EXPERIENCES OF ANTENATAL MOTHERS STAYING IN A MATERNITY WAITING HOME AT MALAMULO MISSION HOSPITAL IN THYOLO

MSc (MIDWIFERY) THESIS

SUSAN SUNDU

UNIVERSITY OF MALAWI

KAMUZU COLLEGE OF NURSING

MARCH, 2011

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MSc (MIDWIFERY)

BY

SUSAN SUNDU

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University of Witwatersrand

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UNIVERSITY OF MALAWI

KAMUZU COLLEGE OF NURSING

MARCH, 2011

DECLARATION

I the undersigned hereby declare that this thesis / dissertation is my own original work which has not been submitted to any other institution for similar purposes. Where other people's work has been used acknowledgements have been made.

___ ___ SUSAN SUNDU________

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Signature

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Date

CERTIFICATE of APPROVAL / CERTIFICATION

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

Signature --------------------------------------Date---

Ellen Chirwa. PhD (Senior Lecturer)

Main Supervisor

Signature ---Date---------------------------------

Angela Chimwaza PhD (Senior Lecturer)

Second Supervisor

DEDICATIONS

This work is dedicated to God the Almighty who makes all things beautiful in His time.

To my beloved children, Patricia, Harvey, Chimwemwe, and Ndepele for believing in me and for the love, support, and encouragement throughout my studies.

To my beloved grandchildren, Tapiwa and Tariro for distracting me once in a while which gave me a breathing space that I badly needed at times.

To Salim and Chrissie, for being in the shoes of my late parents when the going was tough and I needed a shoulder to lean on.

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ABSTRACT

In many areas of the world, and especially in Sub – Sahara Africa, utilization of maternal services is low. In low-resource settings, cost, distance, and the time needed to access care are major barriers for effective uptake of antenatal and particularly intrapartum services. A number of innovative strategies to surmount cost, distance, and time barriers to accessing care were identified and evaluated; one of these strategies is the maternity waiting homes (MWHs), but few studies have reported or evaluated the impact of the wide scale implementation of the strategy.

This study was conducted to explore antenatal mothers' experiences of staying in MWHs in Thyolo District. A qualitative, phenomenological study was conducted utilizing on audio-taped, semi-structured in-depth interviews (IDIs). A purposive sample selection of 15 antenatal mothers staying in MWHs was recruited.

The lived experiences of these 15 mothers were revealed through IDIs. The findings on antenatal mothers' experiences of staying in MWHs revealed several things including motivating factors, benefits, and challenges of staying in MWHs. Some of the motivating factors were proximity to the hospital, birth by skilled attendance, and availability of specialized care. The benefit of staying in MWHs was that the antenatal mothers had adequate time to rest, a thing which was rare at home. They enjoyed peace of mind because they did not have to worry about how they would get to the hospital if labour started, and they made new friends while in MWHs. Challenges that the antenatal mothers reported during their stay in MWHs were lack of privacy, poor sanitation, pests, congestion, poor attitude of midwives, and adverse cultural practices.

Antenatal mothers who reside long distances from the hospital need to be encouraged to wait in MWHs for two to three weeks before the expected time of delivery where they can receive adequate medical care should complications arise.

Health workers need education and training on interpersonal skills, ethics, and attitudes to address the issue of poor attitude of midwives. This could portray a better midwifery image to the community. However, further studies should be conducted on client – provider interaction to address the poor attitude of midwives. Additionally, the hospital management needs to improve the infrastructure in MWHs, and spray the buildings regularly with pesticides to eliminate mosquitoes, ants, and fleas.

The findings indicate the need to address the challenges which will increase the utilization of MWHs. When the challenges are addressed, the number of antenatal mothers utilizing MWHs will increase leading to improved pregnancy outcome.

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LIST OF ACRONYMS and ABBREVIATIONS

ANA	American Nurses' Association
COMREC	College of Medicine Research Committee
MDHS	Malawi Demographic Health Survey
EDD	Expected Date of Delivery
ICN	International Nurses Council
IDIs	In-depth Interviews
LNMP	Last Normal Menstrual Period
MOH	Ministry of Health
MWHs	Maternity Waiting Homes
MICS	Multiple Indicators Cluster Survey
NSO	National Statistical Office
SDA	Seventh Day Adventist
SMP	Safe Motherhood Project
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
URPC	University Research and Publication Committee
USAID	United States Agency for International Development
WCBA	Women of Child bearing Age
WHO	World Health Organization

CHAPTER ONE

Introduction and Background

Introduction

The concept of MWHs has a long history spanning over 100 years (Eckermann & Deodato, 2008). Since the beginning of the 20th century, MWHs have existed in Northern Europe, Canada, and the United States to serve women in remote geographic areas with few obstetric facilities (Aday & Anderson, 1974). In Africa, one of the early experiments with MWHs, also known as "Maternity Villages", was in Eastern Nigeria in the 1950s (Poovan, Kifle, & Kwast, 1990). The rural nature of the population meant that a trip to the hospital during labour often entailed a journey of many miles, usually on foot. They introduced waiting areas next to district hospitals, where high-risk women were housed for the last two to three weeks of pregnancy. Such homes helped to reduce maternal mortality in hospitals from ten to less than one per 1000 deliveries and the stillbirth rate from 116 to 20 per 1000 in Ituk Mbang, Eastern Nigeria (Lawson & Stewart, 1968).

In Uganda in the 1960s recorded maternal deaths in one remote area fell by half once a maternity waiting area was instituted (Minkler, 1972). Cuba built its first MWHs in 1962. By the end of 1984 there were 85 such homes in the country and 99% of babies were delivered in hospital. Maternal mortality fell from 118 to 31 per 100,000 live births. It is reported that by 1989, nearly 30% of all deliveries used MWHs (Cruz, 1990). However, in many areas of the world, and especially in sub-Sahara Africa, utilization of maternal health services is low. Low utilization of maternal health services is mainly a result of barriers to access, contributing to high maternal and perinatal mortality and morbidity (Poovan, et al., 1990). In low-resource settings, cost, distance, and the time

needed to access care are major barriers to effective uptake of antenatal and particularly intrapartum services. A number of innovative strategies to surmount cost, distance, and time barriers to accessing care were identified and evaluated; one of these strategies is the MWHs, but few studies have reported or evaluated the impact of the wide scale implementation of the strategy (Bhutta, Darmstadt, Haws, Yakoob & Lawn, 2009).

It has been suggested that in rural areas, where women live far from a health facility and transport is poor and often impossible when complications of labour occur, MWHs can play an important role in reducing maternal and perinatal mortality. However, it has been observed that some antenatal mothers are reluctant to stay in MWHs. Staying away from the hospital can foster problems to the antenatal mother. Therefore, establishing the causes of the reluctance would assist in improving the utilization of the MWHs (van Lonkhuijzen, Stegeman, Nyirongo & van Roosmalen, 2003).

In less developed countries, more than half a million mothers die each year from causes related to this life-giving event. These deaths are only part of this tragic picture: For every woman who dies, about thirty suffer from devastating health problems such as infertility and damage to their reproductive organs. Ninety-nine percent of these deaths occur in less developed regions, and most are due to inadequate medical care at the time of childbirth. Evidence shows that pregnancy and delivery can be safer for all women. Over the past decade, experts have come to agree on a set of lifesaving strategies, such as MWHs, that can be implemented even in low-resource settings. What remains is for governments to commit to making safe motherhood a priority. Research shows that women's lives can be saved and their suffering reduced if health systems could address

serious and life-threatening complications of pregnancy and childbirth when they occur (van Lonkhuijzen, Stekelenburg & van Roosmalen, 2009).

One of the best ways to reduce complications is to make sure that women receive skilled care at delivery. Only about half of deliveries in less developed countries take place with the assistance of skilled health personnel. Providing skilled care means ensuring that health professionals such as doctors, nurses, or midwives can manage normal deliveries and treat the life-threatening complications of pregnancy and childbirth. With support from functioning health and transportation systems, these professionals can treat or stabilize women and refer them for appropriate care. Ensuring that women receive skilled care at delivery is an essential part of safe motherhood programs. Skilled care, however, can only be effective in the context of health systems that address women's health needs and the obstacles women face en route to emergency care. Effective health systems make obstetric care available to all women, including surgical and technical interventions required to treat life-threatening conditions during pregnancy, delivery, and after childbirth (Bhutta et al., 2009).

Background

Maternity waiting homes are residential facilities located near health facilities where women stay as they await their delivery. These facilities which are called MWHs by the World Health Organization (WHO) are also described as maternity villages, maternity waiting shelters, or maternity dormitories (van Lonkhuijzen et al., 2003). The crucial element of effective MWHs is its access to qualified obstetric services. Consequently, they are located near a hospital with operative facilities. Therefore the essence of MWHs is that, at the time of labour, the delivery could take place with skilled

attendance. The objective of the MWHs is to increase the accessibility to skilled birth attendants, thus reducing maternal mortality (van Lonkhuijzen, Stekelenburg & van Roosmalen, 2009). Furthermore, many consider MWHs to be key element of the strategy to "bridge the geographical gap" in obstetric care between rural areas, with poor access to equipped facilities, and the urban areas (van Lonkhuijzen, et al., 2009). The latest literature reviews show that MWHs increase use of health facility for delivery. Lessons learnt from the review show that MWHs are a potential strategy to increase healthy facility deliveries especially among the very poor (van Lonkhuijzen et al., 2009; Nuwaha & Amooti-Kaguna, 1999).

Around the world, people celebrate the birth of a baby. Societies expect women to bear children, and honor women for their role as mothers. Yet in most of the world, pregnancy and childbirth is a hazardous journey (Bhutta, et al., 2009). On the other hand, in Malawi, just like anywhere around the world, people celebrate the birth of a new baby. Pregnancy brings joy to the couple as well as to the immediate family in the village. However, apart from being the period of anticipation, the elders in the village are also anxious about the outcome of the pregnancy, because a maternal death in the family is devastating to the family as well as to the whole community. The anxiety comes about because geographical barriers or distance in some areas make it difficult to reach the nearest health facility. As a result, this becomes a challenge when the woman goes into labour and especially if it happens at night. Accordingly, the health facilities that are found in these areas have constructed MWHs close to the facility to cater to women coming from very far as they wait for labour (Poovan, et al., 1990). Maternity waiting

homes have been recommended by the World Health Organization to reduce maternal morbidity and mortality (WHO, 1991).

This study was conducted in the southern part of Thyolo district. Travelling from one point to another in this area is difficult because of the Shire valley and the Thyolo escarpments. Consequently, antenatal mothers come to the MWHs to await labour. In actual fact, the women are accommodated in the MWHs to await labour in order to avoid delays which can result in neonatal or even maternal deaths. According to Multiple Indicator Cluster Survey (MICS) of 2006 (NSO & UNICEF, 2008), the maternal mortality for Malawi is now at 807 per 100,000 live births. As for Thyolo, the maternal mortality rate in 1992 was 409 deaths per 100,000 live births (Chiphangwi, Zamaere, Graham, Duncan, Kenyon & Chinyama, 1992). However, the Thyolo district health officer, Dr Beatrice Mwagomba said an estimated 654 maternal related deaths were reported in Thyolo between 2008 and 2009, as compared to 500 reported between 2007 and 2008 (Chinoko, 2009). The neonatal mortality rate is 26 per 1000 live births (NSO & UNICEF, 2008).

Therefore, MWHs are there to provide a solution to the issue of distance. Unfortunately, based on the researcher's observation, most antenatal mothers do not take advantage of the service. However this reluctance to stay in MWHs may be an important factor to consider, in that, when women leave MWHs as users or clients, they should be viewed as potential "ambassadors" of the MWHs. Word of mouth, in much of the world, is still one of the most effective and compelling means of communication. Women who are satisfied with the care and services they received at the MWHs will encourage their family, friends, and neighbours to use the service (van Lonkhuijzen, et al., 2009). It is

therefore essential to establish the experiences of antenatal mothers during their utilization of the MWHs.

Problem Statement

It has been observed that some antenatal mothers are reluctant to stay in the MWHs. There have been insufficient studies to identify factors that cause antenatal mothers to be reluctant. How can antenatal mothers be motivated to utilize MWHs? It is important to explore the experiences of antenatal mothers who have stayed in the MWHs and use the result to improve utilization.

Rationale for Doing the Study

Antenatal mothers living very far away from health facilities frequently are delivered by traditional birth attendants (TBAs) near them. Only 30% of the total annual deliveries in the district are conducted in health facilities (NSO & UNICEF, 2008). However, the new laws of TBAs require them to refrain from conducting deliveries (MOH, 2007). Consequently, antenatal mothers who live very far from the health facility need to come near the health facility and stay in the MWHs to await labour. This study is therefore important because it will help to establish what antenatal mothers experience in the course of their stay in the MWHs in an attempt to make the place more open. On the other hand, when the experiences are known, they could influence the hospital management to formulate policies that can make the environment more conducive and user friendly. Consequently, the stay in the MWHs would be made comfortable and thereby promoting utilization. As more antenatal mothers utilize the MWHs to await labour, pregnancy outcome will be improved.

