culture allows a woman to go to antenatal if a woman is getting sick quite often. For example if she is vomiting heavily, or she has jaundice, p.v bleeding, anaemia and oedema .

#### **5.1.10 Other factors that prevent mothers from attending antenatal care within first trimester.**

Lack of awareness of exact time to start antenatal has been found to cause confusion on when to start antenatal. The messages which are given do not specify when women should start antenatal. There is also lack of campaigns that explain the important of attending antenatal within the first trimester. It was also found that there are no drama groups that are spreading those messages to the people. This information is also not given at family planning clinic. The committees of safe motherhood do not give this information to people by organizing village meetings where they could explain specific time for mothers to start antenatal. The Health surveillance Assistants do not make frequent meetings to update people on issues of safe motherhood that are taking place in the village for example, telling the women that most of the women are not reporting to antenatal clinic within the first trimester. Other women said that they are afraid of being tested HIV because they don't know whether they can become negative or positive. However others mentioned the benefits of attending antenatal within the first trimester such as the following: Problems are identified early for example if anaemic the woman is given iron tablets or blood. Some of the mothers said that it was not very dangerous to start antenatal after three month of pregnancy between 4 and 5 months because she could not feel any problem since she was not sick. One of the participants said that she felt she was not at risk of developing obstetrical complications because after waiting for 5 months she went to the clinic because of abdominal pains and later on she had no further problems. Most of the women agreed that they had started antenatal late because they were waiting for the baby to start fetal movements.

#### **5.1.11 Cultural practices that prevent mothers from attending postnatal checks**

Most of the women said that they waited for the cord of the baby to fall off before the baby had to be taken out of Rooming in. This is commonly known as chikuta. After rooming in which takes a week or with some few days it was found that the traditional birth attendant is the one who is called to bath a baby in the herbal medication. This is done immediately after the cord has foreign off. The medication is intended to assist in the drying and final healing of the stump because if they don't bath the baby in the herbal medication, they believe that the baby stump can be infected resulting in the death of the baby.

### **5.1.12 other factors that prevent mothers from attending postnatal checks.**

The other reasons was found that health workers sometimes tell the mothers wrong time period of postnatal checks for example one mother was told to come back after 2 weeks for postnatal checks instead of one week and the health worker specified that she should come after rooming in (mchikuta ). Therefore she came back after two weeks. This was wrong information to the client. Some of the mothers thought that there was no need to go for check up because they had delivered quite very well with a strong live babies who had no health problems and only those whose children were sick were supposed to go to the hospital. Other women said that they could go to the check up if they were sick or were experiencing p v bleeding, producing foul smelling discharge or had abdominal discomfort. They also mentioned that they could visit the clinic if the baby had fever or not breastfeeding. Most of the women were very much concerned with healing of the stump which they said that if the mother doesn't follow what is expected of her such as rooming in and bathing of the baby in the medicated water then the stump can not get healed resulting in the death of the baby. Some of the mother did not see any danger for not attending postnatal checks as scheduled because they considered a cord which had not fallen off as more dangerous than taking the baby to the clinic. The cord could fall off after 8 to 10 days which was already more than expected time of postnatal checks of one week. A few of the mothers remembered the benefits of attending postnatal care such as being checked if both are alright and reduces the tension which the woman may have about the condition of herself and the baby. One woman mentioned that if the baby and the woman are seen by the doctor or the nurse and are found to have medical or obstetrical problem they are assisted accordingly.

### **5.1.13 Ways of improving utilisation of community Based Maternal Care Programme**

It was found out that the hospital has the responsibility of giving out the message of starting antenatal early within the first trimester and this can be give at family planning clinic, antenatal clinic , and under five clinic using integrated program where by all women from these sections can come together to listen to the health talk. .

It was also found that the women who have delivered should be given the correct information regarding when they are supposed to come for postnatal checks. They are also supposed to be told that they should come exactly after one week if they have no problem and the cultural norm of rooming in or Mchikuta should not prevent them from coming on the appointed date.

