

**STAKEHOLDERS' PERCEPTIONS OF THE
CHANGING ROLE OF TRADITIONAL BIRTH
ATTENDANTS IN THE RURAL AREAS OF CENTRAL
WEST ZONE, MALAWI: A MIXED METHODS STUDY**

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the degree

of

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DECLARATION

I, Evelyn Chitsa Banda hereby declare that this thesis is my own original work. It is being submitted for the degree of Doctor of Philosophy in the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Signed

Date: 17th September 2013

DEDICATION

This work is dedicated to my husband Alfred for being there for me. You are the wind under my wings.

To my children, Yamikani and Melissa for understanding my busy schedule and the support you gave me that I was able to carry on. My little Chisomo, you knew that every evening mom would be working on the computer and you cheerfully fulfilled your role of setting up the equipment for me. Most of all to God, my Lord for making it possible.

PRESENTATIONS ARISING FROM THIS THESIS

A presentation entitled “Perceptions of key stakeholders of the changing role of traditional birth attendants in rural areas of Central West zone, Malawi” was made at the following meetings:

1. Sigma Theta Tau International, Honor Society of Nursing. Tau Lambda-at-Large Chapter. 12th Annual Conference; Sunbird Mount Soche Hotel Blantyre, Malawi, 2nd - 4th July 2012.
2. District Commissioners and District Health Officers meeting; Sun Bird Hotel Livingstonia Beach, Salima, Malawi 21st September 2012
3. Zonal District Health Management Quarterly Review Meetings; Central West Zone, Ntcheu, Malawi, 7th December 2012.
4. Reproductive Health Unit Dissemination meeting Sun Bird Mount Soche Hotel Blantyre, Malawi, 26th-28th March 2013.
5. National Confidential Inquiry into Maternal Deaths Meeting; Reproductive Health Unit, Ministry of Health Lilongwe Malawi. 9th May 2013
6. Ministry of Health Management meeting, Lilongwe Malawi, 18th June 2013

POSTER PRESENTATIONS ARISING FROM THIS THESIS

A poster presentation entitled “The Moratorium on traditional birth attendants: Perceptions of Proponents and Opponents of the traditional birth attendants model in Malawi” was made at the following meeting

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ABSTRACT

Introduction: In 2007, the Ministry of Health in Malawi issued a directive banning traditional birth attendants (TBAs) from delivering mothers and ordered all mothers to access skilled birth attendants in health facilities (MoH, 2007b). Anecdotal reports showed that the influx of pregnant mothers to the health facilities resulted in mothers delivering on make shift beds on the floor and sometimes without the assistance of the skilled provider. The badly stretched health care system continues to force mothers to deliver with the assistance of TBAs who have gone underground for fear of being fined.

Purpose of the study: The purpose of this study was to explore stakeholders' perceptions of the changing role of TBAs in order to obtain a greater breadth of understanding of the reasons why home births persist in the rural areas of Central West Zone (CWZ), Malawi.

Methods: The study employed a mixed method concurrent triangulation design in which 24 health facilities in the districts of Ntcheu, Dedza, Lilongwe and Mchinji, in CWZ, Malawi were included. A non-probability purposive sampling method was used to select 24 health facilities that provide Basic Emergency Obstetric and Neonatal Care (BEmONC) services in rural areas of CWZ. A randomly selected sample was used to collect quantitative data from mothers, using an interview schedule. These were mothers (n=144) who had come to access maternal and neonatal health care but had previously sought the help of a TBA to deliver. A total of 55 nurse midwives who worked in the 24 health facilities and who were available and willing to participate responded to a structured interview schedule. Quantitative data were analyzed using SPSS version 19. Qualitative data were collected using focus group discussions (FGDs) with TBAs (n=4 FGDs, with 6-7 respondents in each discussion group) who lived in the catchment areas of the selected BEmONC sites. Single in- depth interviews were conducted with TBA trainers (n=10) in the districts and health professionals (n=12) from

the Ministry of Health and Nurses and Midwives Council of Malawi. Data were analyzed manually.

Findings: The findings showed that the moratorium on TBAs was implemented without consultation with the relevant stakeholders and as a result, many mothers in rural areas continued to seek the services of TBAs. Untrained TBAs took advantage of the opportunity and together with some trained TBAs who were afraid of punishment went underground to practice. Maternal and neonatal health care in BEmONC facilities were deficient as the health care system struggled with challenges such as the lack of adequate and humane accommodation for waiting mothers, critical shortages of staff, drugs and supplies and negative health care worker attitudes. In addition, long distances and the lack of empowerment of rural women prevented mothers from seeking skilled birth attendants. The study concluded that even though the government had issued a moratorium on TBAs, the health care system is not coping.

Recommendations: It is recommended that having moved away from the TBAs, there is no need to revert to using them since that would mean perpetuating harmful and substandard care for mothers. In addition, TBA services would undermine the government's efforts to improve skilled birth attendance. However, the system needs to urgently deal with the challenges that rural mothers encounter in trying to access skilled birth attendance.

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LIST OF ABBREVIATIONS

AIDS	- Acquired Immuno Deficiency Syndrome
ANC	- Antenatal Care
BEmONC	- Basic Emergency Obstetric and Neonatal Care
CEmONC	- Comprehensive Emergency Obstetric and Neonatal Care
CHAM	- Christian Health Association of Malawi
CMED	- Central Monitoring and Evaluation Department
CMs	- Community Midwives
CWZ	- Central West Zone
DHS	- Demographic Health Survey
DHMT	- District Health Management Team
DHO	- District Health Office (r)
EHP	- Essential Health Package
FANC	- Focused Antenatal Care
FGDs	- Focus Group Discussions
GVH	- Group Village Head
HCWs	- Health Care Workers
HF(s)	- Health Facility (Facilities)
HIV	- Human Immuno Deficiency Virus
HP (s)	- Health Professional (s)
HSAs	- Health Surveillance Assistant (s)
HSSP	- Health Sector Strategic Plan
ITNs	- Insecticide Treated Nets

MCH	- Maternal Child Health
MDGs	- Millennium Development Goals
MDs	- Maternal Deaths
MICS	- Mixed Indicator Cluster Survey
MMR	- Maternal Mortality Rate
MVA	- Manual Vacuum Aspiration
MNH	- Maternal and Neonatal Health
MRP	- Manual Removal of Placenta
MSCE	- Malawi School Certificate of Education
MoH	- Ministry of Health
MoLG	- Ministry of Local Government
NSO	- National Statistics Office
NGOs	- Non Governmental Organizations
NMs	- Nurse- Midwives
PEC	- Problem, Evidence and Conclusion
PMTCT	- Prevention of Mother to Child Transmission
PN	- Post Natal
PoW	- Program of Work
RH	- Reproductive Health
RHU	- Reproductive Health Unit
RNB	- Resuscitation of the Newborn
SM	- Safe Motherhood
SWAp	- Sector Wide Approach
SRHR	- Sexual and Reproductive Health Rights

SBA	- Skilled Birth Attendants
TBAs	- Traditional Birth Attendants
ToT	- Training of Trainers
TTV	- Tetanus Toxoid Vaccine
UN	- United Nations
UNICEF	- United Nations Children Fund
UNFPA	- United Nations Population Fund
UNHCR	- United Nations High Commission for Refugees
USAID	- United States Agency for International Development
WHO	- World Health Organization

DEFINITION OF KEY TERMS

Changing role

Means the transition in which traditional birth attendants' responsibilities were reviewed and were given other responsibilities apart from attending to pregnant mothers antenatally, intranatally as well as postnatally. The new role includes advocating for first trimester antenatal care to pregnant mothers, assisting mothers in the development of birth plans and where necessary participating in the mobilization of transport for mothers in need.

Key stakeholders

Key stakeholders are persons who have been involved in different ways with the activities of the TBAs when TBAs received training to assist them in the acquisition of knowledge and skills in MNH. These people could have been involved in developing and implementing guidelines on TBA activities, developing TBA training content and teaching them or supervising TBAs when they conducted deliveries. These could be health professionals and nurse- midwives (NMs).

- **Health Professionals**

These are health care workers with professional qualifications working in institutions responsible for policy and guidelines development in MNH care. They could be professional nurse-midwives or doctors.

- **Nurse-Midwives**

These are health care workers who are registered or enrolled by the Nurses and Midwives Council of Malawi as nurse-midwives and are given the authority to provide care to pregnant

mothers during the antenatal, labor, and postnatal periods. These could be Registered Nurse-Midwives or Enrolled Nurse-midwives.

Perception

This is the way the moratorium is viewed and understood by key stakeholders

Roles

Roles refer to the responsibilities or tasks that TBAs were expected to perform when caring for pregnant mothers during pregnancy, childbirth and the postnatal periods prior to the moratorium on their services. It also refers to the new responsibilities and tasks in MNH care that TBAs have been assigned since the moratorium.

Traditional Birth Attendants

These are women who assist pregnant mothers antenatally, intranatally and postnatally. They are women who have had children of their own. Generally, the skills are passed on from mother to daughter or granddaughter through an apprenticeship. TBAs operate only in the areas that they come from and they earn the respect of both the community and their traditional leaders.

CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Malawi, a sub Saharan country, is land locked and shares its borders with Mozambique to the east, south and south west, Zambia to the west and north west and Tanzania to the north and north east. It covers 118,484 square kilometers of which 94,276 square kilometers are covered by land (Ministry of Health; MoH, 2011a). It is categorized as one of the most densely populated countries in Africa with 139 persons per square kilometer (MoH, 2011a). The country has a population of 14.4 million (MoH, 2011a) of which 23% are women of reproductive age, giving 720,000 expected pregnancies annually (MoH, 2011b). Malawi is divided into three main regions (provinces): the north, central and south. For effective management, the Ministry of Health split the three regions into five zones. The naming of the zones takes after its geographical location with four to seven districts. The Northern Zone has six districts whilst the Southern region was split into South West comprising of seven districts and South East with six districts. Central West Zone (CWZ) comprises four districts and Central East Zone has five districts. This study took place in the CWZ.

Each district is comprised of several traditional authorities (TAs) which are made up of group village heads (GVH). These GVHs are made up of village heads. Each village is further made up of families; the smallest unit in defining the community. About 81% of the population lives in the rural areas (Demographic Health Survey; DHS, 2010).

Health care services are provided by two main agencies. The government, under the Ministry of Health, provides 60% of the health care free at the point of use with central hospitals having a small paying section for those who can afford it. The Christian Health Association of Malawi (CHAM) is a nongovernmental organization (NGO) contributing about 37% of health care services at a not-for-profit fee for service. The remaining 3% is provided by other NGOs which charge fees, not for profit at the point of use and the private for profit which is mainly confined to the urban centers (MoH, 2007c). With an annual growth rate of 2.3% and a total fertility rate of 6/1000/ year (DHS, 2010), Malawi remains a third world country struggling to meet its basic needs including health. Figure 1 below shows the distribution of government and CHAM health facilities in the CWZ. However health care facilities are unevenly and inadequately distributed whereby most facilities cover a radius of more than 5 kms and cater for a population of more than 25,000 (MoH, 2005) and therefore very few meet the WHO recommendation of a 5 km radius (MoH,1999), catering for a population of less than 25,000.

Apart from the formal provision of health care through the government, NGOs and private facilities, services are also provided through the informal sector. This included Traditional Birth Attendants (TBAs).

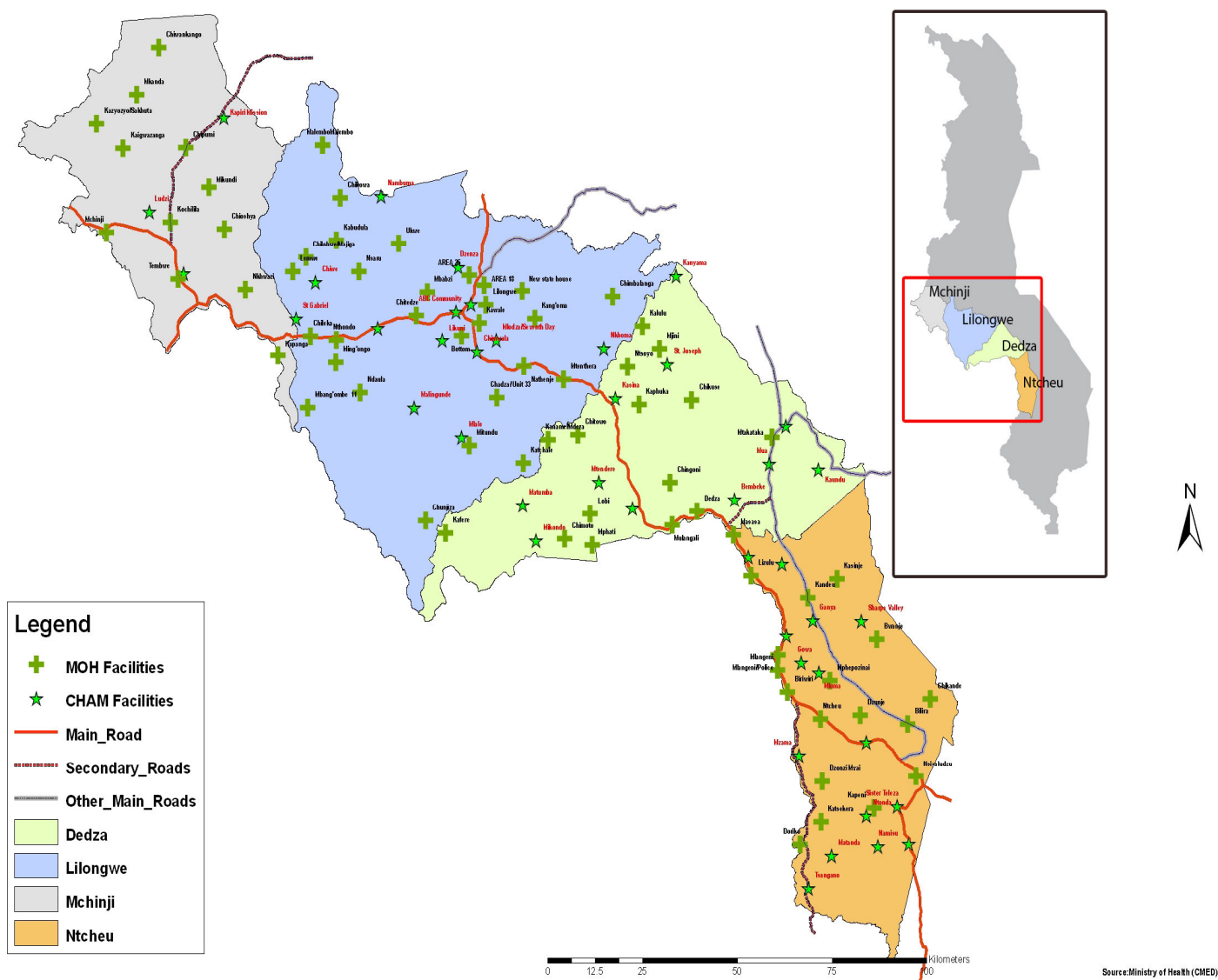


Figure 1.1: Map of Malawi Showing Central West Zone Health Facilities

Source: Ministry of Health (CMED, 2010)

1.2 SOCIOECONOMIC BACKGROUND

Malawi is an agricultural driven economy, which accounts for 35% of its gross domestic product (GDP). In its report of 2011, the World Bank classified Malawi as a low income country with a gross national income per capita of \$330 (World Bank, 2011). Malawi's per capita government expenditure on health was \$42 compared to \$51 of the WHO African region (WHO, 2012) in 2009. In the same year, total health expenditure per capita was \$65 compared to \$73 in neighboring Tanzania (WHO, 2012). Some strides have been made in which total health expenditure as a proportion of total government expenditure reached 14.2 in 2009 compared to 9.6 (WHO, 2012) for the same period for the WHO African region to which Malawi belongs.