Objectives

Broad objective

To explore antenatal mothers' experiences of staying in MWHs

Specific objectives

- To explore what motivates antenatal mothers to stay in the MWHs.
- To explore antenatal mothers' attitude towards MWHs.
- To describe what antenatal mothers liked about being in the MWHs.
- To describe challenges antenatal mothers experience while staying in the MWHs.

CHAPTER TWO

Literature Review

Introduction

In this study, the literature review focused on historical, current, and international trends. As such, several sources were consulted; this included the library and internet. The areas of review were; what motivated antenatal mothers to stay in MWHs, their attitude towards the MWHs, what they liked during their stay and the challenges they experienced in the MWHs.

However, a limited number of studies have been conducted on MWHs, leading to a scarcity of literature on the topic. Several authors have conducted studies on utilization of MWHs and their impact on maternal and neonatal mortality, but they have not examined the mothers' experiences in the MWHs. The acceptability, and utilization of MWHs has been mixed and up to date literature is limited (Gunasekera, Wijesinghe & Goonewardene, 2002).

Antenatal Mothers' Motivation for Staying in MWHs

Credibility of the MWHs is a crucial factor because women and their families may not be easily convinced to move away from home before their expected date of delivery. A study was conducted in Colombia, where rural women were initially reluctant to use the MWHs. Institutional delivery was still unacceptable among women in the area. The flow of clients only increased slowly as women returned to their villages after delivery with favorable reports about the MWHs. Consequently, user satisfaction, and women's perceptions about MWHs are crucial elements to the success or failure of these homes (Bulatao & Ross, 2003).

Studies have shown that antenatal mothers need something to motivate them to stay in MWHs. For some women, hospital births are not acceptable. Separation from family, lack of modesty, and fear of painful and humiliating procedures have been cited as reasons for the reluctance to come to the hospital for delivery. For example, in Ghana, the implementation of MWHs failed due to poor location and lack of community consultation. Therefore, only through careful planning and the involvement of the local women, communities, and institutions can MWHs be successful. In Zimbabwe (Mberengwa district), implementation of MWHs was a success. From 1172 expected births, 1092 were reviewed, and from 1041 births which could be analyzed, 228 (21.9%) occurred at home and 813 (78.1%) occurred in hospital. Maternity waiting homes were used by 616 (59.2%) of all women. Consequently, the MWHs were effective in improving the utilization of obstetric care (Spaans, van Roosmalen & van Wiechen, 1998). In a study done in Zambia, it was found that hospital food given to the antenatal mothers in the MWHs provided a stimulus that encouraged their use (van Lonkhuijzen, et al., 2003). However, in Zaire, the lack of this service was one of the reasons that the MWHs were rarely used (Sambe, 1990).

Geographical barriers were cited as one of the motivating factors for use of MWHs in Southern Lao Peoples' Democratic Republic (Eckermann & Deodato, 2008). In a study done by these authors, they concluded that in one part of the country; more antenatal mothers opted to stay in the MWHs. This area was twenty nine kilometres from the hospital with four rivers to cross. The road was extremely dangerous and slippery even in the dry season. Findings from a study done in a rural district of Ethiopia concluded that MWHs close to rural hospitals are vital where women have to travel long

distances, transport is poor, and obstetric disasters are frequent. Furthermore, the study also established that a maternity service in a rural area requires informed community participation, special attention to antenatal care, a referral system with essential obstetric elements, and MWHs (Poovan et al., 1990).

Nonetheless, in Malawi, because of the presence of the TBAs in the community, the utilization of MWHs has had some resistance because of the highly sensitive cultural traditions regarding confinement and childbirth. As such, mothers frequently utilize the TBA for delivery. Some traditional birth attendants have even accommodated the antenatal mothers in their homes while waiting for delivery. It then follows that, unless the communities embrace the idea of the MWHs, the facilities will be underutilized because of inadequate support from the local government (Huque & Olonchimeg, 1993).

Ekwendeni hospital, in the northern region of Malawi experienced a decline in maternal mortality when antenatal mothers were persuaded to use an antenatal shelter situated about 50 metres from the delivery wards (Knowles, 1988). What came to light in this study is that the antenatal mothers did not come to the MWHs willingly. They had to be persuaded to come and stay at the MWHs. Therefore, it is worthy finding out why they were not willing to stay in the MWHs. In actual fact, it is important to consult potential users not only to identify problems, but also to identify appropriate solutions (Wilson, Collision, Richardson, Kwofie, Senah & Tinkorang, 1997).

In Colombia, Bulatao and Ross (2003) discovered that to be successful, MWHs had to be planned and implemented with community involvement and support. Decision makers in the community, whether they are the husbands, local religious leaders, teachers, politicians, and | or the women themselves, should be involved in both the

establishment, and daily operations of the MWHs. On the other hand, in Nepal, out of the 27 available MWHs, not a single one was utilized by antenatal mothers. Consequently, a study was conducted to examine these MWHs. The study concluded that, to promote utilization of the MWHs, decision-makers in the family should be motivated to accompany antenatal mothers to the MWHs, the stay at the MWHs should be cost-free; the MWHs should be equipped with the basic minimum facilities; and good-quality health services should be ensured. This study concluded that establishing MWHs in remote district hospitals in collaboration with the community could be a viable option for creating a continuum of obstetric care (Shrestha, Rajendra & Shrestha, 2007).

However, this has not been the trend in Malawi. The MWHs are established by the hospitals to which they are attached. They are just buildings but not equipped with the basic minimum facilities. For example, when the antenatal mothers come to stay in the maternity waiting home at Malamulo, they are only given a shelter without provision of the basic necessities. No midwife from maternity comes to check on them. The antenatal mothers use their own initiative to attend the antenatal clinic once a week. At first glance, the concept of MWHs is attractive in many ways. It does not require high technology; and it can serve as a practical way to meet the needs of antenatal mothers. However, one must remember that MWHs are not merely physical facilities and they cannot function in a vacuum. A maternity waiting home is not a stand-alone intervention, but rather serves to link communities with the health system in a continuum of care (WHO, 1994).

Antenatal Mothers' Attitudes towards MWHs

Women who are dissatisfied with the services offered at the MWHs may publicize the MWHs in a negative way which in turn could deter other users. Therefore, the power

of women to determine their own needs and seek their own solutions should not be underestimated (Winful, 1994). A study of four MWHs in Tanzania indicated that user satisfaction and utilization depended upon the services that were provided. For example, in three of the MWHs food was provided and prepared by the antenatal mothers themselves. They stated that their expenditure on food was too high. In one case where food was provided, the women complained that the food was unacceptable, both in terms of quantity and quality. In all four homes management was reported to be poor (Winful, 1994).

Eckermann and Deodato (2008) during their study in Southern Lao Peoples' Democratic Republic found that women who had hospital births felt uncomfortable with the birthing positions used. The women were embarrassed and uncomfortable at exposing their genitals to people entering the room. In addition, the women felt that they were not in control of the birth, especially if their feet were tied into stirrups. However, they tolerated the discomfort for the sake of their safety and the baby's. Nevertheless, given the choice they would have preferred to use the traditional birthing positions such as squatting or kneeling. As such, the antenatal mothers were reluctant to use the MWHs. Consequently, the researchers recommended the use of traditional birthing positions in uncomplicated deliveries. However, very little research has been conducted on antenatal mothers' attitudes towards MWHs as such; it was difficult to find adequate literature.

What Antenatal Mothers Liked During their Stay in the MWHs

K. Dahlin (personal communication, February 24, 1991), observed that in Zimbabwe, the antenatal mothers who used the MWHs spent much of their evenings singing. The time at the MWHs was for many the only "holiday" in their life. This

situation may also apply in the Malawian context because women work all year round. They even work harder than their male counterparts. They do not have time to rest even when they are pregnant. However, Eckermann and Deodato (2008), in their study found that many women said that pregnancy and birthing were the only times when the women's relief from hard physical labour was sanctioned by the community, especially their husbands. Consequently, they looked forward to well – earned rest in the MWHs. Nonetheless, not much information has been documented on what antenatal mothers like about the MWHs. For this reason, it will be interesting to discover what antenatal mothers like about the Malamulo maternity waiting home.

Challenges Experienced by Antenatal Mothers While Staying in the MWHs

Before planning MWHs, the level of need must be determined by conducting a needs assessment. A crucial element of the needs assessment includes determining the level of existing health services and whether or not women use these health services. Constraints to the use of these facilities must be identified before planning to establish MWHs. These constraints could be socio-cultural, financial, or transportation. Nevertheless, one thing to have in mind is that MWHs are merely one link in a chain of comprehensive obstetric services. Any weakness in one link will affect the strength of the entire chain (Maine & McCarthy, 1992).

In a study in Malawi, G. Maynard-Tucker (personal communication, February/March, 1995), identified challenges in the MWHs. These included; absconding from the MWHs before delivery; malnutrition due to poor diet because the antenatal mothers had to bring their own food from home. The antenatal mothers also used local drugs from traditional healers to induce labour while in the MWHs. Labour were induced

to reduce days spent in the MWHs. The reason could be that they were worried about the siblings left at home with no proper care. The induction of labour was dangerous because the antenatal mother could end up with a uterine rupture while staying within easy reach of the hospital. In essence, this indicates that one can learn a lot from the experiences of antenatal mothers who have stayed in MWHs. However, the antenatal mothers from Maynard-Tucker's study were not interviewed to establish what constraints they experienced.

In Mozambique, the women lodged at the Casa de Espera (MWHs) had the responsibility for the daily domestic tasks, food, cleaning, and clothing. They were also contributing to the MWHs' maintenance. These antenatal mothers dedicated their time to handicrafts, dress-making, and food processing. Their products were marketed in order to create funds for maintenance of the Casa de Espera (Cecatti, n.d). Consequently, this study may bring out those unknown experiences of antenatal mothers staying in the MWHs.

Nevertheless, the resources of a community determine the use of MWHs. It can be expected that the use of MWHs will decrease during economic and social hardships. During a study that was conducted in Zimbabwe at Mberengwa, one third of the women who gave birth at home indicated lack of money as the main reason. Women living in low income situations are very well aware of the importance of hospital delivery. However, they are not able to achieve this because of poverty (Dekker & Hoppenbrouwers, 1993). In Zimbabwe, a study examined the use of hospital-based obstetric services, including societal expectations, physical, and cultural distances between health facilities and communities, and the perceived quality of care were

identified as factors which needed to be considered. For example, where women were advised to stay at the MWHs for four weeks because of the difficulties in estimating the date of delivery, duration of the stay was observed to be a possible barrier to use (The Prevention of Maternal Mortality Network, 1992).

In Southern Lao Peoples' Democratic Republic, social, economic, and culture barriers also contributed to challenges of staying in MWHs. The main economic barriers to women using the existing health system involved the cost of services and drugs, the cost of transport to and from health facilities, and lost labour and production during absences from the village for themselves and their families when they visit. Some women's experiences of MWHs were unfavorable. The minority ethnic groups were being patronized and treated badly by health service providers. Consequently, this made them skeptical about using the MWHs. By contrast, some women's experiences of the health system were positive and, given no economic or geographical barrier, they would gladly stay closer to skilled care for delivery (Eckermann & Deodato, 2008). The study recommended intensive training in interpersonal skills for staff to avoid disrespectful and bad treatment which decreased usage.

Summary

While anecdotal evidence indicates that in some areas MWHs are successful in reducing maternal mortality; little research has been conducted to explore the experiences of the antenatal mothers' during their stay in the MWHs. Utilization rates and user satisfaction are also insufficiently documented. Limited access to essential obstetric services continues to endanger the lives of many women. Treatable emergencies occur in environments where the necessary resources are not available. These are preventable

deaths, and MWHs can be viewed as one possible option for managing these emergencies. As this document has demonstrated, multiple models of MWHs exist. The use of MWHs is common in many Southern African countries but does not appear to have achieved high availability worldwide. The increased usage of MWHs would also be a good strategy for Malawi. With the changing roles of the TBAs, facility based births are going to increase. Consequently, antenatal mothers who live very far from the health facilities will need to come and reside in the MWHs while waiting for delivery.

CHAPTER THREE

Methodology

Introduction

This chapter describes the process which was followed, in implementing the study to explore antenatal mothers' experiences of staying in maternity waiting home at Malamulo Mission Hospital in Thyolo. It includes the study design, study population, study setting, sample size, sampling methods, criteria for selection of sample, data collection instrument, and academic rigor. Data management, and analysis, ethical issues, and plan for dissemination of results are also reviewed.