This study revealed that most of the Health Surveillance do not Conduct village meetings on safe motherhood issues therefore, some women suggested that Health Surveillance Assistants should make sure that they conduct village meetings where by they ask the village headman to call the people to his home where the meeting of telling the people importance of attending antenatal early at a time when a woman has missed a period can be mentioned. This meeting can also be the one to brief the women importance of coming for check up after one week. Some women mentioned that other health surveillance assistants do not conduct home visit to visit pregnant women and postnatal mothers in their homes as expected. Therefore the suggested that they should be well supervised to ensure that they are conducting home visits as expected.

The women said that there is lack of proper information on when to start attending antenatal clinics and also when to go for check up, the mothers suggested that the District should organize Safe motherhood activities which will be explaining importance of going to antenatal within the first trimester (first three months). The information can be given as health talks or drummer group members can be given the information which they can include in their plays. There can also be cultural show of the dancing troupes which can be singing the songs of importance of starting antenatal early and also postnatal checks after one week.

Most of the women said that the women should follow the advices that are given by the Health Surveillance Assistants and the nurses or midwives at the hospital. The women should also be telling each other the importance of attending antenatal and postnatal care.

## **CHAPTER SIX**

### **6.0 DISCUSSION OF FINDINGS ON FACTORS THAT CONTRIBUTE TO UNDER-UTILISATION OF COMMUNITY BASED MATERNAL NEWBORN PROGRAMME**

#### **6.1 Demographic Characteristics of the Participants**

##### **6.2 Tribe**

Majority of the women were Lomwe by tribe and the Lomwe tribe believes in confirming the presence of pregnancy by waiting until the fetal movements are felt by the mother and also the pregnancy can easily be viewed by the elders who are within the compound. They also believed that even the Traditional attendant could be in a best position to diagnose the presence of pregnancy. Waiting at home due to cultural beliefs of home confirmation of pregnancy is the factor that contribute to underutilisation of community based maternal new born care programme because even if the Health Surveillance can explain the importance of starting antenatal within the first trimester it can not work because during this period the pregnancy is normally not visible and fetal movements are not present. However they can seek for medical attention when they feel ill and this is exactly how the Lomwe culture applies to health belief model.

##### **6.3 Educational Level**

The majority participants were the women who just attended primary school education. Therefore illiteracy is the factor that contributes to underutilisation of community based maternal new born care because illiteracy makes individuals unable to make informed choices even if the Health Surveillance Assistants can give them advice on importance of starting antenatal within first trimester or to come for postnatal checks after one week of delivery they may not take it as important. The studies done in Gambia by Jaiteh I.& Hydera (2008) Proved that it was necessary that ladies should be well educated for them to form informed choices on their reproductive health issues.

#### **6.4 Perception of mothers on the impact of involving the Health Surveillance Assistants in conducting antenatal and Postnatal Home Visits.**

Most of the women said that Health Surveillance Assistants are doing a good job in conducting home visits because they give the women advises on how they can take care of themselves during antenatal period and also during postnatal period . But most of the mothers perceived that female Health Surveillances were better than the male Health Surveillance Assistants in providing the Community Based Maternal New Born Health Services because of the fact that the female Health Surveillance had undergone the process of pregnancy, delivery and postnatal period and their advices could be evidence based as a result they are rich with information. The preference of female Health Surveillance by most women is a factor that can contribute to underutilization of community based maternal programme because the advices from male Health Surveillance are not taken seriously as opposed to female Health Surveillance Assistants advices. This is in line with the study done by Dr Joshua in 2007 which revealed that female Health Surveillance Assistants were more preferred than male Health Surveillance Assistants. .