1.3 THE NATIONAL HEALTH PLAN AND THE JOINT PROGRAM OF WORK

The National Health Plan (1986-1995) of the Ministry of Health institutionalized the training of TBAs in order to improve their skills. This followed an increase in the proportion of TBA deliveries, a trend which was also alluded to by health facility personnel who observed managing a high number of mothers in ANC but only a few who went back to deliver (Bisika, 2008). However, some were of the opinion that the training provided to the TBAs proved to be ineffective as they demonstrated inadequate skills and harmful practices and thereby continued undermining efforts to achieve the MDGs (Seljeskog, Sundby & Chimango, 2006; WHO, 2005b and Bullough, 1978). Conversely Yazbek, 2012 and Wilson, Gallos, Plana *et al* (2011) state that if trained TBAs are given support they are capable of reducing the number of perinatal deaths. One therefore may argue that TBAs can make a laudable contribution toward improving perinatal health if they are positioned in an enabling environment. What

needs to be analyzed is whether Malawian TBAs were positioned in an enabling environment to perform their work. This could justify the systems' expectations of TBAs positive contribution towards the reduction in perinatal deaths. Consequently, with the emergence of the Sector Wide Approach (SWAp) and the Joint Program of Work (PoW, 2004-2010) that formed a strategic framework, the government adopted the WHO policy on skilled attendance at birth. This necessitated review of the TBA's role in the provision of MNH services. Therefore, the Ministry of Health made a decision to stop TBAs from conducting any type of delivery (MoH, 2007b). This decision was made on a rapid assessment undertaken in the same year that the moratorium was made on the TBAs (MoH, 2007a). The report indicated that the assessment was inconclusive of TBAs effectiveness or ineffectiveness in reducing maternal and neonatal mortality and morbidity. The decision was made despite the resounding favor for TBAs by the communities and some national level respondents in the Ministry of Health to allow TBAs to continue conducting deliveries (MoH, 2007a). Provision was made for making available drugs, supplies and equipment essential for maternal and neonatal health (MNH) services at the health centers, the lowest level of the formal MNH delivery system.

Through this effort, the infrastructure is being improved in order to accommodate the Basic Emergency Obstetric and Neonatal Care (BEmONC) services. Nurse- midwives are being trained in BEmONC services to enable them to manage some of the obstetric emergencies at the health center level. Emphasis is on focused antenatal care (FANC) where every pregnant mother is required to receive a full package of antenatal care (ANC) services. Health care worker training institutions are enrolling to

their full capacity in order to train providers that are more skilled. The government initiated signing of Service Level Agreements (SLA) with CHAM (PoW, 2004-2010) in order to increase mothers' access to skilled birth attendance. The SLAs are a national policy priority, implemented (in the context of decentralization) at the district level. They aim to secure universal financial risk protection with a primary focus on MNH care interventions. Following the expiry of the PoW (2004-2010), a Health Sector Strategic Plan (HSSP), 2011-2016 was developed including MNH services as part of the Essential Health Care package (EHP) (MoH, 2011a).

1.4 THE HEALTH SECTOR STRATEGIC PLAN

The HSSP continues with strategies of its predecessor, the PoW which include infrastructural development, training of more skilled providers and signing of SLAs with the aim of facilitating women's access to skilled birth attendance for the attainment of MDG 4 and 5 by 2015. In Malawi, all skilled deliveries are facility based. Complementing the HSSP is the Road Map on the Acceleration of the Reduction of Maternal Mortality and Morbidity (2011-2016). The Road Map places emphasis on skilled birth attendants and continues to seek involvement of local leaders and significant others in the pursuance of skilled birth attendance for every pregnant mother.

Despite all these efforts, Malawi continues to register high maternal mortality rates at 675/100000 (DHS, 2010). Even though the WHO reports a rate of 460/100000 for the same year, (2010) the Ministry of Health has chosen to use the DHS figure of 675/100000 as its point of reference. The reason given for this preference is that the

ministry considers the DHS a more reliable source, because data is collected from a wider sample through the use of the sisterhood method unlike other reports whose data is collated from various reports. Although the neonatal mortality rate is lower at 27/ 1000 (WHO, 2012) compared to the WHO African Region's neonatal mortality of 34/1000 (WHO, 2012) the trend is not encouraging because it was 27/ 1000 in 2004 (DHS, 2004) and rose to 33/1000 in 2006 (Mixed Indicator Cluster Survey; MICS, 2006). Contributing factors for inadequate performance include inequities in economy and social disempowerment which hinders poor women, especially those in rural and remote areas, from accessing MNH care. Remote areas are characterized by vast distances, difficult terrains; bad or nonexistent roads and a poor transport system that makes access to health facilities impossible. In addition, harmful traditional practices and beliefs deprive young mothers from reaching care on time (MoH, 2007c). Facility based factors include poor staffing levels and fee charging facilities force mothers to deliver at home with the help of a TBA or a relative (Seljeskog *et al*, 2006).

1.5 **TRADITIONAL BIRTH ATTENDANTS IN MALAWI**

Traditional birth attendants in Malawi have since time immemorial provided care to pregnant mothers (Bullough, 1978), when hospitals were few or unavailable. Their role included the provision of antenatal care, attending to mothers in both normal and complicated labor and postnatal care services. Some TBAs managed infertility problems and in most cases the 'luck mother' (luck because her wish of becoming pregnant was realized) would be cautioned to deliver nowhere else but at that particular TBA. That was a precondition for the successful outcome of the pregnancy and a healthy newborn baby.

Individuals practicing as TBAs were elderly women, who were well respected in their area, and had learnt the skills from their grandparents who mentored them. In appreciation of their role in the provision of MNH care, the government of Malawi, with support from its partners formalized TBA training in 1978 (Bullough, 1978). The training was done at district hospital level, a curriculum for TBA training was developed and a position of TBA coordinator designated to train and supervise TBA services was established for each district. The training was scheduled to last four weeks. Upon completion of the training, each TBA received a delivery kit. TBAs were strategically recognized through the 1986-1995 National Health Plan where TBA training and support were emphasized. However, despite incorporating the TBA program into the health care system, TBAs have continued to practice without legislation and without a clear policy to regulate their practice.

1.6 THE MORATORIUM ON TRADITIONAL BIRTH ATTENDANTS IN MALAWI

The ministry argued that although TBAs received training, their contribution towards achievement of MDGs 4 and 5 was negligible (MoH, 2007a). However, no study has been conducted in Malawi to determine the effectiveness of TBAs contribution toward maternal and neonatal health which could have assisted in the formulation of evidence based policy regarding TBA services. In 2007, the Ministry of Health developed a new policy and guidelines on Community Initiatives for Reproductive Health which prohibited TBAs from conducting any type of delivery (MoH, 2007b). With the moratorium on TBAs (MoH, 2007b), authority to ensure compliance was devolved to the community leaders (chiefs and TAs) who were encouraged to institute by laws

prohibiting TBAs from attending to any mother during the antenatal, labor and postnatal periods (MoH, 2007b). If found guilty of non-compliance both the TBA and the mother are fined. Chiefs and TAs are sponsored on education trips to visit areas where these by laws are in place and reinforced. TBAs are advised to play the role of an advocator, advisor and counselor in respect of MNH.

In 2010, the former president, upon his return, from the UN summit announced the need to reconsider TBAs' position and suggested a more formal training for them so that they could make meaningful contributions towards the fight against the high maternal and neonatal morbidity and mortality rates (Safe Motherhood Task Force, 2010). Anecdotal reports indicated that soon after the announcement, TBAs visited hospitals requesting for supplies while pregnant mothers waited on their doorsteps for assistance. All did not support this suggestion. Some argued that training TBAs was not the best solution to the problem. What was needed was an investment in the training of skilled birth attendants. When the current president took over, she immediately assumed the role of the coordinator for Safe Motherhood in Malawi and emphasized the need for hospital delivery for all pregnant mothers. Currently, she is mobilizing the traditional chiefs, who are the gatekeepers of traditional customs, to convince their subjects to deliver with the help of skilled attendants at the health facility. One needs to appreciate how controversial this issue is when the same government banned the TBAs and then lifted the ban, only for the next government to reinstate the ban, demonstrating a lack of evidence for doing it either way.

1.6.1 Effects of the Moratorium on Traditional Birth Attendants in Malawi

As a result of the moratorium, TBAs are encouraged to refer all pregnant mothers to a health facility for care by a skilled birth attendant (MoH, 2007b). However, the health care system is not coping. Anecdotal reports indicate that there is congestion at the health facilities for waiting mothers and their guardians (a companion pregnant mothers bring along from home to assist them with personal needs before and during labor because of a lack of adequate numbers of providers at the health facility). The fact that the majority of health facilities in the rural areas do not have waiting homes or antenatal wards for pregnant mothers means that pregnant mothers are often accommodated with their guardians in an inhumane manner at the guardian shelter. Further, anecdotal reports are that most of these shelters have broken floors and doors, no shelves and inadequate ventilation which may subject mothers to adverse conditions in relation to their health. Structures meant to be kitchens have been turned into shelters. There are no beds in the shelters and mothers sleep on mats provided by themselves or the community.

All these factors challenge efforts to achieve MDGs 4 and 5 unless significant investment is deliberately made to promote safe pregnancy and delivery for mothers in Malawi (MoH, 2011b).

1.7 PROBLEM STATEMENT

Despite the moratorium on TBAs, Malawi continues to register a high maternal mortality rate compared to the WHO African region's rate of 480/100000 (WHO, 2012). Further, inconsistencies in the reduction of the neonatal mortality rate gives rise to

concern as to whether Malawi will achieve the goals of MDGs 4 and 5 by 2015. Lack of the necessary infrastructure and an inadequate human and material resource base continue to undermine government's efforts to achieve the MDGs. Anecdotal reports are that the influx of pregnant mothers to the few health facilities has resulted in mothers delivering on make shift beds on the floor or even at the guardian shelter. The lack of waiting homes and antenatal wards for pregnant mothers in the health centers results in mothers and their companions being accommodated in inhumane and unhygienic conditions. Moreover, mothers sometimes travel great distances to go to a health centre, only to find that there is no provider to attend to them when in labor (Seljeskog *et al*, 2006) and end up being assisted by an unskilled and untrained provider (Kumar, 2007).

The pace at which the maternal mortality rate is reducing has not gained momentum since TBA deliveries were stopped. The health facilities lack resources for the provision of quality care. Moreover, there has been no progress in the establishment of BEmONC sites (MoH, 2010b) in these areas thereby depriving mothers from accessing emergency obstetric care when the need arises. However, some stakeholders are of the opinion that banning TBAs is the right move. A mother who went to a TBA for delivery said, "I once went there and I experienced some problems. After giving birth I was in a coma for a week and was sick for six months" (Kumar, 2007:25). On the other hand, some key stakeholders have observed that although the government has stopped TBAs from conducting deliveries, the health facilities are not equipped to manage the number of women coming to deliver at the health facilities. They assert that banning TBAs will not improve the situation for rural, remote and poor mothers

unless coupled with improved access to health care facilities (Mithi, 2011). This study sought to obtain stakeholders' perceptions regarding the way the moratorium was introduced and is being experienced. It also sought to determine whether the ban is the best and safest option especially for the rural, remote mothers who have no access to a health facility and have no means of reaching one. Further, it also sought to determine communities' reactions to the changes and whether mothers are able to comply with the requirements.

The question that needed to be answered was: What are the perceptions of key stakeholders of the changing role of TBAs, and what are the reasons why mothers in the rural areas of CWZ continue to deliver at home despite the directive to deliver at the health facility?

1.8 PURPOSE OF THE STUDY

It has been observed (WHO, 2005b) that the promotion of skilled birth attendance facilitates the reduction of the maternal mortality rate. Countries have been called upon to institute systems that increase access to skilled delivery. Malawi has put in place a number of policies and guidelines including the moratorium on the TBAs. Despite this, pregnant women continue delivering outside the health facilities. This study therefore sought to explore key stakeholders' perceptions of the TBAs' changing role in order to understand the reasons why home births persist in the rural areas of CWZ, Malawi.

1.9 OBJECTIVES

The objectives of the study were to:

1. Explore mothers' and nurse-midwives' perceptions of the changing role of TBAs.
2. Describe mothers' and nurse-midwives' perceptions of the MNH care system in CWZ, Malawi.
3. Explore mothers' and nurse-midwives' perceptions of the reasons why mothers in the rural areas of CWZ still deliver outside of the health facilities
4. Explore TBAs' perceptions of their changing role.
5. Describe TBA trainers' perceptions of the effectiveness of TBA training, services and the TBAs changing role.
6. Explore Ministry level and Nurses and Midwives Council health professionals' perceptions of the TBAs' changing role.
7. Make recommendations with the aim of improving community MNH services in the rural areas of CWZ, Malawi.