Research Design

An exploratory descriptive design in the qualitative paradigm was used to explore the *(*experiences) motivational factors of antenatal mothers staying in MWHs. Qualitative research provides a full understanding of a topic by viewing it through the eyes of the people who experienced it (Rees, 1997). The aim of this study was to gain insight into the experiences of antenatal mothers who stay at the MWHs. Therefore, since the aim of the study was to gain an in-depth understanding of the antenatal mothers' experiences, a qualitative approach was appropriate (Polit & Beck, 2004). For that reason, information was collected as it was expressed naturally by the antenatal mothers within the context of their stay in the maternity waiting home.

Setting

The study was conducted at Malamulo Mission Hospital in Thyolo. Thyolo district is situated in the southern part of Malawi. It covers an area of 1,715 square kilometers with a density population of 270 per square kilometer. There are 456 villages

under eight traditional authorities and four sub-traditional authorities. It has a total catchment population of 617,012, out of which 34,121 are served by Malamulo Mission Hospital. Out of this population, 128,800 are women of reproductive age (15-49years). Thyolo has a total of 30,581 deliveries annually, of which 30% are conducted in health facilities and the remainder are delivered by TBAs or at patient's home. There are a total of 185 nurse midwives serving the district (NSO & UNICEF, 2008). The district has a total of twenty-six health facilities, two of which are hospitals and the remainder is health centres. Twenty-four of the twenty-six health facilities have MWHs.

Sample

A convenient purposive sample of fifteen antenatal mothers participated in the study. Participants were selected based on their first- hand experience with the phenomenon of interest (Speziale & Carpenter, 2007). In this study the population was all antenatal mothers staying in MWHs. The researcher started with a sample size of ten antenatal mother residents in the maternity waiting home. This number was thoughtfully and intentionally revised as the data analysis suggested new avenues to explore. Saturation was reached after interviewing 12 mothers; three additional antenatal mothers were recruited to verify the findings (Speziale & Carpenter, 2007). Saturation of data is when the data collected become repetitive so that no new information is being added (Gillis & Johnson, 2002; Polit & Beck, 2004).

Inclusion Criteria

Inclusion criteria was, a willingness to participate in the study (written consent form), and that they were antenatal mothers staying in the MWHs for greater than seven days.

Exclusion Criteria

The exclusion criteria was, antenatal mothers who were not residents in the MWHs, those who had stayed in the MWHs for less than seven days, antenatal mothers who could not speak Chichewa fluently, and those who were too ill to participate.

Pilot Study

The researcher visited the maternity waiting home, after permission was granted by the hospital. The resident antenatal mothers were interviewed individually for inclusion criteria. The purpose of the study, and the process to be followed were explained. Two antenatal mothers who met the inclusion criteria were selected to participate in the pilot study. A pilot study was done to test the interview guide and the feasibility of the study (Speziale & Carpenter, 2007). It was through this pilot study that each step of the research process was evaluated. The interview guide was refined following the interviews to improve the quality of the study.

On the following day the researcher conducted a pilot study on the two participants. The private interviews were conducted in special room in maternity ward which was put at the disposal of the researcher by the hospital management. Results from the pilot study formed part of the data since they were found to be appropriate.

Data Collection

Data collection was conducted between February and March 2010. A piloted interview guide was utilized for data collection. Additionally, demographic data of the participants was collected.

Instrument

The interview guide was developed in English (See Appendix H), and translated into Chichewa (See Appendix I) because the interviews were conducted in Chichewa. This interview guide was modified or improved as necessary in the course of data collection.

Step1.

The researcher visited the antenatal mothers in the MWHs. She explained to each of them individually the purpose of the research. Each participant was told that she had been chosen to participate in the study because she was pregnant and staying in MWHs. Her participation in the study was voluntary and that she was free to withdraw at any time. When an informed consent had been given, the antenatal mother was recruited into the study.

Step2.

In-depth interviews (IDIs) were conducted. These tape- recorded IDIs were conducted on a one to one basis. As an interviewer, the researcher would tune the ordering and the depth of probing of individual questions in order to further investigate issues raised, but essentially the questions asked of each participant remained the same. Participants were engaged in a conversational style of questioning. This style was adopted to encourage the participants to articulate their experiences in their own words. The questioning included descriptive, structure, opinion, and probing type questions. Each interview took approximately thirty-five to fifty minutes. The researcher used a tape recorder to record the structured and unstructured interviews for transcription verbatim later. The transcription added notes on pauses, sighs, and / or voice tone. Field notes and

observations helped the researcher to construct a description of the meaning of the experiences. This added reliability to the data.

Data Management and Analysis

The data that was collected from the participants during the in-depth interviews was stored in a locked filling cabinet in the researcher's office to maintain privacy and confidentiality.

Step1.

Apart from the principal researcher, an assistant was required to translate data from Chichewa to English. The assistant was a Registered Nurse/Midwife with a Bachelor of Science Degree in Nursing. She was trained on how to translate the transcribed data from Chichewa to English.

Step2.

Data management and analysis was done manually. All interviews were recorded and each interview was transcribed immediately following the interview. The trained assistant translated the data from Chichewa to English.

Step 3.

Data was printed, and organized by converting it into smaller, more manageable units that could be retrieved and reviewed.

Step 4.

The units that reflect distinct ideas were put into categories called themes and were coded. The categorization of the themes was orderly and carefully defined to avoid overlap which could cause loss of information. Careful reading, listening to the recorded interviews and documentation was done to ensure accuracy.

Step 5.

The identification of the underlying themes followed two distinct stages. The first, initial coding of interviews utilized a set of coding strategies which terminated in the identification of a set of four themes.

Step 6.

The second stage was the in-depth categorization, which took these themes back to the raw transcript data and investigated each one individually. This resulted in a comprehensive coded and structured dataset for each theme.

Step 7.

An expert in qualitative research analyzed data and identified identical themes and sub themes. This procedure addressed the trustworthiness of the data.

Ethical Considerations

The ethical considerations were based upon the ethical principals of justice, beneficence, autonomy, and non-maleficence (Watson, McKenna, and Cowman & Keady, 2008). As such, clearance to carry out the study was obtained from COMREC (See Appendix A), and the Medical Director of Malamulo Mission Hospital (See Appendix B). Participants were informed that taking part in the study was voluntary and that they were free to withdraw at any time. Choosing not to participate or withdrawing from the study would neither affect the relationship between them and the investigator nor have any negative consequences. In addition, their participation in the study could involve some minimal risks such as spending a bit of their time during the interview. They were also told that they may be uncomfortable with some of the questions. However, they were further told that they were free to choose not to respond to any

particular question. The participants were also informed that the investigator would audio tape them if they granted their permission but they could ask the tape recorder to be turned off at any point during the interview if there was something that they did not want to be recorded. All participants in the study gave an informed consent by signing a consent form before participation (See Appendix E and F).

Limitations of the Study

The researcher encountered a number of limitations during the study. The study was conducted during the harvesting season as such, it was difficult to recruit participants. In the harvesting season there is a lot of work to do in the fields. Consequently, antenatal mothers, as well as their guardians, were busy harvesting their crops. For this reason, very few antenatal mothers were found in the MWHs. On some days the place was deserted. Unfortunately, the time for data collection was limited. The study findings are limited in that purposive sampling was done of a naturally occurring group from only one hospital. As a result, generalizability of the results will be limited since the sample was derived from Malamulo only. The findings of this study may, or may not represent others in the population.

CHAPTER 4

Presentation of Results

Introduction

This chapter describes the findings of a study conducted at Malamulo Mission Hospital maternity waiting home. A pilot study to test the interview guide was conducted from 24th to 26th February 2010. Data collection was carried out between the 10th of March and 9th of April 2010. The broad objective of the study was to explore antenatal mothers' experiences of staying in MWHs.

A summary of the themes which emerged from emersion in the data is presented in this chapter. Citations from the interviews have been used to represent the antenatal mothers' experiences. Four themes emerged from the analysis of the data which included: motivating factors, decision making, benefits of staying in MWHs, and challenges of staying in MWHs. These themes emerged in response to the main objective of the study which was to explore antenatal mothers' experiences of staying in MWHs. Demographic data is reviewed to identify the characteristics of the sample. Findings are presented under the following ; demographic data, followed by elaboration of the emergent themes of ; decision making, motivating factors, benefits of staying in MWHs, and challenges of staying in MWHs.

Demographic Data

The sample consisted of antenatal mothers who were residing in the maternity waiting home at Malamulo Mission Hospital and had resided there for a minimum of one week. Fifteen antenatal mothers participated in this study. All the antenatal mothers were residing at the MWHs when interviews were conducted and agreed to participate. Their

ages ranged from 16 to 39 years. The majority were aged between 20 and 34 years followed by adolescents aged between 16 and 19 years .The 35 to 39 year old age group was in minority. The mean age was 24.6 years. Married antenatal mothers constituted the majority of the participants, while a minority was divorced or single. Peasant farming was the occupation for the majority. The remaining were comprised of business ladies or resided with parents.

The participants belonged to different religions. Seventh Day Adventist (SDA) Church members were in majority, followed by Church of Christ and African Church, and the other churches combined were in minority. The majority of the antenatal mothers took 3 to 6 hours to reach the hospital and a minority reported that it took them 1 to 2 hours to reach the hospital. There were three types of transport which were used to travel to the hospital. Majority of the antenatal mothers travelled to the hospital on foot while the minority used pick-up vehicles, or ambulances.

Table 1

Summary of the Demographic Data

DEMOGRAPHIC	DATA(N=15)			
Characteristics	Category	Percentage (%)(N)	Total	(%)
Age (year)	16 – 19	27 (4)		
	22 – 34	60 (9)	100	
	35 – 39	13 (2)		
Marital status	Married	86 (13)		
	Divorced	7 (1)	100	
	Single	7 (1)		
Educational status	No formal	7(1)		
	Primary school	80(12)	100	
	Secondary school	13(2)		
	SDA	53(8)		
Religion	Church of Christ	13(2)	100	
	African	13(2)		
	Others	21(3)		
Type of Work	Peasant farming	80(12)		
	Business	13(2)	100	
	Staying with parents	7 (1)		
Time taken to Reach the Nearest Health Facility	3 – 6 hours	73(11)	100	
	1 – 2 hours	27(4)		
Means of transport	On foot	40(6)		
	Pick-up vehicle	33(5)	100	
	Ambulance	27(4)		
Time Spent in MWH	1 – 2 weeks	73(11)	100	
	3 – 4 weeks	27(4)		
Source of Knowledge	Doctor	73(11)		
	Friends	20(3)	100	
	Self	7(1)		

Source of knowledge

Prior to discussing the participants' experiences in MWHs, the researcher sought background information on their source of knowledge about MWHs and decision making to stay in the MWHs. This information was necessary because it assisted to motivate the antenatal mother to stay in the MWHs. With respect to sources of knowledge, the researcher sought to determine how the participants obtained information about the MWHs. The participants were asked to explain how they learned about the existence of the MWHs at Malamulo. The majority of the participants cited the doctor as their source of knowledge. They met with the doctors either at the antenatal clinic or in the antenatal ward when they were admitted with false labour and, or for management of other medical conditions. Subsequently, on discharge they were encouraged not to go home but to wait at the MWHs because they were term or near term. As many travelled from far and difficult to reach areas, the discharging doctor frequently told the women that it would be better if they stayed in the MWHs until delivery. A few antenatal mothers mentioned friends as their source of knowledge. Only one participant who lives near the Malamulo hospital perimeter responded that she knew previously about the MWHs at Malamulo without being told by others. One participant said the following regarding receiving information about the MWHs:

> The first day when I came here at the hospital with labour pains, when the pains stopped the doctor said it would be better if I went to the waiting home. "You should go and stay at Nchima". He showed me that this is the place. It is the doctor who escorted me to the waiting home, to the house known as Nchima.

Decision Making

The antenatal mothers were asked to explain how they made the decision to stay in the MWHs. They said that culturally, an antenatal mother could not make a decision concerning the pregnancy on her own. She had to consult family members such as her uncle, her spouse, or her mother to assist her with decision making. All the antenatal mothers that were in the MWHs said they made their decisions after consultation. The consultation took place between the antenatal mother and her mother, her spouse, or both. The people who were consulted had to give their approval to support the decision. Some antenatal mothers had physical discomforts which needed medical attention. Others made the decision to stay in the MWHs based on the advice of friends. This was reflected in the following response: "When I told my husband and my mother, they discussed the issue and gave their consent. They gave me the consent after they had discussed the issue between them and came up with one decision. Yes."

However, the response from the consultation about staying at the MWHs was not always positive. Some family members when consulted did not think it was necessary for the antenatal mother to stay at the MWHs regardless of the circumstances. This was reflected in the following response:

> Some people do not understand the goodness of a waiting home. For example yesterday a certain girl came after being sent from the ward. She accepted to come and stay here while her mother-in-law went back home to collect food items. However her sister followed her here and told the girl to go home. The girl tried to refuse but the sister insisted. As a result the sister just took the girl's luggage and started off for home. The girl had no choice but to follow the sister

home. The mother-in-law returned with food items the following day only to find her daughter-in-law gone.