#### **6.5 Cultural Practices that affect mothers in attending antenatal Visits within first Trimester.**

Culturally most women know that they can comfortably explain to other people such as the health worker that they are pregnant if the baby in the uterus starts movements and this is the time when the pregnancy is within 5 to 6 months and sometime they feel its better to go to the hospital when the pregnancy can easily be seen by the nurses or doctors. The culture that directs women to wait for the pregnancy to reach 5 to 6 months is the factor that can cause delay in starting antenatal services within first trimester. This means that the women will be denied of important services such as screening for syphilis and HIV tests which if detected early the woman can be given treatment and advice in order to protect herself and the unborn child. The results showed that mothers were not threatened by not attending antenatal care because they perceived that they were not susceptible to those unhealthy conditions because

they were well. Going to the clinic before the woman starts feeling fetal movements was viewed as an early suggestion because what is in the abdomen can be something else other than the baby. It is believed that the uterus can sometimes carry only the water without a fetus therefore waiting to confirm for presence of live baby is critical at a village level. The culture allows a woman to go to antenatal if is getting sick quite often. For example if she is vomiting heavily, if she has jaundice, p .v bleeding, anaemia, oedema or when the woman is showing signs of malaria or abortion. This is in line with the findings done by Titaley. R et al 2009 and Peter W. et al 2008 in a study which revealed that some community members perceived health services to be necessary if only obstetrical complication occur.

#### **6.6 Other factors that prevent mothers from attending antenatal care within first trimester.**

Lack of awareness of exact time to start antenatal has been found to cause confusion on when to start antenatal. The message was not given to specify when women should start antenatal. This is in line with the findings done by Christina. R. (2009) where by nurses were telling antenatal mothers to go back home and come at 5 months because they had come earlier. There is also lack of campaigns that explain the important of attending antenatal within the first trimester. Lack of massive campaigns on importance of starting antenatal care early within first trimester is a factor that can contribute to underutilisation of community based maternal programme because people will not have adequate information pertaining to antenatal services and behaviour change requires people to be informed on the appropriate behaviour. This is the time when clarifications of the benefits for adopting appropriate behaviour can be emphasized because according to health belief model people adopt a special behaviour only if they perceive the benefit of that particular behaviour. This is in line with the findings from the study which demonstrated the importance of health promotion programs for increasing community awareness about necessity of antenatal services by Titley. R. 2009. There is also lack of community participation on Maternal Newborn issues. This programme was supposed to be owned by the community as their own programme because studies have proved that Community programmes that have gained ownership by the community are easily supported by the community. For example the committees of safe motherhood which were established are not well monitored and do not give this information to people by organizing village meetings where they could explain specific time for mothers to start antenatal. The Health surveillance does not make frequent meetings to update people on issues of safe

motherhood that are taking place in the village for example telling the women that most of the women are not reporting to antenatal clinic within the first trimester. Other women said that they are afraid of being tested HIV because they don't know whether they can become negative or positive. This fear of unknown can affect the starting of antenatal within first trimester because the mothers can procrastinate the dates of starting antenatal. These mothers do not weigh the importance of early antenatal care where HIV test can be done with complete lack of knowledge of HIV status because if they had known the importance of knowing the results they could perceive the benefits of early antenatal care. Some of the mothers said that it was not very dangerous to start antenatal after three month of pregnancy between 4 and 5 months because she could not feel any problem since she was not sick. One of the participants said that she felt she was not at risk of developing obstetrical complications because after waiting for 5 months she went to the clinic because of abdominal pains and later on she had no further problems. This is in line with health belief model which says that lack of perception of seriousness of the consequences of the action is the factor that causes people to maintain their own behaviour. Consequently this contributes to underutilization of the community based maternal newborn care programme.

#### **6.7 Cultural Practices that prevents mothers from attending postnatal checks one week after delivery.**

Most of the women said that they wait for the cord of the baby to fall off before the baby is taken out of Rooming in commonly known as chikuta. Therefore the culture of rooming in is a contributing factor for failure of mothers to attend postnatal checks one week after delivery because the rooming in can take 10 to 14 days this is according to the results found by Ianneli M.D (2007) which is the approximate period when the umbilical cord can fall off. The community based programme advocates for attendance of postnatal check one week after delivery.