1.10 STUDY SETTING

The study was conducted in Malawi, Central West Zone which comprises of Ntcheu, Dedza, Lilongwe and Mchinji districts. This is where the researcher had been working for more than six years. The BEmONC services and bylaws facilitated the promotion of skilled birth attendance for all pregnant mothers in these areas. Therefore, the study targeted the BEmONC facilities operating in rural areas because it was where bylaws on the moratorium on TBAs were institutionalized and local leaders had been empowered to reinforce the implementation of the bylaws. However, home deliveries

continued despite the policy change and institutionalization of bylaws on the TBAs' role in 2007.

1.11 SIGNIFICANCE OF THE STUDY

The findings from the study provide empirical evidence on prevailing perceptions with regard to TBAs' role in MNH services. As Malawi is striving to achieve the MDGs 4 and 5, the recommendations from the study may contribute to the development of an efficient and effective community MNH system in the following: Policy makers might review the implementation of policy and put in place reinforcing mechanisms that will promote skilled birth attendance for all mothers. The study findings can also assist MNH care providers to provide care that is responsive to the unique needs of mothers residing in the rural areas. Incorporation of the recommendations made will assist TBAs to regain their position in society while they actively participate in bringing all pregnant mothers for skilled attendance at delivery. Mothers in rural areas will be able to access MNH care that is acceptable and accessible to them and will be able to enjoy their pregnancy with the anticipation of a good outcome of their pregnancy.

1.12 PHILOSOPHICAL ASSUMPTIONS OF THE RESEARCHER

Slife and Williams (1995) state that philosophical ideas in research remain largely hidden and yet still influence the practice of research hence the need for these to be identified and clarified. A paradigm according to Lincoln and Guba (2000) is a basic set of beliefs that vary according to underlying assumptions in making research decisions. In this study the paradigmatic views of the researcher influenced study design and data collection processes. In clarifying underlying assumptions, the basic philosophical

assumptions of ontology, epistemology and methodology were analyzed. According to Lobiondo-Wood and Haber (2002) and Lincoln and Guba (2000) ontology refers to the nature of reality which is multiple, thus one person's reality may not be the same as another's. Epistemology is how we know what we know. Methodology is the research process and methods. In essence, the paradigm influences the way we know and interpret our reality and the values which culminate in the way we select our research techniques (Doyle, Brady & Byrne, 2009). In this study, a pragmatic approach was adopted in which the researcher was free to borrow from different methodologies in order to obtain a broader understanding of the problem under study.

1.12.1 Pragmatism

Pragmatism refers to a liberal worldview or paradigm where the research problem and the solution to the problem is the central focus rather than the underlying assumptions of a research method (Creswell, 2009). It is an inclusive approach in order to get what works. It offers an epistemological rationale for mixing research approaches. Howe (1988) argued that contemporary researchers need to focus on what works instead of confining themselves to purist philosophical dogmas. Pragmatism rejects both positivism and anti-positivism but calls for a paradigm shift where theory assessment is based on its capacity to provide solutions for the problem at hand (Pansiri, 2005). Powell (2001) asserts that an effective proposal is one that yields fruitful results of human discovery to be deployed, improved and sustained so long as it gives the desired results. Therefore, the researcher in this study used methods that best assisted in gathering data to understand stakeholders' perceptions of the TBAs changing role. Pragmatism recognizes that what is true today may not be true

tomorrow just as what works today may not do so the day after. Therefore, pragmatism allows the use of different methods provided they assist in obtaining results.

It is argued that people need to recognize and appreciate the fact that TBAs have remained a source of help to pregnant mothers especially in the rural and remote areas of Malawi. Mothers have engaged TBAs from time immemorial to assist in delivering their babies and that is their reality. TBAs have proven to yield the desired results because of their subscription to mothers' cultures, values and beliefs. Mothers are allowed to deliver in a friendly environment with all the support they need from their support system. Through apprenticeship, TBAs have acquired skills and mothers have come to accept them as their reality, fruitful paths and profitable leading (Pansiri, 2005). However, the Ministry of Health asserts that TBAs are no longer yielding profitable results and it is asking mothers to move on and engage a more attractive proposal of a skilled birth attendance at every birth which in Malawi is facility based. Mothers' choices however would prove whether TBAs are indeed a failure or whether it is a model that is still fruitful and therefore need not be abandoned but worked on in terms of its weaknesses.

1.12.2 Methodological Assumptions

A pragmatic approach (Cherryholmes, 1992; Morgan, 2007; Creswell, 2009) was adopted in this study. The researcher liberally drew from both quantitative and qualitative assumptions in order to understand stakeholders' experiences and obtain their perceptions as a result of the moratorium on TBAs. With this approach, the researcher was free to choose methods, techniques and procedures of research that best met the needs and purpose of the research (Creswell, 2009). As such,

triangulation of methods, data collection and source as well as data analysis was utilized in this study.

1.12.3 Policy Assumptions

These were based on the Health Sector Strategic Plan (2011-2016), the MNH Conceptual Framework, the National Health Plan (1986-1995 & 1999-2004), the Program of Work (2004-2010), the Essential Health Care Package (2004), the National Sexual and Reproductive Health Rights (SRHR) Policy (2009), the Road Map for accelerating the reduction of Maternal and Neonatal Mortality and Morbidity in Malawi (2011-2016), the TBA curriculum and Guidelines for Community Initiatives for Reproductive Health (2007b).

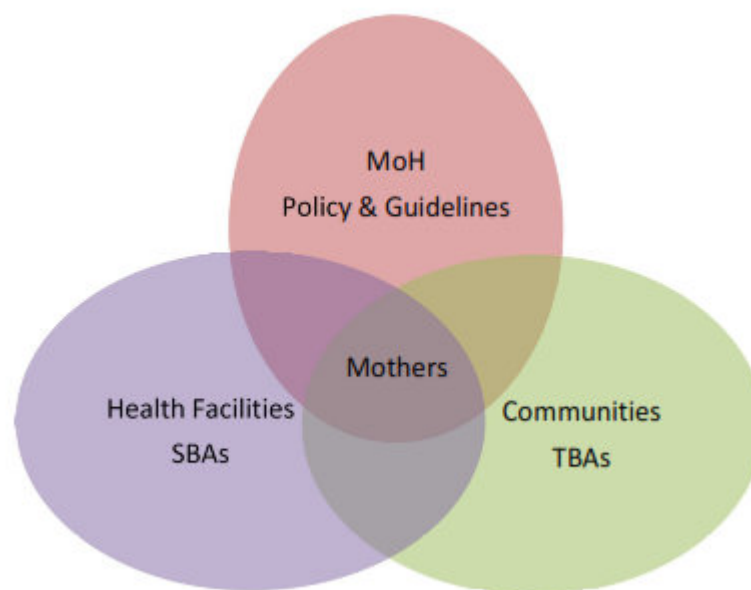


Figure 1.2: Depicts how MoH Policies Impacts the Health of the Mother

Figure 1.2 demonstrates the interaction of policies and guidelines with regard to MNH services and how they may affect the health of the mother. The MNH policies and guidelines set by the Ministry could be an attractive proposal if their implementation

facilitated the achievement of MDGs 4 and 5. On the other hand, implementation of these could also frustrate achievement of the MDGs. At the same time, the TBAs in the community could promote the health and welfare of the mother or endanger the same life they are aiming to save and promote.

1.13 CONCLUSION

In this chapter, an overview of the research study has been presented. In the introduction the background and socioeconomic status of the country has been highlighted. An overview of MNH care has been given describing some of the challenges mothers face as a result of the moratorium on TBAs and the government's commitment to reduce maternal and neonatal mortality rates. It has been learnt that although the government stopped TBAs from conducting deliveries many mothers continue to face challenges in accessing the skilled birth attendants who in Malawi are facility based only. The statement of the problem highlights some of the situations which compound mothers' problems in accessing skilled care during labor. It is being argued that even though TBAs have been stopped from delivering mothers the gains that have been made so far remain negligible and that Malawi may not reach its goal of a maternal mortality rate of 155/100000 and a neonatal mortality rate of less than 25/1000 by 2015. The researcher chose a pragmatic approach in order to achieve the study objectives. This allowed the researcher to freely borrow from either quantitative or qualitative methodologies in order to obtain a wider breadth of understanding of the research problem and make superior inferences of the reasons why mothers in these areas continue to deliver outside health facilities. In the following chapter the literature reviewed, both internationally and nationally will be discussed.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter unfolds a search of the literature related to perceptions of the key stakeholders of the TBAs changing role and the drivers for mothers' continued home births. The chapter begins with an explanation of how the literature search was conducted and identifies the sites visited. Further, the search engines and search words used are stated. This is followed by the UN advocacy of MNH through the MDGs, WHO's advocacy for MNH care, access to maternal and neonatal health services, skilled birth attendance and finally experiences with TBAs at international and national levels.

2.2 STRATEGIES USED IN LITERATURE SEARCH

Both electronic and hard copy searches were used in the review of the literature. A twofold approach was used: a search of relevant literature from the UN, WHO and MoH documents was conducted; some of the reviewed documents from the UN included the MDGs. WHO documents included the Road Map for Accelerating the Attainment of the MDGs related to MNH in the African Region, the WHO statistics (2008-2012), WHO MNH and TBA documents. Those from MoH included the Joint Program of Work (2004-2010), the Health Sector Strategic Plan (HSSP; 2011-2016), the Road Map for Accelerating the reduction in Maternal and Neonatal morbidity and mortality for Malawi; 2011-2016 (2007c) and the Guidelines for Community Initiatives

for Reproductive Health (2007b). Secondly, peer reviewed articles, discussion papers and reports from various search engines were reviewed.

The various specialized databases and websites which were searched included EbscoHost, Academic Search Premier, Africa Journals on Line, HINARI, JSTOR, Cochrane Database of Systematic Reviews, Wiley on line library STM 2011, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Elsevier Databases, Directory of Open Access Journal (DOAJ) and PubMed. The search engine, Google Scholar was also used.

Key words such as traditional birth attendants, skilled birth attendants, MDGs, maternal mortality, neonatal mortality and access to MNH care were used in the search of the literature. The review of the literature involved mapping, analyzing, and synthesizing current understanding of the health care system and the way it operates including gaps in the system and its impact on the MNH care delivery in Malawi.

The review process commenced with mobilization of relevant published journal articles, policy documents and different reports on MNH. Searching for relevant references cited in articles was also made in order to obtain a broader understanding of the concept under study. The process was refined by narrowing down to relevant themes such as MDGs number four and five, skilled delivery at birth and the roles of TBAs.

The next step involved the selection of the most relevant literature from the collected documents giving consideration to relevance, reputability of source or author (WHO,

UNICEF, World Bank, MoH) and year authored (within ten years) unless it was necessary to refer to the old document. This process assisted in further narrowing down the amount of literature for the review. Studies and reports that were accessed reported on the progress on achievement of the MDGs, provision of MNH care, the availability of skilled attendants at birth and experiences with traditional birth attendants in MNH at both national and international levels.

2.3 THE MILLENNIUM DEVELOPMENT GOALS

The emphasis on the health of mothers and newborns emerged long before the 1990s, a consensus, which has harnessed the MNH programs, strategies and activities (WHO, 2005b). The nature of the priority status of maternal and child health has changed over time. WHO (2005b) contends that initially mothers and children were previously considered privileged in MNH programs, but contemporary program managers in MNH are increasingly claiming the right of mothers to access quality care. It is their entitlement that needs to be guaranteed by the national governments. As a result program managers have transformed maternal and child health as critical both morally as well as politically other than being of technical concern only (WHO, 2005b). The understanding led to the development of Millennium Development Goals.

“At the Millennium Summit in September 2000 the United Nations Millennium Declaration was ratified, committing nations to a new global partnership to reduce the dire poverty and poor health indicators with a deadline of 2015, that has become known as the MDGs” (UN, 2002:1). Eight goals were ratified of which this study focused on goals 4 and 5.

- GOAL 1: Eradicate extreme poverty and hunger
- GOAL 2: Achieve universal primary education
- GOAL 3: Promote gender equality and empower women
- GOAL 4: Reduce child mortality
- GOAL 5: Improve maternal health
- GOAL 6: Combat HIV/AIDS, malaria and other diseases
- GOAL 7: Ensure environmental sustainability
- GOAL 8: Develop a global partnership for development

It has been argued that the MDGs were not made with goodwill for the poor people. Ariffin (2004) stated that the MDGs do not include the hard won goals of women's sexual and reproductive health rights such as their right to family planning services, pregnancy, number of children and child spacing. This omission perpetuates women's status as incomplete citizens (Ariffin, 2004). Further, the UN (2012) observed that goal figures were set blindly without considering that when approaching the target number progress becomes more difficult and more costly. Amin (2006) and Quarterman, Tahir and Toor (2010) observed that some UN member states influenced what was included in the MDGs leaving out equally important goals. Amin (2006) asserted that the three powers, America, Europe and Japan, were the authors of these goals and termed it an Americanization of the world. Amin (2006) asserted that the MDGs were developed in sharp contrast to the UN tradition of adequate consultation among the stakeholders. This may mean that the MDGs do not truly reflect the needs of the developing countries and as such, they may not be taken seriously.

During the commissioning of the MDGs project a concrete plan of action for the world was developed. The following targets were set to meet MDGs 4 and 5:

Target 4: Reduce by two thirds between 1990 and 2015 the under five-mortality rate. Indicator for MDG number four: Reduce the neonatal mortality rate to below 25 per 1000 live births by 2015.

Target 5: Reduce by three quarters between 1990 and 2015 the maternal mortality rate. Indicators for MDG number 5: Eighty percent of all births should be assisted by skilled attendants by 2005, a further increase to 85% by 2010 and up to 90% by 2015.

2.3.1 WHO Advocacy on Improved Maternal and Neonatal Health

“Every year more than 536,000 women die from pregnancy and labor related complications and over 3 million stillbirths and 3.7 newborns die worldwide” (WHO, 2008b:1). Ninety nine percent of these deaths occur in the developing countries whose health care systems are still wanting with South Asia and sub-Saharan Africa being the worst (Sibley & Sipe, 2006). The majority of these deaths occur at home especially during the first postnatal week and within the first 24 hours of birth (USAID, 2006).