Motivating Factors

The antenatal mothers had left their homes and families in order to stay at the MWHs. A variety of reasons were given for deciding to stay in the MWHs. These factors were grouped under the following sub themes: physical conditions, social factors, psychological factors, and distance from centre.

Physical condition factors

Antenatal mothers were motivated, after discharge from the antenatal ward, to stay in the MWHs. They had been admitted to the antenatal ward for a variety of health conditions including malaria, pneumonia, and false labour. The antenatal mothers reported that they needed to remain within easy reach of the hospital. Since they had not been feeling well, staying near the hospital after discharge was ideal for them in case the problem recurred. Additionally, most of the women were near term and they thought it was better for them to stay in the MWHs rather than go home. This is how one participant put it:

> I was motivated to stay at the waiting home because every night I had contractions as though I was going to deliver but they stopped in the morning. I thought that if I go went, any time I may have problems. When I was told that there was a maternity waiting home, I received the news very well. That is why I have come.

Social factors

The participants cited family support as another important motivating factor. Initially they may have been motivated by distance or physical condition, but the family members encouraged them to stay. The support encompassed financial support from the spouse, visits by family members, and the presence of a guardian. The antenatal mothers were delighted by the warm welcome on arrival from the other residents of the MWHs. Subsequently, they reported making new friends. The motivation was further sustained with the companionship that developed among the antenatal mothers in the course of their stay. One participant explained:

> I have support from my family. My husband encourages me saying; do not come home until the visitor has arrived. I will be doing the work at home. He is a charcoal burner and he sends some money after selling the charcoal. My younger sister came too and said, they are saying that you should not think of going home but remain where? Remain here. People from home are visiting me. Those who have visited me since I came are my sister, husband and sister-in-law. Even my uncles have been to see me.

Psychological factors

Some antenatal mothers were motivated to stay in the MWHs because of fear of a repeat experience of what happened with their previous delivery. They were afraid of being assisted by unskilled birth attendants because of a bad experience in the previous pregnancy. Some reported being brought to the hospital on a stretcher by men or delivering on the way to the hospital. They felt that what happened with the previous delivery made them lose their dignity. This was recited by one of the participants:

…I lost a lot of blood before delivery. I just started with bleeding at home and because of the bleeding I failed to walk. We had to call for an ambulance to come and collect us. It was serious, I might have died. This is why people are refusing me to go home. They are afraid of that experience… (Smiles) Since my husband stays away from home it is not fair to let other people's husbands carry you on a stretcher and then thereafter start bickering, saying where is your husband. It makes you to lose your dignity.

Distance factor

Proximity to the hospital was a motivating factor for staying in the MWHs. Considering the distance from the hospital to their homes, the antenatal mothers felt they were not ready to face the long walk back home, or to make the return trip when they eventually went into labour. They decided to stay in the MWHs for proximity to the labour ward. This meant that the antenatal mothers did not have to walk for a long distance when they went into labour. A participant said:

> It is better to stay at MWHs because it is near the labour ward. If you start feeling pains you can just walk to the labour ward. That is the goodness of staying in MWHs that I have observed. If I was to choose between staying at home and staying here, I would rather stay here. Home is too far.

Benefits of Staying in MWHs

The study participants identified a number of benefits from staying in the MWHs. These benefits were grouped under the sub themes of physical, psychological, and social benefits.

Physical Benefits

The majority of the antenatal mothers said that they benefited from staying in the MWHs. The proximity to the maternity ward was a benefit to them because they would just walk over if they went into labour. Moreover, they had adequate time to rest. The antenatal mothers were also happy because of the fresh air that they enjoyed during the exercise. They did not have to do their normal strenuous work as one participant alluded to:

> There is nothing that I do because there is no garden here. Yes, we walk to Makwasa and back so that the body should be strong. We also rest by taking a nap. Stretch the body just for a short while and then you wake up and you are up and about. At home you cannot have that chance of having a nap because you are always thinking of what needs to be done next.

Psychological Benefits

Participants also identified psychological benefits of residing at the MWHs. The antenatal mothers felt good and relieved while staying in the MWHs. They said that they had peace of mind because they did not have to worry about how they will travel to the hospital when they were in labour. Staying at the MWHs assured them of quick access to specialised care. This was how one participant cited her experience:

> When you are at home, transport can be a problem. During one of my deliveries I tried to rush to the hospital but I delivered before arrival. At the waiting home, aaah, I stay comfortably. Mmmmh, there is no problem. While at home sometimes you could have worries. You could be thinking that how will I walk to

the hospital when I go into labour since it is far. How will I arrive there? My husband is not here. But as of now, while I am staying here let me say the truth, I do not have any worries. I can just walk across into the ward. When I am told to push, I can have the energy to do so.

Social Benefits

The antenatal mothers also identified social benefits from residing in the MWHs. They made new friends and there was companionship between them. This companionship was vital to them because it kept them occupied and they did not have time to think about home. As they are chatting with each other and exercising together, they build a relationship that is ongoing. When they go home they may continue to network with each other. This is evidenced by this narration:

> There are several of us here and we stay without quarrelling. We joke with each other saying; tomorrow I will escort you to the labour ward. I will carry your basin for you….. (Laughs). We chat with each other as if we are at home.

Challenges of Staying in MWHs

The antenatal mothers reported challenges faced in the course of their stay in the MWH. These challenges have been grouped under the following sub themes: Lack of Privacy, Poor sanitation, Pests, Congestion, Rude Midwives, Witchcraft, Cultural Beliefs, and Myths.

Lack of Privacy

The major challenge that emerged from the study data was a lack of privacy. The majority of antenatal mothers said that they felt very uncomfortable undressing in their

rooms in the MWHs because there was no privacy. People were always going in and out during the day. In the night they usually had adolescents sleeping in the same room with the antenatal mothers. This was how it was narrated by one of them:

> As for privacy, when you feel hot, you cannot take off your clothes because other women are there. The problem is that some women enter the room while others bring young children with them and sleep in the same room. This makes us uncomfortable. And there are different types of people. Some have given birth only once while others have never given birth before. So you are forced to have your clothes on all the time.

Poor sanitation

Poor sanitation was also identified as a challenge. The toilets were said to be very dirty and not cleaned regularly. As a result some of the antenatal mothers were using the male toilets. The antenatal mothers reported that they were not comfortable using the male toilets because they were afraid that men might find them inside. One of the participants commented about the filthiness of the toilets and bathrooms as cited below:

> The bathrooms……Eeeeh……mmmmh, if you have no shoes like me then you cannot go in. the floor is slippery and there is moss going there. The place is really bad. If you are eating and then you want to visit the toilet, you have to think twice. Where am I going to step? For the past few days the place has not been cleaned as a result people are using the male toilets at the far end. As it is now, when someone wants to visit the toilet, they just peep through the door and turn back.

Pests

Another major challenge was the presence of pests. The antenatal mothers cited mosquitoes and ants as pests that disturbed them or gave them sleepless nights. One antenatal mother talked of fleas being among the pests that were found in the MWHs. One participant recounted her experience:

> So when we came, I found that the type of care that is there is somehow difficult for us. We are not able to stay there comfortably because there are a lot of ants. There are a lot of pests there as you can see from the look of my arms…. (Extends the hand to show rash). Fleas are also there .When we tell the watchman that it is not only mosquitoes, they do not take action. They just say as long as you have come to the hospital, you will be assisted. You should tell them those things. What about the ants? They are plucking our hair. Should we also go and explain at the hospital?

Congestion

The antenatal mothers expressed concern that the house they were using was always congested because it was the only local building with a lamp. The other houses did not have lamps; as a result, even guardians from the general wards flocked to the antenatal mothers' house resulting in congestion of people. One participant narrated her experience:

> Last night I observed that there were a lot of people who came to the extent that if I tried to turn like this … (Pretends to turn round), I could not find turning space. I told them that you are hurting me. They started giving rude remarks such as, are

you the first one to be pregnant. Anybody can sleep here. Some people are just taking this as a rest house. They have no patients in the ward. In the morning they go to tea companies to work. Some are busy with piece work (Shelling maize) in the locations.

Poor attitudesof Midwives

The behaviour of the midwives was commented on by a number of participants, in that they were rude and did not visit the MWHs. The interpersonal relationship between the antenatal mothers and the midwives was reported as bad. The midwives did not come to the MWHs to check on the antenatal mothers or assess them. When the antenatal mothers went to the labour ward, they reported that they were not assisted properly. Often they were just sent back without being assessed. This led to some of the antenatal mothers delivering on their own:

> When you tell them that I am coming from the maternity waiting home and I am not feeling well, they just say aaah, you are running away from mosquitoes at the waiting home.......another girl went through the same experience like me. When she went to the labour ward she was sent back on two occasions but instead of going back she put a basin in between her legs. While standing she delivered her baby in the basin without a midwife. The participant further said: "But for the nurse, just to think even once to say 'there are waiting mothers there, let us go there and just say good morning,' they do not come."

Cultural factors

During the study the antenatal mothers identified multiple cultural issues affecting their stay. With a lot of time on their hands, they spent it mostly chatting and discussing issues. Witchcraft, beliefs, and myths were part of their daily discussions. These have been shown in the following narrations.

Witchcraft

A few participants talked of witchcraft in the MWHs. They heard stories of people who were practising witchcraft in the MWHs. Antenatal mothers reported that they were afraid to utilize the MWHs because of the stories that they had heard. One participant cited in the following example:

> Some people bring witchcraft here. You find that when we are sleeping they will come to palpate us on the abdomen. This witch happened to have palpated someone who had protected herself. Suddenly we heard the witch screaming while looking for the door to go out. She opened the door, went out, and continued screaming.

Another reported the use of local herbs:

> Since I have been here I am having a headache, dizziness, and sometimes I feel like fainting. The wife of the watchman observed that I have a problem and she gave me herbs for the headache in the form of oral drugs, and cut tattoos on my forehead.

Beliefs

Some participants reported that they were worried because of what their friends were telling them. These friends said that since their mothers and fathers were engaged in sexual relationships when they visited each other, they were not supposed to cook for the antenatal mothers when they returned to the MWHs. They said that antenatal mothers were not going into labour because they ate food prepared by guardians who have had sexual relationships with their spouses. One participant cited as follows:

> My friends here have been telling me that because when mother goes home she sleeps with my father that is the reason why I am not going into labour. A guardian should not cook for an antenatal mother if she is having sexual intercourse with her husband because she is hot. I do not care, if she wants me to die let me die.

Myths

Prolonged use of family planning methods was identified as a belief that was related to difficult labour. A participant who had used Depo provera was very worried that she was not going into labour because of prolonged use of the method. Friends in the MWHs told her that she had used the Depo provera for too long that was why labour pains were sporadic. They told her that she could even die. This frightened the participant as she narrated:

> Some people are telling me that this is happening because of the family planning method that I was taking. They usually ask me how many times I have had the injections. When I tell them that I had 17 injections they say, "It will kill you,

> Eeeeh, Eeeeh, Eeeeh, how can you take all those 17 injections. That is why you are having labour pains on and off.

Conclusion

This chapter presented the study results according to the major themes that emerged from the data analysis. The themes which emerged were: motivating factors, decision making, benefits of staying in MWHs, and challenges of staying in MWHs.

CHAPTER 5

Discussion of Findings

Introduction

The chapter presents a discussion of the findings of the study whose purpose was to explore antenatal mothers' experiences of staying in a maternity waiting home at Malamulo Mission Hospital in Thyolo. The discussion will focus on the demographic data as well as themes which emerged in respect to the objectives of this study which were to: explore what motivated antenatal mothers to stay in the MWHs, explore antenatal mothers' attitude towards MWHs, describe what antenatal mothers liked about being in the MWHs, and to describe challenges antenatal mothers experienced while staying in MWHs. Finally strengths and limitations of the study, recommendations and conclusions will be presented.

Demographic Data

Age of Participants

The study sample consisted of fifteen antenatal mothers living in MWHs was recruited. The majority of the antenatal mothers were aged between 20 and 34 years. The second most frequent age group was those aged between16 and 19 years. The group of antenatal mothers aged between 35 and 39 years were in minority. This shows that all the antenatal mothers staying in the maternity waiting home represented entire range of women of child bearing age (WCBA) which is 15 to 49 years. The majority were in the 20 to 34 years age bracket which is taken as a low risk age group. However, nationally the two high risk subgroups of antenatal mothers are adolescents and women of 35 years and above. The antenatal mothers in these two age bracket were in high risk for

pregnancy complications. Although every pregnant woman runs the risk of developing a complication during pregnancy, delivery or puerperium, complications are more common among teenagers, older women, women in their first pregnancy, women in their fourth or higher pregnancy, women with short birth intervals, short women and women who had a complication during a prior pregnancy. This was supported by literature because according to Poovan, Kifle, and Kwast (1990), the first MWHs were constructed for women who were expecting their first delivery, grandmultiparous women, very young women and women of later childbearing years. The study sample differed from national statistics with respect to risk group. The majority of the antenatal mothers were in the low risk group (20 to 35 years).