### **6.8 Other factors that prevent mothers from attending postnatal checks one week after delivery.**

Some of the mothers thought that there was no need to go for check up because she delivered quite very well with a strong live baby who had no health problems and only those whose children were sick were supposed to go to the hospital. This result is in line with the results by Titaley. R. (2007) and Peter et al (2008), which revealed that community members perceived health services to be necessary if only obstetrical complications occur. For example in this study it was found that women could go to the check up if they were sick or were experiencing p v bleeding, producing foul smelling discharge or had abdominal discomfort. Waiting for a complication is a contributing factor that is preventing women from attending antenatal care one week after delivery. They also mentioned that they could visit the clinic if the baby had fever or not breastfeeding. Some of the mother did not see any danger for not attending postnatal checks as scheduled because they considered a cord which had not fallen off as more dangerous than taking the baby to the clinic. According to Health belief model individuals comply with the advice from health worker if they understand the benefits of following instructions such as attending one week postnatal checks. One woman mentioned that if the baby and the woman are seen by the doctor or the nurse and are found to have medical or obstetrical problem they are assisted accordingly.

### **6.9 Way of improving utilisation of community based maternal new born Care**

It was found discovered that there were mixed messages as to when the women should start antenatal care and postnatal care therefore the mothers suggested that the midwives should give appropriate health messages pertaining to time for starting antenatal and postnatal care.

It was discovered that some of the women were not visited during their antenatal and postnatal period. Therefore of lack commitment by health surveillance assistants to conduct antenatal and postnatal home visit is one of the contributing factor for underutilisation of community based maternal newborn care programme.

It was also found that the women who have delivered should be given the correct information regarding when they are supposed to come for postnatal checks. They are also supposed to be told that they should come exactly after one week if they have no problem and

the cultural norm of rooming in or Mchikuta should not prevent them from coming on the appointed date.

This study revealed that most of the Health Surveillance do not Conduct village meetings on safe motherhood issues therefore, some women suggested that Health Surveillance Assistants should make sure that they conduct village meetings where by they ask the village headman to call the people to his home where the meeting of telling the people importance of attending antenatal early at a time when a woman has missed a period can be mentioned. This is in line with the findings from the study which demonstrated the importance of health promotion programs for increasing community awareness about necessity of antenatal services by Titley. R. 2009.

The women said that there is lack of proper information on when to start attending antenatal clinics this is a factor which affect the utilisation of community based newborn care programme because every mother has his own time she thinks is appropriate to start antenatal therefore the mothers suggested that the District should organize Safe motherhood activities which will have the message of importance of going to antenatal within the first trimester (first three months).

Lack of ownership of the programme by the community was one of the reasons for underutilisation of the programme. Therefore most of the women said that the women should own the programme strengthening safe motherhood committees and should follow the advices that are given by the Health Surveillance Assistants or midwives at the hospital. This requires that the women become aware of the dangers of not attending antenatal care within the first trimester. They should also be telling each other that they should go for postnatal check up after one week whether the umbilical cord had fallen off or not. Women said that they could still wait for the umbilical cord to fall off before attending postnatal checks. This is not in line with the belief model where by they were supposed to weigh the risks of waiting for the cord to fall off and the benefits of going for check up one week after delivery.

## **CHAPTER SEVEN**

### **7.0 Recommendations**

#### **7.1 Nursing Education**

In nursing education the curriculum should include the content of Community Based Maternal New Born so that students should have knowledge well in advance.

#### **7.2 Nursing Management.**

District Nursing Officer should motivate the existing midwives on Health Promotion messages as should emphasize the importance of starting antenatal Care within the first trimester and also importance of attending postnatal checks after one week.

The District Officer should include activities on Health Promotion during District Implementation Plan. The health promotion should dwell on the awareness of cultural beliefs that are preventing women from starting antenatal care within first trimester and cultural practices that are preventing women from attending postnatal care after one week and how women should behave within their cultural values.

The activities should include conducting campaigns on Antenatal and Postnatal Messages. Whistle stops which can help to disseminate this information.

Drama Group Performance on Safe motherhood week

Traditional Dances singing messages of importance of starting antenatal Care within 1<sup>st</sup> trimester and also importance of attending postnatal checks after one week.

The Safe motherhood Coordinator and Community Based Maternal New Born Care should monitor messages that are given in Maternity Ward and at the maternal and Child Health Department so that the information is correct focuses on appropriate time for antenatal and postnatal checks.