In its 2005 report on Making Every Mother and Child Count, WHO (2005a) observed uneven gains and slow progress in the areas of child health with Africa faring the worst. Newborn deaths contributed about 40% of all under five child deaths globally. Two thirds of these deaths occurred in the WHO African region to which Malawi belongs. These deaths went unnoticed by both national governments and the

international bodies. Secondly, WHO (2005a) observed that there were few signs of improvement in maternal health and negligible progress as over 300 million mothers in developing countries continued to suffer from pregnancy and labor related complications (WHO, 2005a).

2.3.2 WHO: Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in the African Region

WHO (2004) reported that deaths and disabilities in the African region could reach 2.5 million and 49 million, respectively, if urgent and deliberate action was not taken to improve maternal health. In response, WHO (2004) developed a Road Map to guide countries to develop country specific Road Maps. These were meant to accelerate the reduction of maternal and neonatal morbidity and mortality. The Road Map provides a framework for building strategic partnerships for renewed commitment and increased investment in MNH at all levels of service delivery (WHO, 2004). It was proposed that the Road Map be implemented in two phases of five years each. The first phase was to be implemented from 2004-2009 whilst the second phase from 2010-2014, reporting finally in 2015. This result based strategy, which had targets and timelines was proposed in order to advance the MDGs agenda.

2.4 ACCESS TO MATERNAL AND NEONATAL HEALTH SERVICES

WHO (2008c) reported that the maternal mortality rate was 9/100,000 in developed countries, whilst it was 450/100,000 in sub-Saharan Africa and 480/100,000 in the WHO African region. In its report on rating MNH services in developing countries,

WHO, (2002) observed that maternal health programs' efforts were seriously deficient, particularly in the rural areas. Travelling distances, unavailability of skilled providers in facilities and inadequate resources for the provision of MNH care were some of the impeding factors. Rural women were disadvantaged in many respects, but especially in the management and treatment of emergency obstetric conditions. In addition, DFID, 2007 and Ruiz, van Dijk, Berdichevsky *et al*, (2013) observed that costs for transport and food, geographical barriers and sparsely located facilities compounded mothers' access problems. As a result, mothers in developing countries were forced to continue delivering at home.

Thaddeus and Maine's (1994) model identifies three delays in accessing maternal care. The three elements are recognition of complication and making the decision to seek care, transport to reach care and receiving quality MNH care. More recently, writers refer to four deadly delays which include: delay in recognizing that there is a problem, delay in making the decision to seek health care, delay in reaching care due to transport problems and delay in receiving the right treatment (Ghebrehiwet and Morrow, 2007 and Pathfinder International, 2009). These delays are valuable in understanding the underlying causes of maternal, fetal and neonatal deaths. The authors contend that mothers' lack of decision-making power causes delays in accessing reproductive health care in time for better outcomes. Pathfinder international (2009) in Nigeria observed that the four delays significantly contributed to the persistently high maternal mortality rate, which was 1100 per 100,000 (WHO, 2008c). Mothers delayed seeking medical care because of poor understanding of pregnancy complications and access to health care. Both factors required input in the decision

making process from husbands or mothers who would contribute in the final decision to seek care. Moreover, mothers were not satisfied with the quality of care they received because their health facilities did not have the capacity to give blood transfusions or perform a surgery when there was need (Pathfinder International, 2009).

2.5 **SKILLED BIRTH ATTENDANTS**

The International Federation of Gynecology and Obstetrics (FIGO) in collaboration with the International Council of Midwives (ICM) and WHO (2004:1) defined a “skilled birth attendant as an accredited health professional such as a midwife, doctor or a nurse who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, child birth and the immediate postnatal period”. Such professionals were reported to have acquired competencies to safely manage pregnant mothers during antenatal, labor and postnatal periods including complications that may arise (FIGO *et al*, 2004). WHO advised that developing skilled birth attendants alone is not sufficient without the necessary equipment, medicines and an adequate referral system (WHO, 2008b). Improving MNH services requires moving beyond policy reform to strategies that are more practical.

WHO (2008b) advocated for countries to strengthen their health systems using skilled attendants at delivery and referral to facilities able to provide emergency obstetric care. However, WHO warned against quick fixes by instituting systems that are not responsive to the unique needs of particular countries. Countries were therefore encouraged to consider their individual situations and move progressively toward skilled birth attendance for every pregnant mother (WHO, 2008b). The same report

indicated worldwide, 34% of births (translating to 45 million births); occur at home assisted by a TBA or family member or nobody at all. This was reported common especially in developing, poor, rural, remote and hard to reach areas. Similar situations were reported to have been the case in developed countries before the 20th century. Developed countries managed to halve their maternal mortality rates by providing professional midwifery care at birth and improving access to hospitals (WHO, 2008b). On the other hand, Thailand, a developing country, managed to reduce its maternal mortality rate from 200/100,000 to 50 /100,000 live births through a progressive increase in the number of skilled birth attendants (Bergstrom & Goodburn, 2001). Thailand trained more providers and increased the capacity of district hospitals to provide essential obstetric care.

Countries were therefore tasked with the responsibility of reducing the maternal mortality rate indicators of 1990 by 75% by 2015 and reducing neonatal mortality rates to below 25 per 1000 live births (WHO, 2002). To monitor progress towards the reduction of maternal mortality the proportion of births conducted by skilled attendants has become an indicator (Seljeskog *et al*, 2006). An observation was however made that the current number of skilled attendants is critically insufficient to meet this challenge with an estimated shortage of 700 000 (50%) midwives worldwide (WHO, 2008b). The shortage is mostly reported in the poorest countries like Malawi where in 2010, 214 deliveries were estimated to have been conducted by only one midwife per year instead of the WHO's recommendation of 175 deliveries per nurse-midwife (Nove, 2011). Countries are urged to educate more midwives with sufficient competencies to

manage both normal and complicated pregnancies and those who are able to exercise diligence with referral of mothers and babies where need be (WHO, 2008b).

2.6 TRADITIONAL BIRTH ATTENDANTS DEFINED

TBA is defined by FIGO *et al* (2004:8) as “traditional, independent (of the modern health system), non-formally trained and community-based providers of care during pregnancy, child birth, and the postnatal period”. Others have defined TBAs as generally illiterate females in their 50s or more, having children of their own and who have acquired their skills by delivering babies themselves or through an apprenticeship. They conduct deliveries within their communities or families from whence they obtain recognition and respect (Corey & Andes, 2011; Krueger, 2009; Sibley, Sipe, Brown *et al*, 2007; Ofili & Okojie, 2005; UNFPA, 1996; and Bullough, 1978).

2.6.1 Traditional Birth Attendants’ Experiences

WHO (1985) advocated for TBA services at a meeting held in Geneva in 1973. This was followed up by interregional meetings in Manila, (1974) and Mexico (1979). As a result, WHO launched a program supporting countries to integrate TBA services into national MNH programs (WHO, 1985). Countries were supported with the development of policies and laws affecting TBAs, their supervision and the provision of resources. Countries were also supported with sponsorship of TBA studies and publication of several reports. TBA training became integrated into MNH interventions to improve MNH at the community level (WHO, 1985).

An evaluation report on TBA services in seven countries including Malawi conducted by UNFPA (1996) highlighted important limitations to the effectiveness of TBA services. Some of the limitations were failure by countries to include the TBA program in the MNH strategies despite its inclusion in the national plans. Countries tended to rely on donor funding; the program was not integrated in ongoing activities such that separate staff and resources were designated. The only positive finding however was for the TBAs themselves in that the training they underwent improved their status in the community. They were viewed as part of the formal health care system in their communities (UNFPA, 1996). Consequently, TBAs were reluctant to refer mothers with complications because doing so would undermine their capacity to manage complications. In cases where a TBA happened to refer mothers to a facility, mothers would defy TBAs' referral orders and enroll with untrained TBAs. If by chance the mother delivered normally, trained TBAs would lose credibility. As such, trained TBAs chose not to refer. At the facility, reported poor health care attitudes discouraged both the TBAs and mothers (UNFPA, 1996). Persistent high maternal mortality rates led to the establishment of the Safe Motherhood Initiative. The initiative focused on skilled birth attendants (Kruske & Barclay, 2004) whose definition does not include TBAs; this resulted in the withdrawal of funding for supporting TBA services worldwide (Kruske & Barclay, 2004).

2.6.1.1 TBA experiences from other countries

As countries strive to achieve the millennium development goals, reports in sub-Saharan Africa show that despite governments' efforts to institute strategies to encourage mothers to use formal health facilities many mothers continue to use TBA

services. Nigeria which has a maternal mortality rate of 1100 per 100000 live births and a neonatal mortality rate of 49 per 1000 live births (WHO, 2008c) is still struggling with the use of TBA services. A study conducted by Ofili and Okojie (2005) found that some TBAs used herbs and other substances such as animal dung, flies, scarification marks, and cow urine to treat ailments in pregnancy and labor. Ahmed, Odunukwe and Akinwale (2005) in their study also observed that although some of the TBAs recognized danger signs in pregnancy and labor, very few would refer cases for emergency obstetric intervention. Further, Abioye- Kutei, Elias, Familusi, *et al* (2001) in their work involving 26 TBAs found that 54% of those studied had no designated room for deliveries; 12% performed vaginal examinations during labor and only a few recognized complications. Twelve (46.2%) had never referred a patient. TBAs also managed complications such as retained placenta and breech presentations (Bello, Ambe, Yahaya *et al*, 2009). Buowari (2011) recommended the need for on-going training for TBAs especially in countries like Nigeria to improve their contributions towards MNH.

In South Africa Shangase, Pengpid, Peltzer *et al* (2010) have defined the new roles of the TBAs which exclude conducting planned deliveries. The authors stated that TBAs were to perform deliveries in emergencies only. Their role includes identifying pregnant mothers in the community and motivating them to attend ANC, assisting the mother with the preparation of a birth plan and delivery at the health facility among others. However, Yazbek (2012) in her report entitled “TBAs are an effective resource” asserted that mothers continue to subscribe to TBA services because they have been let down by the western medical system. Barriers such as limited financial resources,

poor access to health care services and health care workers' negative attitudes continue to bar women from accessing health care (Yazbek, 2012).

In Tanzania, despite achieving a very high coverage rate of antenatal care (ANC) at over 90% at first visit and approximately 62% completing the four focused antenatal care (FANC), only 43% went back to the health facility to deliver and only 13% received immediate postpartum care (Magoma, Requejo, Campbell *et al*, 2010). Magoma *et al* (2010) reported on the efforts the government of Tanzania instituted in order to increase skilled attendance at birth in 2007 and 2008. Perinatal care was made free at the point of use or was highly subsidized in order to increase access to skilled birth attendants. An extensive network of mobile health clinics were established in order to deliver services to the most rural, remote and hard to reach areas. A functioning radio communication and mobile phone system connected dispensaries to the hospitals and district health headquarters. Air ambulances are mobilized for use in transporting obstetric emergencies to the hospitals free or at a nominal cost. Maternity waiting homes have been constructed for pregnant mothers' accommodation at the facilities. In spite of all these efforts Tanzanian mothers continue to deliver at home with only 47% receiving care from a skilled birth attendant (Magoma *et al*, 2010).

Thus, it can be concluded that Malawi needs a wider consultation of key stakeholders in order to come up with effective strategies that facilitate skilled birth attendance rather than measures which are not responsive to the unique needs of the country.

2.6.5 TBA Experiences in Malawi

There is a very strong political will to reduce the high maternal and neonatal mortality rates as evidenced by a number of interventions instituted countrywide. In Malawi sixteen women continue to die daily from pregnancy and childbirth related complications (MoH, 2007b). As of 2010, only 71% of mothers were able to access skilled care at birth (DHS, 2010). Although the country has registered a reduction in maternal and neonatal mortality rates, more still needs to be done. Debate on whether TBAs have a role in the provision of MNH services continue. Since the institution of the moratorium on TBA services, there has not been a framework for their services as much as MNH care is part of the EHP (MoH, 2011a) which is silent on TBAs contribution to MNH care.

Anecdotal reports show that TBAs continue practicing despite the moratorium. Bisika (2008) in Malawi alluded to the fact that the utilization of TBAs is underreported. The Safe Motherhood Initiative has enjoyed political will since 2004 with little progress on tangible efforts in addressing factors that affect pregnant mothers from accessing skilled birth attendance. In July 2012, the first female president of the Republic of Malawi re-launched the Safe Motherhood program under the theme “No woman should die whilst bringing life”. Community and opinion leaders have been charged with the responsibility of ensuring that all pregnant women deliver at a facility and that no TBA conducts a delivery.

2.6.5.1 **Millennium development goals in Malawi**

In a speech made by the former president of Malawi to the 62nd session of the United Nations General Assembly in 2007 indications were made that Malawi was well on its way toward the achievement of the MDGs number four and five (Government of Malawi; GoM, 2007). The MDG on maternal mortality reduction has prioritized improvement in skilled attendance at birth as the key strategy for preventing maternal mortality (GoM, 2007). In Malawi, all births that are conducted by skilled attendants are facility based. Therefore, the success of the strategy depends on whether health facilities have the capacity to meet the increase in demand for obstetric care and are able to provide effective treatment to women who seek care.

2.6.5.1.1 **Progress made on achieving MDG 4 and 5**

The following is the progress made this far in the achievement of MDGs number four and five in Malawi:

Target 4: Reduce by two thirds between 1990 and 2015 the under five-mortality rate

Indicator for MDG number four: Reduce the neonatal mortality rate to below 25 /1000 live births by 2015. As of 2011 the neonatal mortality rate was 27/1000 (WHO, 2012) an improvement from 33/1000 but the same as in 2004 (seven years back). Malawi needs to take cognizance of experiences that reverse achieved gains and re-strategize if the country is to register success by 2015.

Target 5: Reduce by three quarters between 1990 and 2015 the maternal mortality rate

Malawi is expected to reduce its maternal mortality rate to 155/100 000 by 2015 from the 620/100 000 in 1990 (DHS, 1992). Figure 2.2 shows that the MMR in Malawi increased to 1120 in 2000 (DHS, 2000) and decreased to 984 in 2004 (DHS, 2004). The indicator improved further to 807 in 2006 (MICS, 2006) and was recorded to be 675 in 2010 (DHS, 2010). At the pace at which Malawi is progressing it is unlikely that the 155/100 000 target will be achieved by 2015 unless more deliberate efforts are executed.