Additionally, since these antenatal mothers who participated in this study lived in remote and inaccessible areas transport was poor and often impossible when complications of labour occurred. Consequently, staying in MWHs towards the end of pregnancy could play an important role in reducing maternal and perinatal morbidity and mortality (Bhutta, et al., 2009; Thaddeus & Maine, 1994). According to Malawi Indicators Cluster Survey (MICS) report of 2006 (NSO & UNICEF, 2008), the majority of women live in rural areas and only a minority live in urban areas. The sample population was consistent with the national statistics.

Marital Status

A majority of the antenatal mothers were married while the remaining few were either single or divorced. The marital status influences the type of support that antenatal mothers receive. The presence of a husband at home is very reassuring for the antenatal mother. The married antenatal mothers were encouraged to stay in the MWHs and

supported financially and psychologically by their husbands. Nationally, according to MICS report (NSO & UNICEF, 2008), 71.2 % of women were married, 12.6% divorced, and 16.2% never married. Sample varied from national statistics because in the study sample the majority of women were married while those divorced and single were just a few.

Educational Level

The majority of the antenatal mothers had primary school education, while a few had secondary school education and very few had no formal education at all. Nationally, 19.9% of Malawian women are non-educated, 65.2% attained primary school education and 14.6% secondary education (NSO & UNICEF, 2008). The study population differed with national statistics in that the percentage of those who had primary school education was higher; those with secondary education were almost at par, while the non-educated percentage was less. In Malawi, improved educational status of women is associated with better access to obstetric care (Geubbels, 2006). Education empowers people. People who have some education are in a better position to seek and to comply with health care provider's instructions. Education level itself is an important determinant of access to obstetric care services.

In a Safe Motherhood Project (SMP) survey, higher institutional delivery rates were observed in districts with higher female literacy rates. The number of years of education showed a dose response relation with maternity service attendance: women with primary, secondary or higher education were 4, 5, and 7 times more likely to use services than women without education (Ratsma, 2003). Additionally, Kwast, Kidane-Mariam, Saed, and Fowkes (1984), found that higher educated women used health

facilities more frequently compared to those with lower education. This conclusion was also reached by Raikes (1990) in a study done in Kenya.

Religion

All participants in the study were Christians. Additionally, members of the Seventh Day Adventist were in majority. Christian faith does not restrict their believers' health care seeking behaviour. However, a study done in the United States of America revealed that conservative religious beliefs limit utilization of modern medical services (Geubbels, 2006). On the other hand, no previous literature on MWHs was found that identified common demographics of the current findings on religion during the literature search.

Occupation

A majority of the antenatal mothers were peasant farmers. Peasant farming subjects antenatal mothers to an enormous burden of work and responsibility. These results were consistent with the national statistics where it has shown that women are the backbone of the agricultural part of Malawi's economy. Their average work day lasts 15 hours as compared to 6 hours for men. The majority of all the farm workers in the small-holder agricultural sub-sector are women (NSO, 2001). All the same, this situation changed as they came to stay in the MWHs. The antenatal mothers said that when they were at home they could not think of taking a nap because they were always thinking of what needed to be done next. However, in the MWHs they had the opportunity of resting comfortably. On the other hand, Eckermann and Deodato (2008), in their study found that many women said that pregnancy and birthing were the only times when the community,

especially the husbands, allowed the women to have relief from the hard physical labour. Consequently, the antenatal mothers looked forward to a well – earned rest in the MWHs.

Distance from Home to the Nearest MWHs

The majority of antenatal mothers traveled a great distance to reach the nearest MWHs. Furthermore, the majority had to make this journey on foot. This meant that by choosing to stay in MWHs they had made a wise, practical decision. A Safe Motherhood Project Needs Assessment in the 12 districts of Southern region of Malawi showed that most women lived 2 to 5 kilometres (km) from a health facility, and that walking was the main form of transport, irrespective of the severity of the obstetric condition. One third of women took longer than 2 hours to reach a health facility and one tenth took more than 4 hours (Hofman, 2004). Bhutta et al., (2009), identified in their study that in low-resource settings, cost, distance, and the time needed to access care were major barriers for effective uptake of antenatal and particularly intrapartum services. Many women could not afford to use services, even when fees were low or services were delivered for free. This was due to the additional, often hidden, costs women must cover such as food for themselves and their guardian. Consequently, innovative strategies to surmount cost, distance, and time barriers to accessing care are necessary.

Length of Time Spent in the MWHs

In the current study, the majority spent 1 to 2 weeks in the MWHs. This may indicate that they came to the MWHs at a gestational period of 38 to 39 weeks. Similarly, a few spent 3 to 4 weeks in the MWHs, which indicated they may have come when their gestational period was about 36 to 37 weeks. Confusion over expected date of delivery (EDD) may lead the antenatal mothers to stay away from the MWHs. From the author's

experience, the majority of antenatal mothers, especially those in the rural areas, do not remember the date of their last normal menstrual period (LNMP). Data from previous studies regarding time / duration spent in MWHs was not available and the hospital does not record length of stay at the MWHs.

In a study conducted in Zambia, it was found that the majority of pregnant women were unaware of their EDD. This made the timely decision to travel to MWHs difficult. On the other hand, separation from children and leaving home for a long time led to indirect cost and loss of earnings (Stekelenburg, Kyanamina, Mukelabai, Wolffers, & van Roosmalen, 2004). Women in this study were also not able to remember their LNMP so that the midwife could calculate the EDD though it was not recorded during data collection.

Thematic Analysis

The findings of the current study identified four major themes common to the lived experience of antenatal mothers living in MWHs which will be discussed. Thematic analysis from interviews with the fifteen antenatal mothers provided the basis for these findings.

Source of Knowledge

The initial theme identified was source of knowledge. From the findings it is apparent that the antenatal mothers had external sources which made them aware of the presence of a maternity waiting home at Malamulo mission hospital. There were a variety of sources through which antenatal mothers acquired knowledge about the MWHs. The majority of the participants cited the doctor as their source of knowledge. The antenatal mothers said they were told to come to the MWHs by the doctor in antenatal clinic while

others met the doctor in the maternity ward when they were admitted due various health problems. However, it is possible that the term ‘doctor’ meant a health care provider from the hospital and not a professional doctor because in Malamulo there is a shortage of doctors. Only one doctor and one clinical officer are responsible for obstetric and gynaecological cases. Additionally, the antenatal clinic is run solely by midwives. On the other hand, some of these antenatal mothers were experiencing health problems such that they were referred to the doctor by the midwives for consultation. These results indicate that health professionals caring for antenatal mothers need to clarify their professional qualifications or wear name tags to decrease confusion.

A few antenatal mothers cited friends as their source of information. This is similar to what van Lonkhuijzen, et al., (2009), found in their study. They noted that women who were satisfied with the care and services they received at the MWHs encouraged their family, friends, and neighbours to use the service.

Decision Making

The majority of the participants said that they had to consult somebody before making the decision to stay at the MWHs. They consulted either the husband, or the mother. In societies where the woman’s social status is low, the relatives make decisions related to seeking medical care. Low resource communities tend to delay decision making, or make poor choices when they are complications. However, even where women make decisions about place of delivery, in practice they depend on their husband providing material and financial support (Geubbels, 2006; UNFPA, 2002).

Starrs and Measham (1990), in a survey conducted in Nepal, revealed that the mother-in-law played a key role in the decision-making with regard to family activities,

including care during pregnancy, and childbirth. Additionally, women in many areas of the world lack the power to make choices about their health and this may lead to negative consequences for maternal health (Stekelenburg, et al., 2004). Furthermore, traditional values and occasionally, laws limit women's decision-making on when to seek medical care. In some settings a husband's permission is required for women to receive health services, including life-saving care; in others, mother-in-law decides whether women can use available services (Watts & Zimmerman, 2002). In Malawi, especially in the rural setting due to culture, women are not permitted to make decisions without consultation due to lack of empowerment.

Antenatal Mothers' Motivation for Staying in MWHs

The study revealed that the antenatal mothers had external motivation to come and stay in the MWH. These motivating factors were grouped under the following sub themes: physical condition, social factors, psychological factors, and distance. However, the source of knowledge, and the process of decision making which have been discussed earlier on contributed in motivating the antenatal mothers to stay in the MWHs.

Physical Condition Factors

The majority of antenatal mothers were compelled to stay at the MWHs after they had been discharged from the ward with health conditions. They were admitted to the antenatal ward with a variety of health issues which includes false labour, malaria, and pneumonia. These antenatal mothers took the advice given to them on discharge by the medical personnel. These physical conditions motivated them to stay in the MWHs. No previous studies have identified anything to support the findings of what the current study revealed. However, from the results of the current study, antenatal mothers were

motivated to stay in the MWHs for a variety of physical reasons such as convalescing after a bout of malaria or pneumonia. On the other hand, studies from India and Iraq showed that lack of recognition of perceived seriousness of health problems were significant reasons for not using available health care (Habib & Vaugan, 1986).

Social Factors

The study revealed numerous social factors that motivated antenatal mothers to stay in the MWHs. The support they got from their significant other, including food and financial support motivated them. The hospital provided the shelter only. Furthermore, the companionship that they experienced during their stay in the MWHs also played an important role because the women encouraged each other. When antenatal mothers had nothing and were really desperate, they depended on the friends that they had made in the MWHs. These friends were willing to share their firewood, food, and even guardians. The guardians helped each other go and check on things at home leaving their antenatal mother in the care of another guardian.

Stekelenburg, Spaans, Lonkhuijzen, and van Roosmalen (2004), in a study done in Zambia found that antenatal mothers were willing to stay in MWHs as long as there was provision of food, proper accommodation, free services, regular medical attention, and privacy. Additionally, in another study, it was found that, the fact that the hospital provided food for the antenatal mothers in the MWHs was a stimulus that encouraged its use (van Lonkhuijzen et al., 2003). However, in Zaire, the lack of provision of food was one of the reasons that the MWHs were rarely used. These antenatal mothers rarely reported to the MWHs near the hospital because they did not have food. Additionally, they had no guardian to stay with them at the MWHs. Consequently, the women felt that

the risk associated with staying in the MWHs, with no food and no one to help, was greater than the risk of staying at home (Sambe, 1990).

Psychological Factors

The study on the experiences of the antenatal mothers in Malamulo revealed that the antenatal mothers were motivated to stay in the MWHs because they were afraid of delivering on the way to the hospital or being attended to by unskilled birth attendants. Similarly, it could be because of a bad occurrence which happened in the previous pregnancy that endangered their life. For example, being brought to the hospital on a stretcher by men, or delivering on the way to the hospital were some of the bad experiences. They felt that what happened made them lose their dignity and they did not want a repeat of such an unpleasant incident. Similarly, in a study done by Roghmann, and Haggerty (1972), it was revealed that previous experiences with medical problems, and especially fear of a recurrence including family stress, were important factors that increased the use of services by antenatal mothers.

Distance Factor

In rural areas, not only are there fewer health facilities necessitating women to travel further to reach them, but women are also more likely to experience problems arising from scarcity of transport (Riddell, 2006). In a related study it was found that many households did not have reliable, suitable, and affordable transport services essential for access to care during critical perinatal and neonatal periods. This was particularly vital for women because of many childbirth-related complications. Furthermore, the study established that in much of the developing world, barriers to health care are so great that many women do not benefit from the health care system.

Long distances, poor transport facilities, and inadequate distribution of health care facilities made it difficult for antenatal mothers to access care (Babinard & Roberts, 2006). Additionally, Touray-Daffeh, Lungu, Ashwood-Smith, Bokosi, and Ratsma (2003), revealed in a study done in southern Malawi that the perceived easy access to skilled attendance during delivery was a motivating factor to stay in MWHs.

In the current study, distance motivated antenatal mothers to stay at the MWHs to avoid a problem with transportation. The majority of the antenatal mothers decided to stay in the MWHs for proximity to the labour ward. Consequently, this relieved them of the worry of how they would get to the hospital when they went into labour. The study revealed that antenatal mothers felt it was necessary for them to stay at the MWHs because it was nearer to the hospital. If the antenatal mother started feeling pains she could just walk to the labour ward.

Maternity Waiting Home Factors

Benefits of staying in the MWHs

The study examined the attitudes of the antenatal mothers towards the MWHs. The antenatal mothers perceived benefits of staying in the MWHs. The study participants identified a number of benefits from staying in the MWHs. These benefits were grouped under the sub themes of physical, psychological, and social benefits. What the antenatal mothers liked about the MWHs was also captured under the benefits of staying in the MWHs. Additionally; the antenatal mothers played an advocacy role for the MWHs to new residents, families and friends.