The Community Based Maternal Newborn Care Coordinator should strengthen supervision of Health Surveillance Assistants so that antenatal mothers and postnatal mothers are visited according to recommended schedule.

The villagers should be empowered with the information pertaining to community based maternal newborn and should own this programme by strengthening the already existing structures of safe motherhood committees at Traditional authority level as well as at village level.

Other stake Holders who are working with the District Such as Save the Children and UNICEF Should continue Supporting the Community Based Maternal Newborn Programme.

### **7.3 Nursing Research**

Other areas of research include challenges faced by health surveillance assistants in implementation of Community based maternal and neonatal programme.

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APPENDIX A

**INTERVIEW GUIDE FOR POSTNATAL MOTHERS ON COMMUNITY BASED  
MATERNAL NEWBORN PROGRAMME IMPLEMENTATION.  
CODE NO;**

Date Data was collected \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_.....

Instruction: Tick in the space provided.

**DEMOGRAPHIC FACTORS CONTRIBUTING TO UNDER IMPLEMENTATION OF  
COMMUNITY BASED MATERNAL NEW BORN PROGRAMME**

**1. Age of Participant in Years.**

- 18 – 25 [ ]  
26 – 36 [ ]  
36 – 45 [ ]  
46 – 55 [ ] Over 55 [ ]

**2. Marital Status**

- (a) Single [ ]  
(b) Married [ ]  
(c) Divorced [ ]  
(d) On separation [ ]

**3. Number of children**

- (a) 1 [ ]  
(b) 2 [ ]  
(c) 3 [ ]  
(d) 4 and above [ ]

**4 Tribe**

- (a) Tumbuka [ ]  
(b) Chewa [ ]

- (c)Tonga [ ]
- (d)Ngoni [ ]
- (e)Other specify.....

**5. Which denomination do you belong?**

- (a) CCAP [ ]
- (b) Catholic [ ]
- (c) Islam [ ]
- (d) Others (specify).....

**6. Respondent's highest level of education.**

- (a)Primary School [ ]
- (b)Secondary School [ ]
- (c)Other (specify).....

**SECTION B**

1. What are your views or perception on the importance of involving the Health Surveillance Assistants in Maternal New Born Health (MNH) Issues?
- 2 Which category of Health Surveillance Assistants do you prefer to be involved in Community Based Maternal New Born Programme between male and female Health Surveillance and Why?
3. What are the cultural norms in your village pertaining attendance of antenatal care?
4. What are the cultural practices that prevent women from starting antenatal care within first-trimester?
5. At what situation can you culture accept you to attend antenatal care as early as within first trimester?
- 6 What do you think should be done to remove these cultural barriers that affect women attending antenatal care within first trimester?
7. What information do you have from other sources pertaining importance of early antenatal care

8. What do you think are the barriers for accepting Health Surveillance assistant's advice on attending antenatal care early within first trimester?
9. What are the dangers of attending first antenatal care later than 3 months of pregnancy?
10. What are the benefits of attending first antenatal within the first three months of pregnancy?
11. Are you aware that you yourself are at risk of developing obstetric complications if you start antenatal care later than 3 months of pregnancy?
12. What do you think should be done to improve attendance of women within first trimester?
13. Give reasons why women don't go for postnatal care one week after delivery?
14. In which situations can your culture allow you to attend the postnatal care within one week after delivery?
14. What are Cultural norms that prevent women from attending postnatal care on after delivery?
15. What are the barriers for accepting Health Surveillance Assistants advice on attendance of postnatal care one week after delivery?
16. What are the dangers of not attending postnatal care within after one of delivery?
17. Explain the information you have on benefits of attending postnatal care one week after delivery?
18. Are you aware that you yourself are at risk of developing obstetric complications within one week after delivery if yes, what are these complications?
19. What advice have you received from your friends pertaining attending one week postnatal care?
20. What should be done to improve the utilisation of community based maternal newborn care programme by mothers since currently the Health Surveillance Assistants are providing all the necessary antenatal and postnatal information?