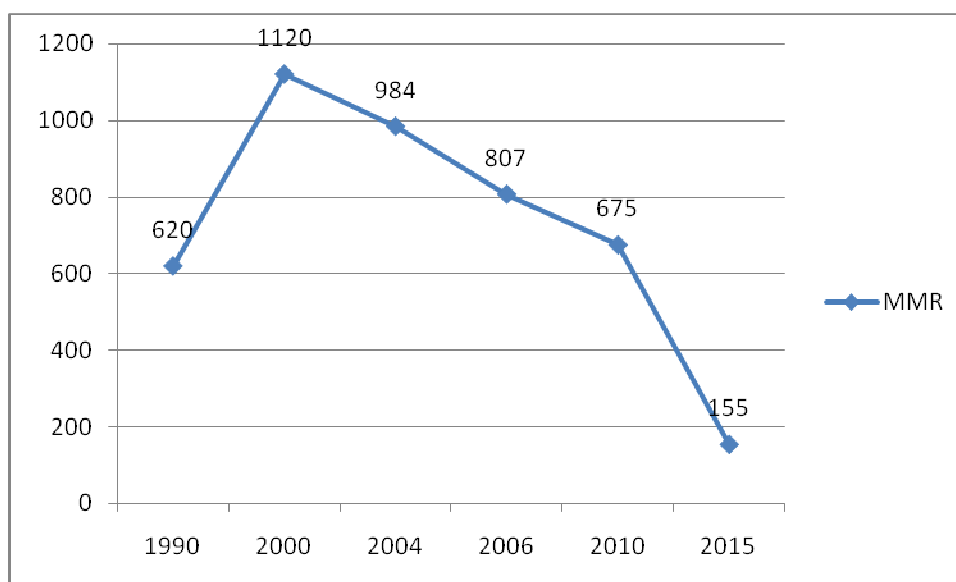


Figure 2.1: Progress in Reducing the Maternal Mortality Rate in Malawi

(Source: reconstructed from DHS (1992, 2000, 2004, and 2010); MICS report 2006 and HSSP 2011-2016).

Indicator for MDG number five: Eighty percent of all births should be assisted by skilled attendants by 2005, a further increase to 85% by 2010 and to reach 90% by 2015 (MDGs, 2000). In Malawi skilled attendants at birth have increased from 54% in 2006 (MICS, 2006) to 71% in 2010 (DHS, 2010) revealing a gap of 14% for the 2010 target. The progress is not encouraging with the MMR projection at 435/100000 in 2015 (DHS, 2010). Malawi will have fallen short of the 155/100000 target. It is imperative that more aggressive and practical strategies are instituted to register commendable gains in 2015.

2.6.5.2 Road map for the acceleration of reduction of maternal and neonatal morbidity and mortality in Malawi

Although there is some progress in the decline of the neonatal mortality rate, there is an apparent slow improvement in the maternal mortality rate. Malawi continues to experience challenges with its MNH system which include: limited availability and utilization of MNH care services and weak procurement and logistic systems for drugs, supplies and equipment (MoH, 2007c).

As a result, in 2007 Malawi adopted the WHO's proposal on developing a Road Map for the Acceleration of the Reduction of Maternal and Neonatal Morbidity and Mortality. The Malawi Road Map draws and builds on the HSSP 2011-2016 report which replaced the SWAp Joint Program of Work 2004-2010. It is a goal driven result based strategy with targets and timelines advancing the MDGs agenda (MoH, 2007c). The reviewed Road Map (2011-2016) is being

implemented concurrently with the HSSP (2012-2016). One of the priorities in the HSSP is the development of human resources including skilled attendants at birth. Trainers are being deployed by government into both public and CHAM training institutions. In-service training for MNH providers is ongoing to improve their competencies in managing obstetric complications.

2.6.5.3 Access to MNH care services

In order to increase access and achieve the MDGs four and five the government of Malawi entered into a contractual arrangement with CHAM. The arrangement is known as Service Level Agreement (PoW, 2004). Through this agreement, mothers and their children access services at CHAM facilities which are mostly located in the rural areas serving the poor. CHAM charges a minimal fee which acts as a deterrent for poor households to access care. Under the agreement, mothers and their children access services at CHAM facilities for free at the point of use. The government through its District Health Office takes the responsibility of settling the bills on behalf of the clients (mothers and children). Despite these efforts access to MNH care remains a challenge in Malawi with the skilled birth attendant rate at 71% (DHS, 2010) far below the 2010 target of 85%. The three delays by Thaddeus and Maine (1994): delay in recognizing danger signs and making a decision to seek care, delay in reaching care and delay in receiving appropriate care, hamper the efforts to achieving intended improvements in MDGs number four and five (MoH, 2007a). These delays reveal the presence of deeper systemic, socioeconomic, infrastructural and administrative problems in which case the care is not only delayed but may not

be available altogether (Sharan, Ahmed, Malata *et al*, 2010). In addition, Malawi's coverage of BEmONC services is stagnant at 2% since 2005 (MoH, 2010) implying that many poor rural women are denied basic emergency care when in need (MoH, 2010).

2.7.5.4 Skilled birth attendants in Malawi

Like many other developing countries, Malawi continues to suffer from the effects of the brain drain, where health workers migrate to developed countries in Europe, especially Britain in search of better working conditions. WHO (2008b) estimated that Malawi has less than one doctor to 10,000 population and six nurse-midwives to 10,000 population. These figures are lower than estimates in the rest of the WHO African region which indicate 2 doctors to 10,000 population and 11 nurse-midwives to 10,000 populations. This disparity may confirm the deeper systemic problems observed by Sharan *et al* (2010) that led to a nursing personnel vacancy rate of 65% with about 59% of Malawi-born physicians practicing outside the country (WHO, 2008a).

2.6.5.5 Amount of support provided to the TBAs in Malawi

Support for TBA services following training depended on donor interest (MoH, 2007a). There were no clear guidelines at national level to ration donor support. The decision on the support TBAs received depended on the District Health Management Teams. This resulted in erratic and in some instances nonexistent support. Transport constraints affected supervision by health providers. Bisika

(2008) alluded to the fact that supervision and the provision of adequate supplies for TBAs was paramount for the success of the program.

However, following the decision to integrate TBA training into MNH interventions as per the WHO directive (WHO, 1985) the proportion of TBA deliveries increased from 18% in 1992 (Bisika, 2008) to 22.7% in 2000 (DHS, 2000) and was 26% in 2004 (DHS, 2004). At the time a high number of mothers attended ANC but only a few went back to deliver (Bisika, 2008). Although TBA deliveries steadily increased after the integration of TBA training in the 1986- 1999 National Health Plan, maternal deaths kept on rising (Figure 2.1) until 2000 when the rate reached its peak of 1120/100000. Some possible contributing factors could have been related to personal characteristics of the TBA. For example due to their advanced age and high illiteracy levels, TBAs were not capable of adopting the scientific ways of managing pregnant mothers. The ministry's rapid assessment concluded that TBAs failed to adopt the required safe practices (MoH, 2007a). It should be noted that the assessment did not produce any evidence of their unsafe practice and its resultant implications. Moreover, UNFPA's evaluation of several countries, including Malawi observed that the training of trainers was of short duration and poorly structured to adequately prepare them to teach the illiterate elderly learners (UNFPA, 1996). It was further noted that TBAs mostly worked in areas where emergency care and back up services were not well developed and referral systems were nonfunctional which compounded the problem (UNFPA, 1996).

2.6.5.6 **The changing role of TBAs in Malawi**

The government of Malawi was concerned that the TBAs' contribution towards the reduction of maternal and neonatal mortality rates was not significant and as a result the 2004-2010 Joint Program of Work policy, excluded TBA services. The Reproductive Health Unit developed guidelines for Community Initiatives for Reproductive Health (MoH, 2007b) in which TBA roles were redefined. This decision however was made as a result of an assessment of the future roles of TBAs in which participants recommended the need to empower TBAs and allow them to continue assisting mothers in labor while providing them with the required support (MoH, 2007b). One could therefore argue that the assessment was made not necessarily to inform the policy makers on what to do with the TBAs but as a means to ratify a decision already made. The TBAs' new role includes advocating for skilled attendants at birth, counseling and referring mothers to health facilities for antenatal, labor and postnatal care and assisting pregnant mothers in developing a birth preparedness plan. The guidelines exclude TBAs from conducting planned deliveries. In the case of a mother arriving at a TBA when referral is not possible and the TBA ends up assisting with the delivery, the TBA is required to accompany both the mother and the newborn baby to the nearest health facility immediately after birth. Chiefs were sensitized in various fora to be at the forefront in redirecting pregnant mothers to the skilled birth attendant at the health facility. Bylaws were introduced penalizing TBAs and mothers who did not comply (Kumar, 2007). In spite of all this, Malawi has not managed to achieve the 85% target of skilled birth

attendant which was the target for 2010 (DHS, 2010) three years after TBAs were banned.

2.7 CONCLUSION

Efforts to reduce maternal and neonatal mortality rates have attracted the attention of global and national commitments. One such commitment is increasing skilled birth attendance. For Malawi, additional efforts have included involvement of traditional leaders; putting in place bylaws and re-launching the Safe Motherhood Initiative with total commitment from the Head of State. Plans for constructing waiting homes for pregnant mothers are underway. However, continued TBA services in Malawi pose a challenge to the successful achievement of MDGs 4 and 5. On the other hand, it offers the opportunity for the Ministry of Health to avoid quick fixes by instituting sustainable systems. The next chapter will discuss the conceptual framework which was used to guide the study.

CHAPTER THREE

MATERNAL AND NEONATAL HEALTH FRAMEWORK

3.1 INTRODUCTION

This chapter describes the maternal and neonatal health framework that guided the identification of the study design, sampling approach and choice of appropriate data collection tools. The chapter will describe the value of a framework in a study. This will be followed by a description of the framework developed for this study.

3.2 MATERNAL AND NEONATAL HEALTH FRAMEWORK

Stanhope and Lancaster (2004) state that a framework provides a basis for priority setting and systematic program evaluation that affords identification of discrepancies, inadequacies and inefficient areas of the program. It is also described as a structure of concepts put together as a blue print for the study with the aim of identifying ideas which are synthesized to organize thinking processes and bring about the direction of the study (LoBiondo-Wood & Haber 2002).

The Malawi government developed concepts around the MNH care delivery system that forms the MNH framework adapted in this study (refer Figure 3.1).

3.2.1 The MNH Framework

The MNH framework links the central, zone, district and community levels. The framework was designed to facilitate delivery of MNH care services through decentralized structures.

3.2.1.1 Ministry of health headquarters

The central level of the Ministry of Health is responsible for the interpretation of global instruments such as MDGs and WHO resolutions among others. Apart from global instruments, it also interprets national policies such as the Malawi Growth and Development Strategy (MGDS, 2011) into health sector specific strategies. In addition, the MoH in liaison with relevant government ministries and development partners is responsible for policy formulation, developing standards and guidelines, and mobilizing resources for the delivery of the Essential Health Care Package (EHP) which includes MNH.

3.2.1.2 The central hospital and the health zone level

These two structures form a second level in the ministerial hierarchy with distinct roles. They are responsible for interpreting health sector strategies and policies related to implementation of the health care package. Central hospitals are major referral centers for specialized care. Mothers and newborns in need of specialist care are referred to such centers. There are a total of four central hospitals in Malawi.

On the other hand, the Zone is responsible for overseeing the activities of the District Health services under a decentralized structure. The Zone is therefore responsible for facilitating the interpretation of health sector strategies and policies as well as setting up systems for the implementation of the EHP services that include MNH care. It also links the districts with the MoH central level and the central hospitals. The country has five Zones and one of them is the Central West Zone which was the study site.

3.2.1.3 District health services

The district health services fall into two categories. First, there are District hospitals which provide secondary level care and they act as referral centers for primary health care level facilities. This is where mothers and newborns are referred to receive Comprehensive Emergency Obstetric and Neonatal Care (CEmONC). In the CWZ, there are a total of four districts and these were all included in the study. Three districts (Ntcheu, Dedza and Mchinji) each have a district hospital. All the four districts have health centers and maternity units which provide MNH care services. Lilongwe district does not have a fully-fledged district hospital. It has a maternity hospital operating at a secondary level. In addition, it has two community hospitals which also provide MNH and CEmONC services.

3.2.1.4 **Health centers and maternity units**

Health centers and maternity units form the primary health care level. These are the communities' first point of contact with the formal health care system. At these facilities, the majority of the MNH providers are enrolled nurse- midwives who are categorized as second level of nursing and midwifery workers. Not all of the facilities in the zone provide MNH. As of March 2010, 112 (79%) of the 141 health facilities provided MNH services in Central West Zone. At the time of the study, a total of 24 health centers offered Basic Emergency Obstetric Care (BEmONC) services in the rural areas. All of the BEmONC facilities participated in the study.

3.2.1.5 **Communities**

These are households or families made up of individuals residing in the same geographical area forming a village or a cluster of several villages. A community is almost homogeneous having people who share some common interests, values and needs. This is the same level where TBAs also live and used to work.

3.2.1.6 **Traditional birth attendants**

Traditional Birth Attendants in Malawi are generally women who used to assist mothers during pregnancy, labor and delivery. They used to perform 1-25 deliveries per month at a small fee deemed affordable by the majority of the mothers in the served communities. TBAs were incorporated into the health care system in order to bring MNH care closer to where mothers live and as one

of the strategies to reduce the maternal and neonatal mortality rates (UNFPA, 1996). TBAs therefore commanded a certain amount of respect and status in the communities in which they were working.

3.2.1.6.1 **TBA training**

The content of the TBA training curriculum included antenatal, intranatal and postnatal care services. They were taught care of the newborn and recognition of danger signs. The period of training was four weeks. This included both the theory and observation periods. No hands on practicum were included but TBAs were taken to health facilities' labor wards where they were required to observe how deliveries were conducted in a safe manner. Trainers were recruited mainly from a pool of enrolled nurse-midwives. At the passing of the moratorium on TBAs, about 40% of them had received training (Bisika, 2008).

3.2.1.6.2 **Roles of traditional birth attendants**

The training prepared the TBAs to care for the pregnant woman during antenatal, intranatal (including assisting the mother with a normal delivery) and postpartum periods (MoH, 1982). Their roles also included referring mothers with complications or those with a poor obstetric history for health facility management. TBAs were given their scope of practice that confined them to preparing mothers for birth; conducting normal deliveries; identifying danger signs in the mother and baby and referral. In liaison with the communities, TBAs were expected to facilitate (mobilize transport) referral of a mother requiring health facility management (MoH, 1982).