Physical Benefits

The majority of the antenatal mothers said that they benefited from staying in the MWHs. They had adequate time to do exercise and to rest. They did not have to do strenuous work like they did at home because they had a guardian who addressed their needs. Additionally, in a study conducted by SMP in Malawi, it was revealed that the proximity of the Antenatal Clinic (ANC) and the maternity ward meant the antenatal mothers could go there any time if they needed to consult (Touray – Daffeh et al., 2003). Moreover, being near the hospital they were assured of attendance by a skilled person, including a safe delivery.

Psychological Benefits

There were psychological benefits identified by the participants. The antenatal mothers reported feeling good and relieved while staying in the MWHs. They said that they had peace of mind because they did not have to worry about how they would travel to the hospital when they were in labour. Staying at the MWHs assured them of quick access to specialised care. These findings were supported by a study done in Malawi which revealed that antenatal mothers found it beneficial to stay in MWHs because of the easy access to antenatal care and skilled birth attendants (Touray – Daffeh et al., 2003). However, a study in Ghana revealed that the cost of living was higher in MWHs. Women could not take care of their families and farms as they were residing at the MWHs (Wilson, 1997). Similarly, in Nicaragua, being away from the family was considered the main drawback of staying in MWHs by the antenatal mothers (Wessel, 1990). The study respondents found sanitation and accommodation as the main drawback in staying at the MWHs.

Social Benefits

The antenatal mothers also benefited socially while staying in the MWHs. They made new friends and there was companionship. Furthermore, they became advocates for the MWHs. They encouraged new antenatal mothers who came to the MWHs. They said they would also encourage their families and friends at home when they were discharged to use the MWHs. Similarly, in a study done in Malawi, development of new friendships in the MWHs was cited as a benefit (Touray – Daffeh et al., 2003). This benefit needs to be shared with health care providers as they consult.

Challenges Experienced while Staying in the MWHs

The participants in the study experienced challenges during their stay in the MWHs. These challenges made their stay in the MWHs uncomfortable. The challenges have been organised into sub themes; congestion, rude midwives, poor sanitation, lack of privacy, and cultural factors.

Congestion

The majority of the antenatal mothers in the current study were not happy with the living conditions in the MWHs. They said the place was congested as such, they were not sleeping comfortably. The place was very crowded so it was not easy to find adequate space to sleep comfortably. The house was being used by others in addition to antenatal mothers. Other people, who were not antenatal clients, used the MWHs as a base while they were working in the nearby gardens. They sought free accommodation at the expense of the antenatal mothers. As the researcher went around the maternity waiting home, she observed that the buildings were very small, poorly ventilated and infested

with mosquitoes, and ants. As a result, during the day, the women spent most of their time outdoors. Similarly, the results in a study by Touray-Daffeh et al., (2003), and Van den Heuvel, De Mey, Buddingh, and Bots (1999) revealed complaints which antenatal mothers had about the life in the MWHs. They complained that the houses were too small and crowded. As such, the antenatal mothers were not comfortable during their stay in the MWHs. These comfort issues need to be addressed to ensure utilization of the MWHs.

Poor Attitude of Midwives towards Mothers in MWHs

Expectations of health services are often affected by former interactions with health care providers. In the current study participants expressed negative sentiments about the behaviour of the midwives. It was said that the midwives never went to the MWHs to see how the mothers were doing. Additionally, participants reported that when the antenatal mothers came to the labour ward, they were told to go back to the MWHs. The midwives said the antenatal mothers were running away from mosquitoes. Similar findings have been reported in other studies done previously. Studies that were done noted that too often health care service providers were rude, unsympathetic, and uncaring. They often did not respect women's cultural preferences for privacy, and birth position (Eckermann & Deodato, 2008). This lack of sensitivity by providers may account for underutilization of the MWHs.

Furthermore, in a study conducted in Malawi, Touray-Daffeh et al., (2003) documented the concerns raised by the antenatal mothers about lack of supervision by midwives and poor staff attitudes as factors which hindered the antenatal mothers from using the MWHs. If the midwives supervised the antenatal mothers in the MWHs it could be an opportunity for them to get acquainted with the antenatal mothers before they went

into labour. The midwives could also take this opportunity to conduct health education to the mothers and their guardians. Some of the negative cultural beliefs about midwives could be reduced through a change in their care.

Moreover, the MWHs are ideal locations for family planning counseling, including counseling for sterilization and support of women (Stekelenburg et al., 2004). In a Safe Motherhood Project(SMP) Needs Assessment study in Zomba, Phalombe, and Chiradzulu districts, women mentioned health workers' unwillingness to assist pregnant women, beating pregnant women, especially when they are in labour, rudeness, use of abusive language, discrimination of poor women, and delays in treating women (Geubbels,2006). These reports support the findings of the current study.

Poor Sanitation

Poor sanitation was a major issue which emerged from the study. The majority of the participants complained about poor sanitation. The antenatal mothers said moss grew in the bathrooms making them slippery and hazardous. The toilets were not cleaned regularly and antenatal mothers had to use the toilets and bathrooms in the maternity ward. They even went to the extent of using the male toilet because the female toilets had not been cleaned. The researcher visited the toilets and bathrooms and found that they were very filthy. These findings have been supported by a study done in Zimbabwe by Nhindiri, Munjanja, Zhanda, Lindmark, and Nystrom (1996). The study revealed that poor hygiene was an important factor which prevented women from using MWHs. In another study, antenatal mothers complained that toilets needed improvement and that there was shortage of water in the MWHs (Van den Heuvel et al., 1999). Similarly, IRIN

(2003) concluded that poor sanitation and waste disposal facilities were a hazard to both health workers and patients.

Lack of Privacy

In the current study the majority of participants revealed that there was no privacy in the MWHs. This made them uncomfortable because they could not take off their clothing for the fear that somebody may come in. Similarly, the findings in this study supported a study in Lao, which identified potential barriers before MWHs were established including lack of privacy (Watts & Zimmerman, 2002). Eckermann and Deodato (2008) reported similar findings of lack of privacy. In another related study done in Zambia, it was revealed that antenatal mothers were willing to stay in MWHs if there was adequate privacy (Stekelenburg et al., 2004).

Community / Family Factors

Cultural Factors

The antenatal mothers discussed freely the cultural issues that they encountered during their stay in the MWHs. A participant in the current study revealed that she was using local medicine because she was having severe headaches and sometimes ‘twitching’. She even resorted to tattoos as treatment for her complaints:

> …since I have been here I am having a headache, dizziness and sometimes I feel like fainting. The wife of the watchman saw that I have a problem and she gave me herbs for the headache in the form of oral drugs and cut tattoos on my forehead.

This was done while she was staying in the maternity waiting home. It was difficult to know the real action of the drugs that she was given. This antenatal mother had stayed in the maternity waiting home for more than two weeks. If she were to experience adverse effects, the medical personnel would not know what caused it because they were not aware of the herbal treatment. The researcher saw the tattoos that the participants got on the forehead and temporal bones. The participants also showed the researcher the service provider of the local medicine. To support these findings, Maynard-Tucker (1995) in his study in the northern part of Malawi, found that when antenatal mothers stayed too long in the MWHs, they used local herbs to induce labour. Labour was induced to reduce days spent in the MWHs. This was unsafe because some of the antenatal mothers developed ruptured uterus. Additionally, a study conducted Stekelenburg et al., (2004), revealed that cultural norms was an important aspect of the community. It played a role in the social interaction, values, and traditions of that particular community. Consequently, it may contribute positively or negatively to the antenatal mothers' health. If these stories continued, they could have a negative impact on the future utilization of the MWHs.

Strengths of the Study

This is an under researched area that is of vital importance to the health, and care of antenatal mothers, and therefore, this is a ground breaker study. The researcher was of similar sex to the participants as a result, the participant expressed themselves freely. This contributed to collection of rich data. Furthermore, there was no refusal to participate. All the antenatal mothers who were asked to participate in the study responded favourably.

Limitations of the Study

The researcher encountered a number of limitations during the study. The study was conducted during the harvesting season as such, it was difficult to recruit participants. In the harvesting season there is a lot of work to do in the fields. Consequently, antenatal mothers, as well as their guardians, were busy harvesting their crops. For this reason, very few antenatal mothers were found in the MWHs. On some days the place was deserted. Unfortunately, the time for data collection was limited. Furthermore, the study findings are limited in that purposive sampling was done of a naturally occurring group from only one hospital. As a result, generalizability of the results will be limited since the sample was derived from Malamulo only. The findings of this study may, or may not represent others in the population.

Summary and Conclusion

The findings of this contextual qualitative study, though not generalizable, provide further understanding of MWHs. The maternity waiting home has potential as a tool to increase the number of deliveries by skilled birth attendants. The use of MWHs will also increase in the context of the current health care environment where the traditional birth attendants (TBAs) have been given new roles. The maternity waiting home is vital for keeping antenatal mothers close to the hospital. An understanding of antenatal mothers' lived experiences staying in MWHs has been captured by this study. It is the author's hope that the thoughts and ideas presented by these fifteen antenatal mothers will provide information which will be of benefit to the hospital management, policy makers in the government and other antenatal mothers who will stay in MWHs in

the future. Additionally, health care professionals providing care to antenatal mothers living in MWHs and their families will benefit from this study.

Recommendations

The study findings have revealed that antenatal mothers staying in MWHs have a variety of experiences. These experiences are both positive, making the stay in MWHs beneficial and negative which can be very challenging to the antenatal mothers. Based on the results of the current study, the following recommendations are made. These suggestions could assist management and policy makers in planning and improving the MWHs' services.

Antenatal mothers who reside long distances from the hospital and high risk antenatal mothers need to be encouraged to wait in MWHs for two to three weeks before the expected time of delivery (Fawcus, Mbizvo, Lindmark, & Nystrom, 1996). This could keep them close to a health facility where they can receive adequate medical care should complications arise (Bulatao and Ross, 2003). Furthermore, the introduction of regular visits by midwives and doctors to the MWHs is recommended (Ackermann & Deodato, 2008). During these visits, the antenatal mothers can be assessed and given health education about pregnancy, giving birth, and neonatal care. This could assist to reduce maternal and neonatal morbidity and mortality and allow a more comprehensive assessment of antenatal women and their support system.

The Malamulo maternity waiting home has an advantage because of the Nursing and Midwifery College which is situated close by. The college and the hospital could work together in deploying the third year students in the maternity waiting home to conduct activities such as health talks and antenatal care. This will assist them to in

improving their communication with the antenatal mothers staying in the maternity waiting homes. By the time the students complete their training, they would have built knowledge, skills, and attitudes for improving their interpersonal relationship.

Additionally, during this period the antenatal mothers could be educated on matters related to health promotion and disease prevention as well as provide basic health information. The MWHs have potential as a teaching area for the antenatal mothers. They are ideal locations for education regarding Family Planning counseling, nutrition, hygiene, and care of the newborn, including education on the action of family planning drugs to address the myths in the MWHs as well as the whole community. Moreover, it is very important to foster good interpersonal and communication skills that will improve the relationship between the midwives and the antenatal mothers. Health workers need education and training on interpersonal skills, ethics, and attitudes to address the poor attitude of midwives this could portray a better midwifery image to the community (Touray-Daffeh et al., 2003).

The findings of this study will assist educators in the development of relevant information, education, and communication (IEC) materials for use in MWHs. Additionally, the findings necessitate the revision of midwifery curriculum to strengthen the importance of good midwifery interpersonal and communication skills including issues on ethics and the importance of incorporating care to the women residing in the MWHs.

The existing literature describing the experiences of antenatal mothers' experiences of living in MWHs is very limited. Very little research has been conducted in the area of the lived experience of antenatal mothers staying in MWHs. Consequently,

the analysis of this data raised a number of questions that could provide the basis for further research into this topic to other districts of Malawi. Further studies should be conducted on client – provider interaction to address the rudeness of midwives. However, the results of this study will add to the body of knowledge in midwifery practice.

The hospital management has an important task to ensure that the MWHs are in a habitable state. Management needs to deploy watchmen in the MWHs to issue accommodation to the antenatal mothers appropriately. The use of Nchima house should be limited to antenatal mothers and their guardians. In addition, the hospital management needs to improve the infrastructure in the MWHs, and spray the buildings regularly with pesticides to eliminate mosquitoes, ants, and fleas (Van den Heuvel, et al., 1999).

A mechanism is needed to oversee that things which have been revealed in this study such as, poor attitudes of the midwives, poor sanitation, congestion, and pests are addressed appropriately. This information will assist in planning interventions which will improve the welfare of the antenatal mothers staying in the MWHs. The study results will also help decision makers / policy-makers effectively plan and develop better policies focused on how to run the MWHs efficiently.

Dissemination of these study findings will target specific groups of potential users. Scholarly and professional meetings will be organized to disseminate the findings. These findings will also be communicated to the participants of the study. Furthermore, reports will be submitted to the Hospital Director of Malamulo Mission hospital where the study was conducted, the College of Medicine Research and Ethics Committee (COMREC), College of Medicine Library, the Health Science Committee and the

University Research and Publication Committee (URPC), through COMREC.

Additionally, the findings will be published in professional journals.