APPENDIX B

**CHIKALATA CHAKAFUKUFUKUA WA UCHEMBERE KOMANSO  
CHISAMALIRO CHA ANA AKHANDA KUDZERA KWA AMAYI OMWE  
ALANDIRA MPHATSO YA MWANA NDIPO MWANA WAKWANITSA MILUNGU  
ISANO NDI UMODZI(6).**

1 .Tsiku \_\_\_\_\_ Mwezi \_\_\_\_\_ Chaka \_\_\_\_\_

Langizo: Chongani pamalo oyenera

**DEMOGARAFE**

**2 MULI PATI PA NKHANI YA ZAKA**

18- 25 [ ]

26-36 [ ]

36-45 [ ]

Opitirira 55 [ ]

**Nkhani ya banja**

Mbeta [ ]

Wokwatira [ ]

Wosiyidwa Ukwati [ ]

Ali pa mpatuko wa panja [ ]

**3 CHIWERENGERO CHA ANA**

1 [ ]

2 [ ]

3 [ ]

4 ndi kuposera apo [ ]

**4. FUKO LANU**

(a) Tumbuka [ ]

(b) Chewa [ ]

(c)Tonga [ ]

(d)Ngoni [ ]

(e) Ntundu wina womwe sunatchulidwe

## 5 CHIPEMBEZO CHANU

- (a) CCAP [ ]
- (b) Roman Catholic [ ]
- (c) Pentecostal [ ]
- (d) Chisiramu [ ]
- (e) Mipingo ina yomwe siinatchulidwe

## 6 POMWE ANALEKEZERA MAPHUNZIRO

- Primary [ ]
- Junior Certificate [ ]
- MSCE [ ]
- Certificate ina yomwe sinatchulidwe [ ]

## 7. NTCHITO YOMWE MUMAGWIRA

- Bisinezi [ ]
- Ulimi [ ]
- Ntchito ina kupatura zatchulidwa kale [ ]

## CHIDZIWITSO CHOMWE AMAYI ALI NACHO PANKHANI YA UCHEMBERE NDI CHISAMALIRO CHA ANA AKHANDA KUMUDZI.

### GAWO LACHIWIRI LAMAFUNSO

1. Fotokozani kufunikira kwake kolola a zaumoyo kutenga nawo mbali pa Ntchito yosamalira amayi a pakati komanso ana ongobadwa kumene ?
2. Kodi ndi a zaumoyo ati pakati pa akazi ndi a muna mungakonde kuti azigwira Ntchito iyi ya pologalamu ya chisamaliro cha amayi a pakati ndi ana amakanda? Fotokozani zifukwa chake
3. Kodi ndi malamulo ati a chikhalidwe kumudzi omwe amakamba zakulola amayi oyembekezera kupita kusikero
4. Fotokozani zifukwa zina zomwe zimapangitsa kuti amayi apakati aziyamba sikero mochedwa kupatula zikhulupiriro zakumudzi.