3.2.1.6.3 **TBA support**

Support to TBAs was in the form of kits, training, refresher courses, supportive visits and transport for referral. The nearest health facility was to provide supportive supervision. Agreements were made with TBAs to call for transport from their nearest facility if they had a mother who needed referral. The TBA coordinator was designated at the district to mobilize support from partners in the districts. The national level on the other hand was responsible for advocating for the program among development partners. It also had the responsibility of developing policies and guidelines for TBA practice. Through such advocacy, UNFPA provided bicycles to TBA supervisors to relieve transport constraints for the program (UNFPA, 1998). The government considered increasing the number of nurse-midwives in health centers in order to ensure adequate support of TBA services at that level.

3.2.1.7 **Efficiency of community MNH care system**

In this study efficiency means that results are obtained after the minimum use of resources such as money, raw materials and time. TBA services were meant to reduce the financial burden on mothers through meeting transport related costs to facilities as well as for daily living expenditures while waiting at the facilities. It was also envisaged that mothers would not have to leave home for many days to access a health facility since care from the TBAs was within easy reach.

3.2.1.8 **Effectiveness of community MNH care system**

In this study, effectiveness means the capability to produce the intended result. The structure of the MNH care system was designed with the purpose of facilitating attainment of the reduction of maternal and neonatal mortality. By bringing MNH care close to where mothers live through the use of TBAs it was intended that mothers would have an attendant at the time of birth, closer to home (Bisika, 2008) and have a safe delivery.

3.2.2 **Application of the MNH framework to the study**

The framework facilitated in identifying key stakeholders to be involved in the exploration of the perceptions around the role of the TBA. From the central level, policy makers as health professionals were identified who included NMCM because of their regulatory function in MNH. Other critical key stakeholders to provide pertinent information were the providers, trainers, TBAs themselves and mothers. Since the study aimed at understanding perceptions and the extent to which change was perceived, a mixed method was deemed the most appropriate. Triangulation was used during the design of the study methods, instrument development, data collection and analysis in order to confirm findings. The findings were integrated to provide rich explanations to stakeholders perceptions.

3.3 **CONCLUSION**

The MNH framework was used to guide the study decisions. The framework has shown the inseparable link from community to the central level. The framework ably guided the selection of the method, tools and data analysis. By borrowing from the

MNH concepts at health center and community levels in the framework, the researcher was able to use the framework in order to identify stakeholders to be involved in the study. The study purpose was to learn about stakeholders' perceptions of the changing role of TBAs in order to obtain a greater breadth of understanding of the reasons why home births persist in the rural areas of Central West Zone, Malawi. The next chapter will present the methodology of the study used to explore the key stakeholders' perceptions of the TBAs changing role.

CHAPTER FOUR

RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

This chapter describes the research methodology used to explore stakeholders' perceptions of the changing role of TBAs in the rural areas of Central West Zone, Malawi. Research designs are plans and procedures which spread from broad philosophical assumptions to data collection and analysis (Creswell, 2009). The aim is to establish a detailed protocol to be followed in addressing a research question. It presents the target population, data collection and analysis methods used in the study. It also includes ethical considerations and strategies used in order to achieve trustworthiness of the study. Data were collected in five phases.

4.2 RESEARCH DESIGN

4.2.1 Mixed Methods Research Design

Doyle *et al* (2009) asserted that research should not be restricted by the blind use of traditional, conservative approaches; rather it needs to be guided by a critical base of enquiry underlying the study. Creswell (2009) and De Vos, Strydom, Fouche *et al* (2009) define mixed method as an approach to research which combines both quantitative and qualitative designs. This approach allows the flexibility of borrowing from either perspective in quest of a broader understanding of the problem under study (Johnson & Onwuegbuzie 2004). This approach allowed the researcher to obtain a deeper understanding of the TBAs changing role as she was at liberty to use either

methodology in pursuance of the drivers for mothers continued home births. This was done through integrating both the emic and etic views, inductive and deductive reasoning in the analysis of the research problem and allowed for corroboration, convergence and confirmation of findings from both approaches in order to make superior inferences for the results (Johnson, Anthony, Onwuegbuzie *et al*, 2007; and Doyle *et al*, 2009). Thus, the researcher was able to infer from findings from both approaches and brought afore a deeper understanding of the reasons for continued home births. The approach provided for robust opportunities to make recommendations for effective change (Tashakkori & Teddlie, 2010). The mixed method approach allowed the researcher to explore the problem from, a number of angles, such as the perceptions of different stakeholders, the availability of MNH services and policy makers.

Exploratory and descriptive methods were used to gather new data to be able to determine emerging patterns (Mouton, 2003) and describe stakeholders' perceptions of the changing role of the TBAs. A survey was employed to obtain attributes of a larger population on the issue under study (Creswell, 2009) and explore the contexts of interest as they currently exist (Polit & Hungler, 2004). This assisted in making some inferences from the study sample to a larger population. Qualitative methods facilitated a holistic analysis of the study problem bringing ashore a panoramic view of the stakeholders perceptions (Creswell, 2009). It was therefore possible to make meta-inferences which enhanced the understanding of why mothers in rural areas continue to deliver without assistance from a skilled provider.

4.2.2 Concurrent Triangulation Method

Both quantitative and qualitative data were collected simultaneously and the databases were then compared for convergence and divergence in the discussion phase of the study. Weighting in this study was equal in which a discussion of the quantitative results was followed by confirming or disconfirming discussion of the qualitative findings with some verbatim substantiating the argument (Creswell, 2009). In this study, triangulation was achieved in two ways. Firstly, the study used between method triangulation through use of both quantitative and qualitative designs. Secondly, triangulation was done within the method; in the quantitative design, triangulation was done using two different sources to collect data. In the qualitative phases of the study, data from TBAs' focus group discussions, in-depth interviews with TBA trainers and the health professionals were triangulated (Denzin, 1978; and Halcomb & Andrew, 2005). Data were also considered simultaneously triangulated by concurrent use of both approaches in collecting data.

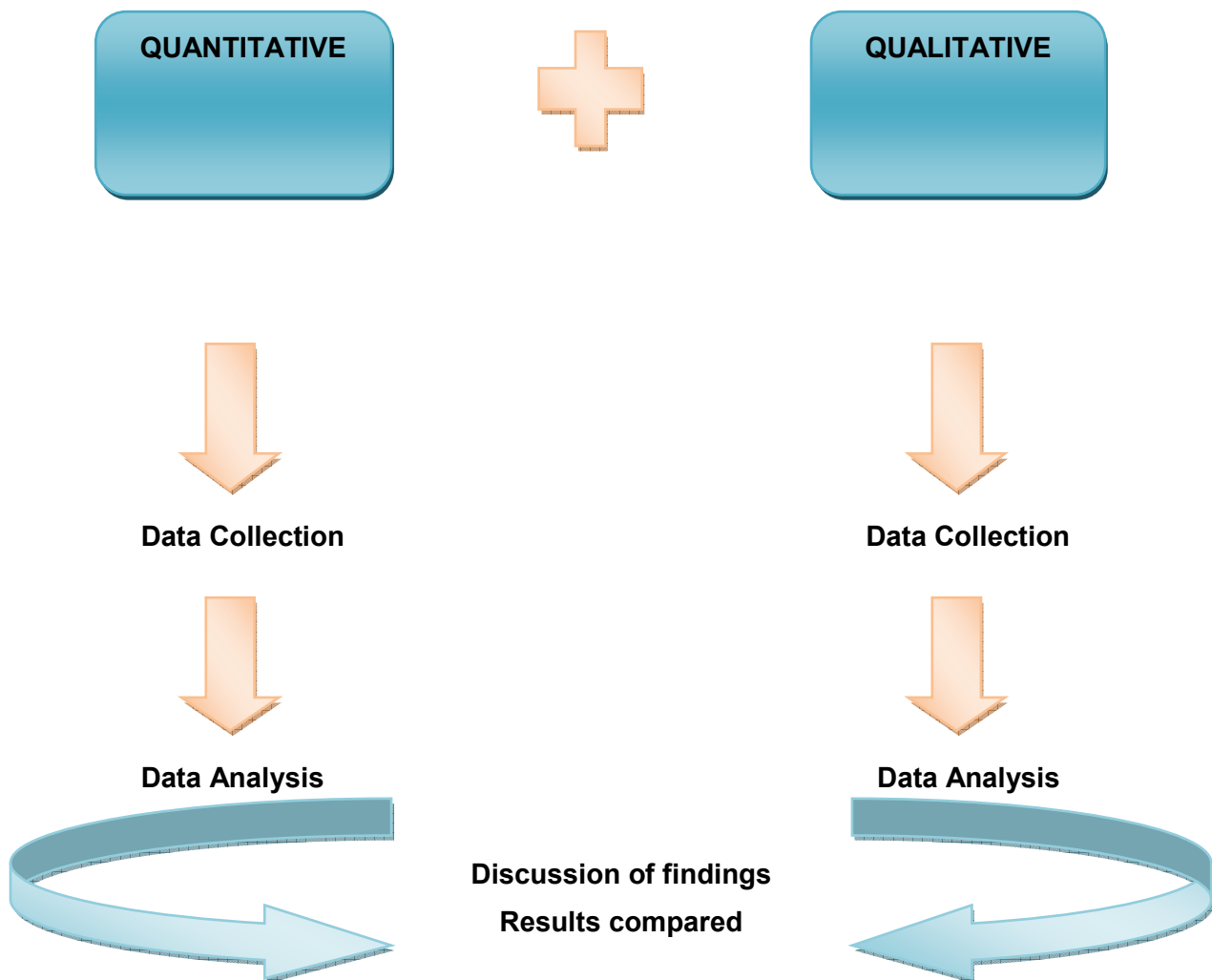


Figure 4.1: Mixed Method Concurrent Triangulation Design

(Adapted from Creswell et al, 2003)

Figure 4.1 shows how the mixed method approach was implemented where both quantitative and qualitative data were collected concurrently with equal weighting. Data were analyzed separately and the findings converged or diverged in the discussion phase (Creswell, 2009).

4.3 DATA COLLECTION PROCESS

In this mixed method approach data were collected in five phases. Quantitative procedures were used in phases one and two of the study. In phase one the researcher used a quantitative approach because some mothers were day visitors who had come for either antenatal or postnatal care and needed to return home the same day. It was considered unethical to keep them waiting until there were sufficient numbers for a focus group discussion and therefore, mothers were interviewed as they came for the services. The target population in this phase were mothers accessing MNH care in the selected 24 BEmONC facilities. The second phase of the study involved nurse-midwives who provided MNH care services in these facilities. Quantitative procedures were used in this phase because distances between the facilities prohibited getting the participants together for a focus group discussion. Face to face interviews contributed towards a high response rate.

Qualitative procedures were used in phases three to five of the study. Phase three involved TBAs who came from the catchment areas of the 24 health facilities. In this phase, four focus group sessions were conducted. This method allowed the participants to interact with each other which provided for an in-depth discussion of the problem under study. Phase four involved nurse-midwives who were TBA trainers from the participating districts and phase five involved health professionals responsible for development of MNH policies and guidelines who were either working at the Ministry of Health headquarters or the Nurses and Midwives Council of Malawi. In phases four and five use was made of in-depth interviews. This method was chosen because participants were recruited from different areas in the Zone where their numbers were limited. Further, the researcher sought to obtain a greater breadth of understanding of

the participants' perceptions of the TBAs changing role and the reasons why mothers continue to seek TBA services.

Prior to interviews each participant was required to provide consent either by thumbprint or in writing in order to demonstrate that they had voluntarily accepted to participate in the study. Participants were given an opportunity to ask questions or give any comment regarding the topic under discussion at the end of the interviews.

4.3.1 Sampling of Health Facilities

Of the 141 health facilities in the Zone, 112 provide MNH care services. A total of 91 health facilities provided MNH care services in the rural areas of the four districts in the Zone. The researcher was interested in the facilities operating in the rural areas because this is where access to MNH care services is poorest and staffing levels are very low. A non- probability purposive sampling method (Rossouw, 2003) was used in order to select the rural health facilities (24 in total) that provide Basic Emergency Obstetric Care in the rural areas of the Zone. This method was used because the researcher was interested in involving all of the BEmONC health facilities since these were considered rich in information regarding the TBAs changing role (Patton, 2002) and skilled birth attendance' emphasis. Data were collected in November and December 2011.

4.3.2 Phase One

In this phase an exploratory descriptive survey design (De Vos *et al*, 2009) was used to collect data from pregnant and postnatal mothers who had accessed MNH services

at the 24 selected facilities. It aimed at describing and exploring mothers' perceptions of the TBAs changing role and the MNH care system in CWZ, Malawi. The following three specific objectives were achieved using mother respondents:

- Explore mothers' perceptions of the changing role of TBAs.
- Describe mothers' perceptions of the MNH care system in CWZ, Malawi.
- Explore mothers' perceptions of the reasons why mothers in rural areas of CWZ are still delivering outside health facilities

4.3.2.1 **Data collection instrument**

Data were collected using a structured interview schedule. Denscombe, (2008) has defined an interview schedule as an instrument with a series of written questions designed to gather information directly from people. In this study, the main purpose of the interview schedule was to explore and describe mothers' perceptions of the TBAs changing role and the MNH care system (Annexure A). This was done in order to gain further understanding of the drivers for mothers continued preference for home births.

The development of the interview schedule was guided by using descriptions from Gillham (2007) and Rossouw (2003). Both authors recommend that the process starts with definition of the research problem, question and objectives. In addition, with reference to the main documents referred to in the study, items were formulated one at a time giving equal legitimacy to all questions and options. Item questions were formulated and matched with study objectives and the MNH framework. The questions were then coded and categorized. Finally,

the questions and topics were ordered for systematic and logical flow avoiding redundancy. The schedule was subdivided into three sections: mothers' demographic data with seven items, mothers' perceptions of the TBAs changing role with ten items and mothers' perceptions of the MNH care system with five items. The interview schedule was translated and administered in Chichewa by the researcher.

4.3.2.2 Phase one pilot study

A smaller version of the study was conducted in order to refine the tool (Burns & Grove, 2005) using similar subjects in the same setting (from eight of the selected 24 health facilities). The instrument was used to conduct interviews with 16 mothers who had come to access MNH care. A probability simple random sampling method (Rossouw, 2003) was used in order to select two mothers from eight facilities. The random sampling used was as follows: two identical sets of numbers were written on a small piece of paper. One set was issued to every eligible mother. The remaining set was put in an urn and mixed thoroughly. One mother was asked to pick one piece of paper from the urn without looking in the urn. The chosen number represented the mother with an identical number in hand. The piece of paper was then replaced in the urn for another draw in order to select the second mother.