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APPENDIX A

LETTER OF APPROVAL FROM COMREC TO CONDUCT THE STUDY

UNIVERSITY OF MALAŴI

Principal

Prof. R.L. Broadhead, MBBS, FRCP, FRCPCH, DCH

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 01 877 245
01 877 291
Fax: 01 874 700
Telex: 43744

Our Ref.:

Your Ref.: P.11/09/847

1st February 2010

Mrs Susan Sundu
Kamuzu College of Nursing
Blantyre Campus
Blantyre 3

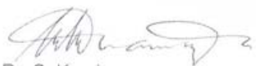
Dear Mrs Sundu,

Antenatal mothers' experiences of staying in a maternity waiting home at Malamulo Mission Hospital in Thyolo

I write to inform you that COMREC reviewed your proposal which you resubmitted for expedited review. I am pleased to inform you that your proposal was approved on 27th January 2010 after considering that you addressed all the queries which were raised during the previous review.

As you proceed with the implementation of your study I would like you to take note that all requirements by the college are followed as indicated on the attached page.

Yours sincerely,



Dr. S. Kamiza
For:CHAIRMAN – COMREC.

SK/ck

APPENDIX B

LETTER OF APPROVAL FROM MALAMULO TO CONDUCT THE STUDY.

Private bag 2, Makwasa, Malawi, Africa
Telephone: +265 (0) 1 470 222 / 243 / 255
Fax: 01 470 231
E-mail: malamulohosp@gmail.com

4th February, 2010

Mrs. Susan Sundu

Dear Madam,

PERMISSION TO CONDUCT RESEARCH

The bearer of this letter Mrs. Susan Sundu has permission to conduct research at the Malamulo Hospital on “Antenatal Mothers experiences of staying in a maternity waiting home at Malamulo SDA Hospital”.

She would like to have interviews with Antenatal Mothers staying in maternity waiting home.

I look forward to your usual support.

Yours faithfully

Dr. Godwin Chipoka
Acting Chief of Medical Staff

A SEVENTH - DAY ADVENTIST MEDICAL INSTITUTION

APPENDIX C

Participants' Information

Introduction

You are being asked to participate in a research study that is looking at "antenatal mothers' experiences of staying in a maternity waiting home". You are being requested to participate in this study because you are staying the maternity waiting home. This study is important because it will help to establish what antenatal mothers experience in the course of their stay in the maternity waiting home in an attempt to make the place more user-friendly.

Procedures

As a participant of this study, you will meet the investigator at a place where there is audio-visual privacy. The investigator will audio tape you and take detailed notes later. This will only be done if you grant the permission. You are free to tell the investigator to turn off the recorder at any point in the conversation if you are not comfortable with what we will be talking about. After the interview, the tape will be transcribed .You may see the transcript upon request and delete anything you do not want included in the interview. At any time during the interview you may decide to withdraw, you are free to do so. If you withdraw, no more information will be collected from you. When you indicate your wish to withdraw, the investigator will ask if the materials already collected in the study can be used.

Risks

Your participation in the study may involve the following minimal risks. A bit of your time will be spent during the interview. You may be uncomfortable with some of the questions. If you feel uncomfortable, you may decide not to answer them and you may withdraw at any time.

Benefits

There will be no direct benefits for your participation in this study. The potential benefit is that your participation in this study may assist the researcher's understanding on antenatal mothers' experience of staying in a maternity waiting home. This knowledge

might help us to re-organize the environment in the maternity waiting home and make it more conducive. This information is very useful for policy makers.

Confidentiality

Participation in this study may result in your loss of privacy in that other people may see the results. Only the researcher, her supervisor and her research assistant may view the study results. They are required to maintain confidentiality regarding your identity. Results of this study may be used for teaching, research, publications or presentations at scientific meetings. If your individual results are discussed your identity will be protected by using a study code number rather than your name or other identifying information.

Centralized data collection or registries

At the end of this consent form, you will be given the option of allowing us to make audiotape recordings of you, which may be used in analyzing the research data or at scientific publications and presentations. All recordings will be destroyed after analysis is completed.

Financial information

Your participation in this study will involve no cost to you. Unfortunately you cannot be paid for participation in this study. However, in the event that you have spent money for transport and lunch during this research activity, you will be reimbursed.

Subjects' Rights:

Your participation in the study is voluntary and you are free to withdraw at any time. Choosing not to participate or withdrawing from this study will not affect any relationship and will not have any negative consequences. You are free to choose not to respond to any particular questions if you do not want to you may ask the tape recorder to be turned off at any point during the interview if there is something that you do not want to be recorded.

Contact Persons:

If you have any questions about this study you may call Susan Sundu on phone numbers 0888857847 and 0993401363 or my supervisor, Dr E.Chirwa at Kamuzu College of Nursing on phone numbers 01873623 or 01880183. You may even contact

Professor J.M.Mfutso Bengo of College of medicine on phone number 0999957805 or 01871911 extension 310.

Consent

I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. Should I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and I will receive a copy of this consent form after I have signed it.

- I give my permission to audio tape the interviews. Please tick in the box before signing if

  you agree. [ ].

Participant's Name and Signature ------------------------------------- Date ---------------------

Name and Signature of Person Obtaining Consent ---

Date----------------------------------

APPENDIX D

Kalata Yofotokozera Otenga Mbali Mu Kafukufuku

(Chichewa Version)

Mau Oyamba

Mulikupemphedwa kutenga mbali mu kafukufuku wofufuza "Zimene Amai Apakati Amakumana Nazo Ku Chithando Cha Amai Oyembekezera." Inuyo mukupemphedwa kutenga mbali mukafukufukuyu chifukwa muli kuno kuchithando cha amai oyembekezera. Kafukufukuyu ndi ofunika kwambiri chifukwa adzathandiza kudziwa zimene amai apakati amakumana nazo pamene akuyembekezera ku chithando.

Ndondomeko.

Inu monga m'modzi wa otenga mbali mu kafukufukuyu, mudzakumana ndi amene akupangitsa kafukufukuyu pamalo poduka mphepo. Wopangitsa kafukufukuwa adzakujambulani mau ndi kulemba zina pa pepala. Zonsezi zidzachitika pokha-pokha inu mutabvomereza. Inu ndinu omasuka kuwauza ochititsa kafukufukuwa kusiya kujambula ngati simukusangalatsidwa ndi zimene akukambazo. Atatha kukujambulani, opangitsa kafukufukuwa adzazitanthauzira zojambulazo mu mau polemba pa pepala. Ndinu omasuka kuwerenga ngati mukufuna, komanso kufafanizitsa zomwe sizinakusangalatseni. Nthawi ina iri yonse mukhale omasuka kutuluka mukafukufuyu ngati zomwe zikukambidwazo simukugwirizana nazo. Ngati mutasintha maganizo anu, ndipo mukufuna kutuluka mukafukufukuyu, opangitsa kafukufuku adzakufunsa ngati angathe kugwiritsa ntchito zomwe akujambulani kalezo.

Zobvuta Zomwe Zingakhalepo

Kutenga mbali kwanu mu kafukufukuyu kungakupangitseni kukhala ndi timabvuto pang'ono. Timabvutoti ndi monga; kukutayirani kanthawi yanu pang'ono poyankha mafunso, komanso mafunso ena angakhale okupangitsani kusowa mtendere. Ngati mutaona kuti mukusowa mtendere ndi mafunso ena, khalani omasuka kusawayankha mafunsowo, kapena kutuluka mukafukufukuyu.

Cholowa Chomwe Chingakhalepo.

Palibe Cholowa chiri clones chimene mudzapeza chifukwa chotenga mbali mukafukufukuyu. Kungoti, mukatenga nawo mbali mukafukufukuyu, zidzathandiza

opangitsa kafukufukuyu kum'mvetsa zimene amai apakati amakumana nazo ku chithando cha amai oyembekezera. Wochititsa kafukufukuyu atatha kum'mvetsa zimene amai apakati amakumana nazo ku chithando cha amai oyembekezera, zidzawathandiza kukonza malowa kuti akhale osangalatsa pamene amai oyembekezera akukhalako. Zotsatira za kafukufuku ameneyu zidzawathandiza omwe amakonza ndondomeko za makhalidwe a ku chithando cha amai oyembekezera.

Kusunga Chinsinsi.

Kutenga nawo mbali mu kafukufukuyu kutha kupangitsa kuti kukusungirani chinsinsi kwanu kutaike chifukwa anthu ena adzaona zotsatira za kafukufukuyu. Amene akupangitsa kafukufukuyu, mphunzitsi wankulu ndi omuthandizira ndi amene atadzaone zotsatirazo. Iwowa adzayesetsa kukusungirani chinsinsi posaulula kuti munatenga nawo mbali mu kafukufukuyu. Zotsatira za kafukufuku ameneyu zidzagwiritsidwa ntchito pophunzitsira, kupangira a kafukufuku ena, kulengezetsa m'mapepala a za sayansi, komanso ku misonkhano yokambirana za sayansi. Ngati patafunika kuti tikambirane za zimene inu mwatipatsa, sitidzagwiritsa nchito dzina lanu ai, koma nambala yanu yachinsinsi ija.

Malo Osungira Zofufuza.

Ndikatha kukamba nanu zopempha chirolezozi, mupatsidwa mwai osankha ngati mukulolera kujambidwa mau, zomwe titakagwiritse nchito pounguza-unguza komanso kulengezetsa m'mapepala a za sayansi, komanso ku misonkhano yokambirana za sayansi. Titatha kutero, zonse zimene tinajambula ndi kulemba tidzazionong'a.

Kukamba Za Ndalama

Simukusowa kupereka ndalama kuti mutenge mbali mu kafukufukuyu. Komanso, simulipidwa chifukwa chotenga mbali mu kafukufuku ameneyu. Koma ngati mwagwiritsa ntchito ndalama zanu kuyendera pobwera ku kafukufukuyu kapena kugulira nkhomaliro podikira kafukufukuyu, ndalama zimenezo tikubwezerani.

Ufulu Wanu Wachibadwidwe

Mutenga mbali mu kafukufukuyu pogwiritsa nchito ufulu wanu wachibadwidwe komanso mosakakamizidwa. Kusatenga mbali kwanu mu kafukufukuyu sikuwononga ubale wathu munjira ina iri yonse. Palibenso chobvuta chiri chonse chimene chingatsatire chifukwa cha kusatenga mbali kwanu. Ndinu ololedwa kusankha mafunso amene

mukufuna kuyankha. Ngati mukufuna mutha kunena kuti tisakujamuleni poyankha mafunso.

Anthu Ofunika

Ngati muli ndi mafunso okhudzana ndi kafukufukuyu mutha kutchayira foni a Susan Sundu pa nambala izi: 0888857847 kapena 0993401363. Muthanso kuyimbira aphunzitsi anga a Dr E.Chirwa a ku Kamuzu College of Nursing pa manambala awa: 01873623 kapena 01880183. Komanso mutha kufunsa a Professor J.M.Mfutso Bengo a ku College of medicine pa foni nambala 01871911 extension 310, kapena 09957805

Chilolezo

Ndawerenga zomwe zalembedwa mukalatayi, komanso andifotokozera ndondomeko yonse ya kafukufukuyu. Ndinapatsidwanso mwai ofunsa mafunso ndipo mafunso anga anayankhidwa. Komanso ndapatsidwa maina ndi manambala amafoni a anthu amene ndingathe kuwafunsa ngati ndiri ndi mafunso ena. Ine ndikubvomera kutenga nawo mbali mu kafukufukuyu ndipo ndilandira kalata yozonyeza kulola kwanga ndikatha kusaina kalata yachilolezoyi.

- Ndi kupereka chilolezo changa kuti atha kundijambula mau pamene akundifunsa mafunso. Chonde chongani mukabokosika musanasaine ngati mwalola [ ].

Dzina la otenga mbali ndi saini yake. --

Tsiku. ---

Dzina opangitsa kafukufuku ndi saini yake --

Tsiku. ---

APPENDIX E

University of Malawi
Kamuzu College of Nursing
P/ Bag 1
Lilongwe
1st November, 2009.

Madam,

RE: Participant Information and Informed Consent.

I am a final year Masters of Science Degree in Midwifery student at Kamuzu College of Nursing. I am conducting a study entitled: “Antenatal Mothers’ Experiences of Staying in a Maternity Waiting Home”.

During the interview, you will not be asked to state your name in order to maintain anonymity. Also be assured that the information gathered shall be confidential, as the answers will be put in a confidential file. Your participation is voluntary and you are free to withdrawal your consent and discontinue participation in the study at any time. You will not be given any penalty following such withdrawal or refusal. However, there is no compensation for your participation in the study. Your participation in the study may involve the following minimal risks. A bit of your time will be spent during the interview. You may be uncomfortable with some of the questions. If you feel uncomfortable, you may decide not to answer them and you may withdraw at any time.