5. Kodi zinthu zikafika potani pamene mzimayi wamimba atha kuloledwa kupita kusikero mimba isanapitirire miyezi itatu.
6. Kodi mukuona kuti chipangike ndi chiyani kuti zikhulupiriro izi zitheretu zolepheretsa amayi oyembekezera kuyamba sikero miyezi itatu isanathe.
7. Nanga ndi uthenga otani omwe muli nawo wokhuza kufunikira kwake koyamba sikero ya amayi a pakati mwamsanga miyezi itatu isanathe.
8. Nanga mukuganiza kuti ndiziletso ziti zomwe zikupangitsa kuti uthenga wa a zaumoyo usamagwiritsidwe ntchito mokwanira.
9. Fotokozani zoopsa zomwe mzimayi angakumane nazo ngati angayambe sikero mochedwa kupitirira miyezi itatu.
10. Fotokozani ubwino wake oyamba sikero ya amayi a pakati mwamsanga miyezi itatu isanathe?
11. Kodi inuyu mukudziwa kuti munali pa chiophyezo chopezeka ndimavuto a uchembere chifukwa choyamba sikero ya apamayi a pakati mochedwa (kupitirira miyezi itatu ya mimba).
12. Kodi mukuganiza kuti papangike chiyani kupititsa patsogolo kuyamba msanga kwa sikero ya amayi a pakati.
13. Fotokozani zifukwa zomwe amayi samabwerera kuchipatala pakatha mulungu umodzi atangochira.
14. Kodi zithu zikafika potani pamene mzimayi amaloledwa monga mwa mwambo wa kumudzi kuti apite kuchipatala akangochira mulungu umodzi usanathe.
15. Kodi ndi ziletso ziti zomwe zilipo zomwe zopangitsa kusamvomereza malangizo a zaumoyo ouza amayi omwe achira kupita kuchipatala pakatha mulungu umodzi.
16. Nanga ndizoophya zotani zomwe amayi ndi mwana angakumane nazo ngati sangabwere kuchipatala kuzaonedwa pakangotha mulungu umodzi.
17. Fotokozani uthenga omwe muli nawo pa zabwino zomwe mungapeze mukabwera kuzaonedwa kuchipatala pamodzi ndi mwana mulungu umodzi ukangotha mwana atabadwa.
18. Kodi inuyo mukutha kuziona kuti munali pa chiophyezo chokumana ndi mavuto a uchembere pamene simunabwere kuzaonedwa pamodzi ndi mwana kuno kuchipatala, ngati chiophyezo cho chinalipo ndichotani.
19. Fotokozani malangizo omwe munalandira okhuza chisamaliro cha amayi ndi mwana akabadwa kuchokerau kwa anzanu.
20. Kodi zomwe ziyenera kupangika kumudzi ndi ziti zomwe zingathandize kupititsa patasogolo programme ya chisamaliro chakumudzi cha amayi oyembekezera, mayi ochira, komanso mwana wongobadwa kumene.

APPENDIX C: CONCENT FORM IN ENGLISH.

University of Malawi  
Kamuzu College of Nursing  
Private Bag 1  
LILONGWE

Date.....

Dear Participant

**CONSENT TO PARTICIPATE IN A STUDY**

My name is Albert Mndala a second year student pursuing a Bachelor of Science degree programme at Kamuzu College of Nursing. In partial fulfilment of the program, I am required to conduct a research study and write a dissertation there after.

I am conducting a study on factors that contribute to under utilisation of Community Based Maternal Care Programme by mothers in Mchiramwera Village in Thyolo.

You have been selected to be one of the participants to answer questions related to the study. Any information that you give, will be kept in confidence, no one except me and my supervisor shall have access to the information. It will not be publicized without your consent.

You will be required to answer some questions which will take within the range of 30 to 45 minutes. Names will not be necessary but code numbers will be used to represent your name to maintain confidentiality and anonymity. The interview will be one to one in the private room where other people will not be able to see or hear. Your participation is voluntary and you are free to accept, refuse to participate or withdraw from the study at any point you will decide not to continue. You will not receive any ill treatment because of you decision of not to continue. There are no risks associated with this study and no direct benefits but your participation will lead to improvement of the services which will benefit the community as the whole. Therefore if you wish to participate in the study, you are requested to sign or print your finger print below to show that you understand the information provided and that you agree to take part in the study.

**TO BE COMPLETED BY THE PARTICIPANT**

I have read and understood the information above and I freely give consent to take part in the study as a subject in this research study.

PARTICIPANT  
SIGNATURE.....DATE.....  
.....

RESEARCHERS  
NAME.....DATE.....  
.....

RESEARCHERS  
SIGNATURE.....DATE.....  
.....

THANK YOU VERY MUCH FOR ACCEPTING TO TAKE PART IN THE STUDY.

Siginetcha yawopanganawo kafukufuku .....  
Date.....

Dzina lawopanga kafukufuku.....  
Date.....

Siginetcha yawopanga kafukufuku.....  
Date.....

**APPENDIX E: LETTER TO RESEARCH COMMITTEE**

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

The Chairman,  
Research and Publications Committee  
Kamuzu College of Nursing  
Private Bag 1  
LILONGWE

Dear Sir/Madam

**REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT THYOLO DISTRICT HOSPITAL  
FOCUSING MCHIRAMWERA VILLAGE**

I am a second year Bachelor of Science degree in nursing (mature entry) student intending to conduct a research study on factors that contribute to under utilisation of Community Based Maternal and New Born Care Programme by mothers in Thyolo District.