4.3.2.2.1 **Results of the pilot study**

Minor changes were required in all three sections of the interview schedule.

Question 1, 3-4, 7, 11-12, 17 and 19 were modified by removing or adding some options for answers. Question 2 was deleted because it became irrelevant after modifications in the other questions. Questions 5-6 under demographics and 15 were added.

4.3.2.3 **Sampling of mother participants**

A probability simple random sampling method, as described by Rossouw (2003), was used at each health facility to select mothers to participate in the study. In consultation with a statistician, six mothers per facility were selected to participate in the study making a total of 144 mothers. These mothers were sampled from the 24 identified facilities. The same procedure used during the pilot study was used in this phase.

Inclusion criteria

The sample was selected using the following inclusion criteria:

- Multigravidae/multiparas mothers.
- Had delivered at a TBA before.
- Had come to one of the selected health facilities to access MNH care services such as antenatal care, labor and delivery, first week postnatal care or were waiting for the onset of labor at the health facility.
- Were willing to participate in the study.

Exclusion criteria

The following criteria were used to exclude potential participants:

- Were not multigravidas.
- Had not previously accessed TBA services for delivery.
- Did not come to the health facility for MNH care.

4.3.2.4 Data collection methods

Face to face interviews as described by Mouton (2003) and Rossouw (2003) were conducted to achieve a high response rate. Participants were invited into a designated private room within the facility for interviews. The interviews were conducted in Chichewa which is the common vernacular language in Malawi. Participants were required to sign or provide a thumbprint after an explanation of the activity was made in order to show that they understood the purpose of the interview and that they were willing to participate in the study.

4.3.3 Phase Two

An exploratory descriptive survey design targeted nurse-midwives who provided MNH care in the selected 24 facilities. The aim was to obtain nurse-midwives perceptions of the MNH care system and the TBAs changing role in CWZ, Malawi. The following objectives as in phase one were achieved using nurse-midwives respondents:

- Explore nurse-midwives' perceptions of the changing role of TBAs.
- Describe nurse-midwives' perceptions of the MNH care system in CWZ, Malawi.

- Explore nurse-midwives perceptions of the reasons why mothers in rural areas of CWZ are still delivering outside health facilities.

4.3.3.1 **Data collection instrument**

Data were collected using a structured interview schedule (Annexure B). The process followed for the development of the schedule was the same as described in 4.3.2.1 above. The interview schedule was divided into three sections: characteristics of nurse-midwives with three items, perceptions of the MNH care system with four items and nurse-midwives perceptions of the TBAs changing role with 13 items.

4.3.3.2 **Data collection process**

The researcher is a supervisor in the study context. Her responsibilities include conducting supportive visits to the facilities under study. Therefore, to avoid bias a field assistant was employed to collect data from nurse- midwives who provided MNH care services in the selected study sites. The field assistant was a professional nurse-midwife with a master's degree in nursing and a lecturer at one of the nursing colleges in Lilongwe, an institution under the Ministry of Education. The field assistant was only involved in phase two of the study. She collected data from the nurse-midwives who were working in the selected BEmONC facilities in the zone.

4.3.3.2.1 Orientation of the field assistant

As described by Melone (2010) the researcher conducted a one-day orientation for the field assistant, during which time the assistant was oriented to the interview schedule. A role-play was conducted in which the researcher played the role of the nurse-midwife and the assistant played her role of collecting data to ensure efficiency and accuracy of the process. Any areas which needed strengthening and clarification were made accordingly. The assistant was instructed to find a private and quiet room within the health facility where the interviews could be conducted. She was required to obtain written consent from each participant who participated in the study before administering the interview schedule. The assistant was instructed to explain the purpose of the study, reminding the potential participant of her/his rights regarding voluntary participation in the study and informing the participant of the need to sign the consent form to show that she/he was willing to participate. In addition, the assistant was instructed to ask all respondents the same questions in the same order and manner. She was instructed to ensure proper storage of completed interview schedules using a lockable box and the maintenance of confidentiality. Emphasis on detail, organization and order was made to ensure collection of useful data. The same assistant was used in collecting data during both the pilot study and the main study.

4.3.3.3 Phase two pilot study

In this phase, eight nurse-midwives were purposefully sampled (Rossouw, 2003) from the selected 24 BEmONC sites which had more than two nurse-

midwives. This was done in order to ensure that at least two nurse-midwives remained for the main study. Convenience sampling was used. These nurse-midwives were excluded in the main study.

4.3.3.3.1 Results of the pilot study

Minor changes were required in all three sections of the interview schedule.

Questions 3, 5-6, 10, 17 and 20 were modified by adding or removing some of the options. Question 4 was deleted because question 3 was modified and included information relating to question 4.

4.3.3.4 Sampling of nurse-midwife participants

Fifty-five nurse midwives were sampled. Purposive sampling was used to recruit nurse-midwives (Rossouw, 2003) from the selected facilities. A purposive sampling method was chosen in order to obtain information from nurse-midwives who had current knowledge and information of the MNH services. A minimum of two nurse-midwives from each BEmONC site were sampled. All nurse-midwives who were available and willing to participate who had not participated in the pilot study were given the opportunity to participate.

Inclusion criteria

The study participants were selected using the following inclusion criteria:

- Nurse-midwives
- Provided MNH care services at the time of the study.
- Worked in the selected facilities.

- Were willing to participate in the study.

Exclusion criteria

The following criteria were used to eliminate potential participants:

- Nurse-midwives not working in the study facilities.
- Nurse-midwives who did not provide MNH care at the time of the study.
- Nurse-midwives who participated in the pilot study

4.3.3.5 Data collection methods

In order to obtain a high response rate, face to face interviews as described by Babbie and Mouton (2003) were conducted in order to describe and explore nurse-midwives' perceptions of the MNH care services and the TBAs changing role in CWZ, Malawi. A field assistant who was a professional nurse- midwife undertook data collection. Data were collected in a quiet and private room of the facility which was selected for the purpose. All participants were interviewed and responded in English. During this phase, facility data using a tool developed for the purpose (Annexure C) was collected in order to complement the findings from the respondents.

4.3.4 Phase Three

An exploratory, descriptive qualitative study design was used to explore TBAs experiences and perceptions of their role in MNH care. The following objective was achieved in this phase:

8. Explore TBAs' perceptions of their MNH care roles.

4.3.4.1 **Development of an interview guide**

The researcher developed an unstructured interview guide (Denzin & Lincoln, 2000) which facilitated the collection of data from participants using focus group discussions. The study question, purpose and the objectives influenced the construction of the question items. The tool was designed in such a way as to obtain a greater breadth of data from participants' diverse experiences. The researcher's prolonged engagement in the field of study provided the basis for the development of the question items for the focus group interview guide. Question items on the interview guide included respondents' experiences when they were caring for pregnant mothers and the quality of training they received. Ethical issues were also considered integral in this research endeavour. A private room (usually the hospital's conference room) was used for the focus group discussions. Participants were required to sign or provide a thumbprint after an explanation of the purpose of the discussion in order to show that they had understood and were willing to participate in the study. The researcher was able to gain entrance into the respondents' worlds and brought afore their perceptions of the changing role.

The interview guide allowed flexibility and probing in order to obtain a deeper understanding of the question under study (Patton, 2002). Cues were given to encourage respondents to provide the desired level of response. Probing areas included the amount of support in relation to equipment, drugs and supplies TBAs received; the possibility of every pregnant mother being delivered by a skilled birth attendant; and whether government involved the relevant

stakeholders during the decision making process of the moratorium on TBAs (see Annexure D). The interviews were conducted in Chichewa language. Data were transcribed verbatim for the purpose of analysis.

4.3.4.2 Recruitment of TBA participants for focus group discussions

Use was made of the health surveillance assistants (HSAs; these are the equivalent of community health workers) in the recruitment of potential participants in the FGDs. HSAs were requested to ask TBAs to come to the district health office on a given date. The HSAs were informed of the purpose of the meeting which was narrated to the TBAs at home. The researcher made phone calls to the HSAs to find out whether the information had reached the targeted population. To ensure privacy, discussions were conducted in the district health officers' conference rooms with prior arrangements. Participants were required to sign a consent form after the purpose of the interview had been explained. Signed consent demonstrated that they understood and were willing to participate in the study. The seating arrangement was around a table to allow all participants to be able to see one another. A total of seven TBAs per district (28 in total) were invited and a total of 26 TBAs participated (with a range of six-seven TBAs per discussion session).

4.3.4.3 Sampling of TBA participants

A purposive sampling method (Rossouw, 2003) was used in order to obtain participants for the FGDs. TBAs were selected purposefully because they were unique cases capable of providing the required information for the study

(Rossouw, 2003). Data saturation which determined the sample size was achieved after four FGDs, one in each of the four districts in the Zone (De Vos *et al*, 2009).

Inclusion criteria

The following criteria guided the sampling of the target population:

- Traditional birth attendants.
- Used to provide labor and delivery services until 2005 when the government stopped training TBAs.
- Both trained and untrained TBAs were invited.
- Could still be conducting deliveries or had complied with the moratorium.
- Came from the catchment area of the selected 24 health facilities.
- Willing to participate in the study.

Exclusion criteria

The following criteria were used to exclude potential participants:

- TBAs who started delivering mothers after 2005.
- Did not come from the catchment areas of the selected 24 facilities.

4.3.4.4 Data collection method

Due to a high rate of illiteracy and in quest of a high response rate, focus group discussions as described by Mouton (2003) and Denzin and Lincoln (2000) were conducted by the researcher in order to explore TBAs perceptions of their changing role. Participants' beliefs, feelings and behaviors were explored in

order to understand the problem under study (Polit & Beck, 2004). The discussions were audio- taped with permission from the participants. Field notes were also taken in the course of the discussion.

Data were transcribed verbatim soon after the discussions. This assisted in the determination of the type of probing questions to be made in the next focus group discussion (Polit & Beck, 2004). A total of four focus group discussion sessions were conducted with the TBAs. The moderator, who was the researcher herself, was sensitive to language and concepts that were used and allowed flexibility in the discussion process. Where necessary, probing was used to obtain a deeper understanding of the reasons for mothers continued home birth. The audiotaped discussions were transcribed verbatim into English for the purpose of analysis.

4.3.5 Phase Four

An exploratory, descriptive qualitative study design was used to explore TBA trainers' perceptions of the effectiveness of TBA training and services. The following objective was achieved in this phase:

9. Describe TBA trainers' perceptions of the effectiveness of TBA training, services and the TBAs changing role.

4.3.5.1 Development of the interview guide

The same process for the development of the data collection tool was followed as in phase three of the study. Question items included participants' perceptions

of TBAs training and whether it prepared the TBAs adequately for their role of caring for pregnant mothers during pregnancy, labor and after the birth of the child (Annexure E). Further probing included participants' perceptions of why some TBAs were still conducting deliveries despite the moratorium.

4.3.5.2 **Recruitment of TBA trainer participants**

A purposive sampling method (Rossouw, 2003) was employed to sample TBA trainers from the target population. The study targeted nurse-midwives who used to train TBAs. The researcher sought the help of TBA coordinators at the district health office who provided the researcher with contact details of TBA trainers available in the district. The researcher made individual calls to the trainers and asked them if they would participate in the study. Arrangements were made to meet on an agreed date with those who were willing to participate in the study. A follow up call was made to the potential participants on the day of the meeting or the day before to confirm the meeting. Ethical issues were also considered integral in this research endeavour. Interviews were conducted privately at a venue of the participant's choice where privacy could be ensured. Participants were required to sign a consent form after the purpose of the interview had been given. Signed consent demonstrated that they understood and were willing to participate in the study. Data saturation guided the sample size (De Vos *et al*, 2009) and a total of ten TBA trainers were interviewed. Interviews were conducted in English and data were transcribed verbatim for the purposes of analysis.

Inclusion criteria

The sample included TBA trainers who met the following inclusion criteria:

- Both trained and untrained TBA trainers.
- Had participated in the training or refresher course for TBAs.
- Came from the four districts in the Zone.
- Willing to participate in the study.

Exclusion criteria

The following criteria guided the exclusion of potential participants:

- Nurse-midwives who had never trained or provided refresher courses to TBAs.

4.3.5.3 Data collection methods

The researcher conducted in-depth single interviews (Mouton, 2003). The interviews were audio taped with permission from the participants and field notes were taken to complement the data. Data were collected privately at a venue chosen by the participants.

4.3.6 Phase Five

An exploratory, descriptive study design was used. Phase five targeted Ministry level and Nurses and Midwives Council of Malawi (NMCM) health professionals to explore their perceptions of the TBAs changing role. The following objective was achieved:

- Explore Ministry level and Nurses and Midwives Council health professionals' perceptions of the TBAs' changing role

4.3.6.1 **Development of an interview guide**

The same process as described in phase three was followed to develop the tool for collecting data in this phase (Denzin & Lincoln, 2000). An unstructured interview guide was used to explore health professionals' perceptions about the TBAs' changing role. Probing questions were similar to those in phases three and four but it included an item on whether they were aware of incentives and compensation (to replace TBAs' loss of income) to reinforce the moratorium on TBA services (See Annexure F). In-depth single interviews (Babbie & Mouton, 2003) were conducted.

4.3.6.2 **Recruitment of health professional participants**

A purposive sampling method was used. The study targeted health professionals in the Reproductive Health Unit, a department responsible for the development of MNH policies and guidelines and the Directorate of Nursing and Midwifery services in the ministry. The SWAp secretariat responsible for the development of the Ministry of Health's strategic plans and the Director of the Nurses and Midwives Council of Malawi were also invited to participate in the study. The researcher made personal calls to health professionals in these offices to book an appointment on an agreed date and venue suitable for the participant. A follow up telephone call was made to each participant on the day of the meeting or a day before to confirm the meeting. Ethical issues were also considered integral in this research endeavour. Interviews took place either in the privacy of participants' offices or places of their convenience. Participants were required to sign a consent form after explanation of the purpose of the

interviews, to demonstrate that they understood and were willing to participate in the study. Saturation of data was achieved after interviewing 12 health professionals (De Vos *et al*, 2009).