You will also be allowed to ask questions and or clarification wherever necessary. In case of queries, my contact is: Mrs. Sundu, phone number 0888857847 or 0993401363. You may also call my supervisor, Dr E.Chirwa at Kamuzu College of Nursing on the following phone numbers: 01873623 or 01880183. You may even contact Professor J.M.Mfutso Bengo of College of medicine on phone number 0999957805 or 01871911 extension 310.

I would therefore, like to ask if you can give your informed consent to participate by signing below:

I ………………………………would like to participate in this study, having understood all the explanation given to me by the researcher relating to the study.

…………………………………….. …………………………… Signature of participant \Date

…………………………………….. ……………………………. Signature of student researcher Date.

APPENDIX F

University of Malawi
Kamuzu College of Nursing
P/ Bag 1
Lilongwe
1st November, 2009.

Amai,

Kalata Yofotokozera Otenga Mbali Mu Kafukufuku Komanso Yowapempha Kutenga Mbali Mukafukufukuyo.

Mutu wa Kafukufuku: “Zomwe Amai Achiyembekezo Amakumana Nazo Ku Chithando Cha Amai Oyembekezera Pa Chipatala Cha Mishoni Cha Malamulo”.

Ine ndine mphunzi wa zaukachenjede wa zauzamba wachaka chotsiriza ku sukulu ya za ukachenjede wa anamwino ndi azamba ya Kamuzu College ku Blantyre. Ndikupanga kafukufuku wofuna kudziwa zomwe amai oyembekezera amakumana nazo panthawi imene alikudikira matenda kuti ayambe ku chithando cha amai oyembekezera Mukukambirana kwathu sindifuna kuti munene dzina lanu chifukwa chofuna kukusungirani chinsinsi. Choncho mukhale mtima m’malo chifukwa zonse tikambirane pano zikhala za chinsinsi.

Simukukakamizidwa kutenga nawo mbali mu kafukufuku ameneyu, choncho mutha kuthetsa kukambirana kwathu nthawi ina iri yonse ngati mukuona kuti simungathe kupitiriza ndipo palibe mulandu uli wonse. Palibe choopsya china chiri chonse chomwe chingakuchitikireni chifukwa chotenga mbali mu kafukufuku ameneyu.

Koma ngati mungakhale ndi funso liri lonse, mutha kunditchayira phone pa nambala iyi: Mrs. Sundu, phone number 0888857847 or 0993401363. Muthanso kuyimbira aphunzitsi anga a Dr E.Chirwa a ku Kamuzu College of Nursing pa manambala awa: 01873623 kapena 01880183.Ndiye ngati mwamvetsa zomwe ndafotokozazi, ndipo ndinu okonzeka kutenga nawo mbali mukafukufukuyu, ndikukupemphani kuti mundilembele dzina lanu kapena kudinda ndi chala chanu chachikulu cha dzanja la manja pa kanzere ka dododo kali m’musika.

Ine, ---, atatha kundifotokozera cholinga cha kafukufukuyu, ndabvomera kutenga nawo mbali.

Dzina la wotenga mbali mukafukufuku--------------------------- Tsiku-----------------------

Dzina la wochititsa kafukufuku---Tsiku----------------------

APPENDIX G

University of Malawi
Kamuzu College of Nursing
P/ Bag 1
Lilongwe
1st November, 2009

The Hospital Director
Malamulo Mission Hospital,
P /Bag 2
Makwasa

Dear Sir,

RE: Permission to Conduct a Research Study in Your Hospital

I am a final year Masters of Science Degree in Midwifery student at Kamuzu College of Nursing. I am conducting a study entitled: "Antenatal Mothers' experiences of Staying in a Maternity Waiting Home" as a requirement for the Masters of Science Degree in Midwifery. The purpose for doing this study is to explore antenatal mothers' experiences of staying in the maternity waiting home.

It is believed that if the experiences are known, appropriate interventions would be instituted to promote utilization of the maternity waiting home and consequently, improve pregnancy outcome. The study will involve in-depth interviews with antenatal mothers who are waiting in the maternity waiting home. This letter is written to you to request for approval to conduct the study at your hospital.

Looking forward to your favorable consideration.

Yours faithfully,

Susan Sundu.

APPENDIX H

Interview Guide.

Code Number----------------------------------

Date of Interview------------------------------

Name of Interviewer--------------------------

SECTION A: *Demographic Data.*

I am going to ask some information about yourself.

1. Age: [ ]

2. What is your marital status?

a) Married [ ]
b) Single [ ]
c) Divorced [ ]
d) Separated [ ]
e) Widow [ ]
f) Living together [ ]

3. Educational level

a) None [ ]
b) Primary [ ]
c) Secondary [ ]
e) Tertiary [ ]

4. How many children do you have? [ ]

5. Which denomination do you belong to? --

6. What type of work do you do? ---

7. How long does it take you to walk to your nearest health facility?

a) 6 hours [ ]
b) 12 hours [ ]
c) 2 days [ ]
d) Other Specify [ ]

8. What mode of transport is readily available in your village to take you to the hospital?

a) Pick-up vehicle [ ]

b) Bicycle ambulance [ ]

c) Ox cart [ ]

d) Other Specify [ ]

9. How long have you stayed in the MWH?

a).one week [ ]

b).two weeks [ ]

c).other Specify [ ]

SECTION B

Women's knowledge about MWH.

Now I am going to ask you the following questions in relation to MWH.

1. *How did you know about the MWH at Malamulo?*

Probes:

- Who informed you?
- How were you informed?
- Why do you think they informed you?
- What did they say about the MWH?
- What perception did you have about the MWH after the information?
- How did you react to the information?

2. *Now, I would like to know what motivated you to come and await labour in the MWH.*

Probes:

- Who motivated you?
- How were you motivated?
- How long did it take you to decide to come to the MWH?
- Whom did you involve in making the decision?
- Whom did you inform about your decision?
- How did the other people react when you informed them of your decision?
- Have you ever stayed in a MWH before?

3. *I would like you to tell me what your attitudes are towards MWHs.*

Probes:

- How do you feel about staying in the MWH?
- Why is it necessary for an antenatal mother to stay in a MWH?
- What do you think are the benefits of staying in the MWH?
- How can you differentiate between staying at home while waiting for labour and staying in the MWH?

4. *Now, I would like you to tell me what you liked while in the MWH.*

Probe on:

- How comfortable she was during her stay in the MWH?
- How she spent her time?
- How she was welcomed on her arrival?
- What she liked about:
    - Sleeping arrangements
    - Interaction with peers
    - Interaction with health care personnel
    - Support from family

5. *I would like to know the challenges that you have experienced during your stay in the MWH.*

Probes on challenges related to:

- Sanitation?
- Maintaining privacy?
- Being supported by family while in MWH?
- Care of children at home?
- Length of stay?
- Financial support?
- Availability of food?
- Receiving visitors from home?
- Food preparation?

- What made it difficult to:
    - Interact with other antenatal mothers?
    - Interact with the health service providers?
    - Have problems attended to?
    - Receive antenatal care?

Lastly:

- What information would she share with peers who found her in the MWH?
- What information would she share with relatives at home about the MWH?

THANK YOU

APPENDIX I

Interview Guide (Chichewa Version)

Code Number--

Date of Interview------------------------------------

Name of Interviewer--------------------------------

Gawo Loyamba

Ndikufunsani mafunso okhudzana ndi inuyo.

1. Muli ndi zaka zingati? [ ]

2. Pankhani ya banja muli mbali iti?
   - a) Wokwatiwa [ ]
   - b) Mbeta [ ]
   - c) Chikwati chinatha [ ]
   - d) Tayamba tapatukana kaye [ ]
   - e) Bambo akunyumba anamwalira [ ]
   - d) Kukhalira limodzi wosamanga ukwati [ ]

3. Malekezero a maphunziro.
   - a) Sindinaphunzire sukulu [ ]
   - b) Ndinalekezera kupulayimale [ ]
   - c) Ndinalekezera kusekondale [ ]
   - e) Ndinafika ku koleji [ ]

4. Muli ndi ana angati? [ ]

5. Mumapemphera mpingo wanji? --

6. Mumagwira ntchito yanji? ---

7. Zimakutengerani nthawi yayitali bwanji kuyenda kuchokera kumudzi kwanu kukafika chipatala chapafupi?
   - a) Maola 6 [ ]
   - b) Maola 12 [ ]
   - c) Masiku awiri [ ]
   - d) Tchulani inuyo--

8. Ndinjira yanji yamayendedwe yopezeka mosabvuta yomwe mumagwiritsa ntchito m'mudzi mwanu popita kuchipatala?

a) Matola a Pikapu [ ]

b) Ambulasi ya njinga [ ]

c) Ngolo ya ng'ombe [ ]

d) Tchulani chomwe sindinatchule [ ]

9. Mwakhala nthawi yayitali bwanji ku chithando choyembekezera?

a). Sabata imodzi [ ]

b).Sabata ziwiri. [ ]

c).Tchulani chomwe sindinatchule. ---

GAWO LACHIWIRI

Tsopano ndikufunsani zokhudzana ndi ku chithando cha amai oyembekezera.

1. *Ine ndikufuna ndidziwe kuti kodi inu munadziwa bwanji zachithando cha amai oyembekezera kuno Malamulo?*

Kufunsitsitsa:

- Anakudziwitsani ndi ndani?
- Anakudziwitsani bwanji?
- Inu mukuganiza kuti anakuuzani chifukwa chiani?
- Wokudziwitsaniwo ananena zotani zokhudzana ndi chithando cha amai oyembekezera?
- Mukuganiza kuti anakudziwitsani chifukwa chiani?
- Inu munachilandira bwanji chidziwitso chimenechi?

2. *Ndikufuna kudziwa kuti kodi ndichiyani chinakukopani inu kuti mudzayembekezere kuchithando kuno?*

Kufunsitsitsa:

- Anakukopani ndi ndani?
- Munakopedwa bwanji?
- Zinakutengerani nthawi yayitali bwanji kuti mupange chitsankho choti mubwere mudzakhale kuno kuchithando cha amai oyembekezera?

- o Ndi ndani munamufunsa kuti akuthandizeni kupanga chisankhochi?
- o Ndi ndani munamudziwitsa zachisankho chanu?
- o Achibale ena anachilandira bwanji chisankho chanu mutawauza?
- o Kodi munayamba mwakhalapo kuchithando cha amai oyembekezera m'mbuyomu?

3. *Tsopano ndikufuna kuti ndidziwe kuti maganizo anu ndiotani pankhani ya chithando cha amai oyembekezera*

Kufunsitsitsa:

- o Inu mukumva bwanji pankhani yokhala kuchithando cha amai oyembekezera?
- o Mumaganizo mwanu, mukuganiza kuti ndikofunika kuti mai oyembekezera adzayembekezere kuchithando?
- o Ubwino okhala kuchithando cha amai oyembekezera ndi otani?
- o Mungasiyanitse bwanji pakati pakukhala kunyumba podikira matenda, ndi kukhala kuchithando choyembekezera

4. *Mungandiuze kuti ndi chiani chimene chinakusangalatsani panthawi imene mumakhala ku chithando cha amai oyembekezera?*

Kufunsitsitsa:

- o Anali omasuka bwanji panthawi yomwe amayembekezera ku chithando?
- o Analandiridwa bwanji tsiku limene munafika?
- o Nthawi yawo anayigwiritsa ntchito bwanji?
- o Ndi chiani chinawakondweretsa pa zotsatirazi?
    - Malo ogona?
    - M'mene amakhalira ndi amai anzao oyembekezera?
    - M'mene amakhalira ndi anthu ogwira ntchito za chipatala?
    - Chithandizo kuchokera ku banja?

5. *Tsopano ndikufuna ndidziwe kuti ndizobetchera zotani zomwe mwakumana nazo pamene mumayembekezera kuno kuchithando?*

Kufunsitsitsa pa zobetchera zokhudzana ndi:

- Kudzisungira Chinsinsi pa gulu?
- Zokhudzana ndi ukhondo wa madzi, kubafa ndi kuchimbuzi?
- Chirimbikitso kuchokera kwa akubanja?
- Chisamaliro cha ana otsala kunyumba?
- Kutalika kwa nthawi yokhalira kuchithando?
- Chithandizo cha zachuma?
- Kupezeka kwa chakudya?
- Makonzedwe a chakudya?
- Kulandira alendo kuchokera kunyumba?
- Machezedwe ndi amai ena oyembekezera (ngati panali bvuto)?
- Ngati panali kusemphana Chichewa ndi ogwira ntchito za chipatala?
- Ngati panali bvuto lomwe linayenera kukonzedwa?
- Kulandira chithandizo chachiyeso cha amai oyembekezera?

Potsiriza:

- Kodi ndi mau otani amene mungagawane ndi amai oyembekezera anzanu okupezani kuno kuchithando choyembekezera?
- Nanga ndi mau otani amene mungagawane ndi achibale amene munawasiya kumudzi pa nkhani ya chithando cha amai oyembekezera?

ZIKOMO KWAMBIRI