This study is required in partial fulfilment of my degree program. The aim of writing this letter is to request for your permission to conduct this study. Enclosed is the full research proposal for your comments and approval.

Your consideration will be highly appreciated.

Yours faithfully,

Albert Mndala.

**APPENDIX F: LETTER TO DISTRICT HEALTH OFFICER**

University of Malawi

Kamuzu College of Nursing

Private Bag 1

Lilongwe.

The District Health Officer

Thyolo District Hospital

P O Box 21

Thyolo.

Dear Sir/Madam

**APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT THYOLO DISTRICT HOSPITAL FOCUSING MCHIRAMWERA VILLAGE.**

I am a second year Bachelor of Science degree in nursing (mature entry) student intending to conduct a research study on factors that contribute to under utilisation of Community Based maternal new born Care programme in Thyolo District focusing Mchiramwera village.

This study is required in partial fulfilment of my degree program. The aim of writing this letter is to request for your permission to interview mothers at maternal and child health clinic at Thyolo District Hospital . The study is expected to be conducted in September 2011.

Your consideration will be highly appreciated.

Yours faithfully,

Albert Mndala.

University of Malawi  
**KAMUZU COLLEGE OF NURSING**

**RESEARCH AND PUBLICATIONS COMMITTEE**

**APPROVAL CERTIFICATE**

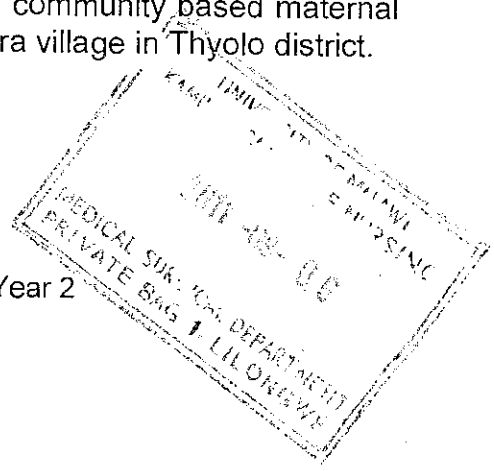
**TITLE:** Factors that contribute to under utilization of community based maternal new born care programme by mothers at Mchiramwera village in Thyolo district.

**INVESTIGATORS:** Albert Mndala

**DEPARTMENT/YEAR OF STUDY:** Basics Department/ Year 2

**REVIEW DATE:** 6<sup>th</sup> September, 2011

**DECISION OF THE COMMITTEE:** APPROVED



**SIGNATURE:** ..... *MNDAL* ..... **DATE:** 06/09/2011  
DEAN, POSTGRADUATE STUDIES & RESEARCH

cc Supervisor:

**DECLARATION OF INVESTIGATOR(S)**

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

DATE.....SIGNATURE(S).....

Telephone: + 265 1 473 411  
Facsimile: + 265 1 473 409



In reply please quote NoTDH/PF/  
Ministry of Health,  
Thyolo District Hospital,  
P.O. Box 21,  
Thyolo.


All Communications should be addressed to:  
The District Health Officer:

19<sup>th</sup> September, 2011

Albert Mndala  
Kamuzu College of Nursing,  
Basics Department,  
P/Bag 1,  
Liolongwe.

**SUBJECT: LETTER OF AUTHORITY TO CONDUCT A STUDY ON CBMNH IN THYOLO DISTRICT.**

Following the approval of your proposal by the Research and Publications Committee of the Kamuzu College of Nursing as per their certificate of approval dated 6<sup>th</sup> September, 2011, I grant you the authority to conduct a study under the title *'Factors that Contribute to under Utilization of Community Based Maternal New Born Care Program by Mothers at Mchiramwera Village in Thyolo District.'* Please share with us the your findings.

  
DISTRICT HEALTH OFFICER  
DISTRICT HOSPITAL  
SEP 2011  
Dr. Al Likaka 21, THYOLO  
DISTRICT HEALTH OFFICER