Inclusion criteria

The following inclusion criteria guided the selection of the study sample:

- Health professional staff who either worked in the Ministry of Health headquarters or the Nurses and Midwives Council of Malawi.
- Participated in the development of MNH policies.
- Were willing to participate in the study.

Exclusion criteria

The following criteria were used to exclude potential participants:

- Health professionals who were not involved in developing MNH policies and guidelines.
- Health professionals who were not working in the Ministry of Health or the Nurses and Midwives Council at the time of the study.

4.3.6.3 Data collection method

The researcher conducted in-depth single interviews (Babbie & Mouton, 2003) in order to obtain health professionals' perceptions of the TBAs changing role. With permission from the participants, the interviews were audio tape-recorded and field notes were made. Data were transcribed verbatim for analysis.

4.4 DATA ANALYSIS IN ALL PHASES

Data analysis made use of both inductive and deductive reasoning. Quantitative descriptive analysis (Creswell 2003; Gillham, 2007) was performed on the data collected from interviews with mothers and nurse-midwives. SPSS version 19 was used to enter, clean and manage data (Mouton, 2003). into proportions, bar graphs, pie charts and tables. The analysis was limited to the characteristics of the text – reading according to the lines (Rossouw, 2003). Accuracy of entered data was checked against 12% of copies of the questionnaires. Data were summarized using frequencies and percentages for categorized variables. There were two main outcome measures in this design; participants' perceptions of the TBAs changing role and their perceptions of the MNH system. Secondary outcomes included reasons for TBAs continued delivery, mothers' preference of a provider and the capacity of the MNH system to manage every pregnant mother seeking skilled birth attendance. The proportions and frequencies of participants' perceptions of TBAs changing role and the MNH system were reported. Rigor was reflected in narrowness, conciseness, objectivity and precise statistical analysis (Burns & Grove, 2005).

Qualitative data from in-depth and focus group interviews with TBAs, TBA trainers and health professionals were analyzed using content analysis. Analysis was done manually. According to Polit and Beck (2004) qualitative analysis is a process of matching data, bringing the invisible afore, of connecting and attributing consequences to antecedents. First data were organized during transcription when field notes were merged with tape-recorded information to get a sense of the whole (De Vos *et al*, 2009). During analysis, there was increased awareness of the richness of the data

collected which revealed salient themes and belief patterns of stakeholders and their perceptions of the changing role of TBAs (De Vos *et al*, 2009). Data were evaluated for their usefulness in illuminating the reasons why mothers continue to deliver outside health facilities in the Central West Zone. Data were coded using different colours with the purpose of generating categories according to their theoretical importance. Categories were then reduced into a set of themes presented in the narrative (Creswell, 2009). This assisted in the interpretation of data by attaching a deeper meaning and significance to the analysis. Member checking was done in order to ensure neutrality, reliability and truth-value of the data collected. The process involved contacting some of the participants asking them to confirm responses provided during the interviews. Rigor and trustworthiness of the study were maintained through accurate identification and description of the target population and study context. While generalization of the findings to other contexts is not the responsibility of the researcher, a clear description of study parameters has been provided in order to allow investigators to determine whether the findings can be generalized to other contexts. In this study design, triangulation has been used in order to strengthen the study's applicability to other settings.

Data reduction were done while retaining the meaning as expressed by the interviewee (Gillham, 2007). Rigor was associated with openness, strict compliance to philosophical perspective, completeness in data collection and inclusion of all data on the problem under study (Burns & Grove, 2011). Rigor was also measured by the logic of the emerging statement (Burns & Grove, 2011). The outcome of the data analysis

was a theoretical statement responding to the study question validated by examples of the data (direct quotes from the respondents).

This process enabled ordering code dependencies between the reader of the text and the content and structure of messages. Categories which were meaningful units of analysis were developed with a single classification principle. This separated and described the content under study (Rossouw, 2003). The coder was allowed to deduce latent meaning of messages by reading in-between the lines. The process required reading and rereading of the transcribed text whilst listening to the tapes to validate the accuracy of the information and keep all narrative statements as original as possible and the process ensured that all data were used (Creswell, 2009). Data were also given to a co-coder who read and re-read the data in order to come to a consensus on the identified common themes.

4.5 VALIDITY, RELIABILITY AND TRUSTWORTHINESS OF THE STUDY

As described by Rossouw (2003) the researcher was cautious and alert in ensuring that holistic fallacy did not occur by ensuring the validity, reliability and trustworthiness of the study in the following

4.5.1 Consistency

The researcher ensured that data collected did not contradict each other but that there was harmony by carefully selecting the field assistant and orientating the field assistant. This assistant was used consistently from pilot study to main data collection process. Availability of a time frame for the data collection period, availability of a

budget for the study including the pilot study was set out in order to facilitate consistency. A thick description of the research methods has been provided to enable repetition of the study. Furthermore, the pilot study assisted in establishing respondents' understanding of the questions in the tools.

4.5.2 Applicability

The study did not aim to make generalized conclusions but the researcher has provided inductive arguments from the sample to the target population by looking for saturation of data in which no more new information was coming to the fore. Through use of a representative sample, findings could be generalized to the target population. The study was done during the same season across the four districts in order to avoid variances because of changes that might occur because of a longer time span in data collection.

4.5.3 Truth value and neutrality

Truth-value and neutrality of the research refers to the degree to which methods used to generate data may be trustworthy. The researcher therefore looked for objectivity through peer group interaction in which the researcher gained insights of the phenomena from colleagues who were also pursuing similar studies or had a role in MNH service provision. Further, member checking with study participants and triangulation (use of multiple data collection methods, multiple data sources, multiple data analysis methods, multiple researchers and multiple perspectives). Compliance with ethical standards and competence in data collection promoted truth-value.

Prolonged engagement of the researcher in the field of study also promoted the trustworthiness of the study.

4.5.4 Theoretical validity

In quest of theoretical validity, the researcher provided good theoretical definitions and conducted a thorough analysis of key terms used in the study. By identifying and analyzing the connotations of the core terms the researcher avoided ambiguity, circular, too narrow and too broad a definition.

4.5.5 Inferential validity

In research, inferential validity refers to the flow of arguments in a logical manner translating into an accountable research. The study has culminated in an accountable research through demonstration of the logical link between the problem, empirical arguments, qualified conclusions and inferences from the theoretical base. Objectivity or neutrality of the data, which brings an agreement between two or more independent people about the data's relevance or meaning is necessary (Polit & Hungler, 1999; Sandelowski, 2001). As a result, the research findings were co-coded with assistance from an expert in the field in order to reach a consensus on the identified themes.

4.6 ETHICAL CONSIDERATIONS

Ethical measures (De Vos *et al*, 2009; Creswell, 2009 and Polit & Beck, 2004) were considered through the following:

4.6.1 Consent

Clearance was obtained from the following relevant institutions:

- The University of the Witwatersrand's Human Research Ethics Committee to conduct this study in Central West Zone. Clearance certificate # M11O416 (Annexure G).
- The Faculty of Health Sciences Graduates Committee of the University (Annexure H).
- The National Health Sciences Research Committee of the Ministry of Health in Malawi. Approval NHSRC # 954 (Annexure I)
- The Reproductive Health Unit, Malawi (Annexure J)
- The Nurses and Midwives Council of Malawi, (Annexure K)
- The Christian Health Association of Malawi, (Annexure L)
- The District Commissioners from the four districts of CWZ, Malawi (Annexures M-P)
- The District Health Officers from the four districts in CWZ, Malawi (Annexures Q-T)
- Potential participants and guardians of minors (Annexures U-II)

Participation in this study was voluntary. An explanation of the study purpose and methodology was provided to all stakeholders including potential participants. Informed consent was obtained whether in writing or by thumbprint from participants who were willing to participate in the study. Consent for use of a tape recorder was also obtained in writing or thumbprint from the participants.

4.6.2 Confidentiality and Anonymity

All individual confidential statements were properly secured in locked cupboards to which the researcher only has access. No personal participants' identities were obtained to ensure anonymity and so that no connection could be made between the data collected and the source. Instead, codes were used in case there was need for follow up. Participants were assured that data collected would in no way be used against them and no findings will be associated to individual participants. Although confidentiality cannot be guaranteed with focus group discussions, the researcher maintained the issues of confidentiality by separating data collection tools from the master sheet which contained participants' names and contact details. Tapes will be kept for five years after publication of the study and shall be destroyed thereafter according to policy of the approving ethical committees.

4.6.3 Privacy

Inevitably, all research which involves human beings intrudes in people's privacy. The study ensured privacy during interviews. A conducive environment for interviews was created by identifying comfortable rooms for meeting with the participants. Participants' self worth and dignity was upheld by avoiding asking questions that would embarrass them. They were informed that they were not compelled to share information they were uncomfortable with or did not wish to disclose and that no penalty would befall them for doing so. Interviews were conducted in private rooms away from disturbances and noise in all phases of data collection.

4.7 **CONCLUSION**

A rigorous process was followed to ensure study integrity. A number of tools have been developed that can be used in similar future studies. The phased approach of the study enabled rich collection of data for each target group and this provided comprehensive information in understanding the study problem and question. The following chapter will present the findings of the study from both quantitative and qualitative designs.

CHAPTER FIVE

PRESENTATION OF FINDINGS

5.1 INTRODUCTION

This chapter presents the findings from the five phases of the study on perceptions of key stakeholders of the changing role of TBAs in rural areas of CWZ, Malawi. Phase one focused on mothers accessing MNH in the 24 health facilities providing BEmONC services in the rural areas of CWZ. The second phase targeted nurse-midwives working in the same selected 24 health facilities. TBAs were sampled for the third phase which was followed by the fourth phase that focused on TBA trainers who were nurse- midwives working in the zone. Finally, the fifth phase focused on health professionals (policy makers) working at the Ministry of Health headquarters and Nurses and Midwives Council of Malawi. Both qualitative and quantitative data were collected simultaneously.

5.2. PHASE ONE

In this phase, data from mother respondents were collected through a structured interview schedule consisting of three main sections: mothers' demographic data, mothers' perceptions of the changing role of TBAs and mothers' perceptions of the MNH care system.

5.2.1 Section A: Demographic Data

Mother respondents' demographic data were obtained to provide a general overview of the mothers' characteristics and social status that had a bearing on their access to MNH care services. Data obtained included respondents' age, marital status,

occupation, number of pregnancies. The study categorized mothers' age as those below 18 years in order to capture the adolescent pregnancies, while 18-35 years is considered safe for someone to become pregnant. Mothers over the age of 35 years are at greater risk of delivering a baby with congenital anomalies and they themselves are at greater risk of a complicated labor (MoH, 2010).

The study targeted and categorized mothers who had 2-4 pregnancies because the first delivery must have been assisted by a TBA and four showing that they were falling within the low risk category. While mothers with 5+ pregnancies meant that other than having been assisted by a TBA before they were in high-risk category.

The categories of 1-5 and 6+ for the number of living children were chosen based on the national average fertility rate of 5.7/1000 women. The category of 1-5 would fall within the national average and 6+ would constitute an above average number of children. In this study the target population were mothers who had had more than one pregnancy. It was therefore assumed that mothers may or may not have living children.

WHO has recommended a distance of five kilometers radius between facilities (MoH, 1986). The study therefore sought to determine the proportion of mothers who were residing within the accepted distance from the facility.

Table 5.1: Mothers' socio-demographic data (n=144)

	N (%)
Age (years)	
<18	1 (0.7)
18-35	107 (74.3)
>35	36 (25.0)
Marital Status	
Married	134 (93.1)
Single	3 (2.1)
Divorced	7 (4.9)
Widowed	0 (0.0)
Highest Educational Level	
No formal education	21 (14.6)
Standard 1-4	69 (47.9)
Standard 5-8	47 (32.6)
Form 1-2	6 (4.2)
Form 3-4	1 (0.7)
Occupation	
Employed	1 (0.7)
Unemployed	1 (0.7)
House wife	0 (0.0)
Subsistence Farmer	137 (95.1)
Business woman	5 (3.5)
Piace jobs (laborer)	0 (0.0)
Number of Pregnancies	
2-4	64 (44.4)
5+	80 (55.6)
Number of Living Children	
1-5	121 (84.0)
6+	23 (16.0)
Distance to the Nearest HF (km)	
<5	38 (26.4)
5+	106 (73.6)

Almost three-quarters (73.6%) of the mother respondents were in the age group 18-35 years and 25% were elderly mothers. More than 90% were married. Almost half

(47.9%) had attained education up to standard four while only 4.2% had attained junior secondary education. Ninety-five per cent of the respondents were subsistent farmers. More than half (55.6%) had had more than five pregnancies. Eighty-four per cent had 1-5 living children, while 16% had more than six living children. Almost three-quarters of the mothers (74.1%) lived more than five kilometers from the health facility (Table 5.1).

5.2.2 Section B: Mothers' Perceptions of the Changing Role of TBAs

This section addressed mother respondents' perceptions of whether TBAs continued to conduct deliveries, mothers' involvement in the decision making process on the moratorium on TBAs, mothers' preference for place of delivery and TBAs competency in conducting deliveries.

Table 5.2: TBAs' availability and continued practice (n=144)

Characteristic	N (%)
Availability of TBA in or near home village (n=144)	
Yes	132 (91.7)
No	12 (8.3)
TBAs practice (n=132)	
Yes	55 (41.7)
No	77(58.3)
Reasons TBAs still practicing (n= 55)	
Health facility far	
Yes	29 (52.7)
No	26 (47.3)
Provide better care	
Yes	4 (7.3)
No	51 (92.7)
Change not wanted	
Yes	26 (47.3)
No	29 (52.7)
Cultural influence	
Yes	29 (52.7)
No	26 (47.3)

Table 5.2 shows that almost all the mother respondents (91.7%) indicated that TBAs were available in their villages or near their villages. Forty-seven percent believed that TBAs had not stopped conducting deliveries in their villages. Of the 55 respondents who reported that TBAs were still delivering, 52.7% felt that the most common reasons why TBAs were still delivering were travelling distance to the health facility and culture. Forty- seven percent said people did not want change.

**Table 5.3: Communities' involvement in government's decision-making
(n=144)**

	N (%)
Were involved	5 (3.5)
Not involved	139 (96.5)

Table 5.3 indicates that 96.5% of the mother respondents reported that government did not consult their communities about stopping TBAs from conducting deliveries. If consulted, 48.2% respondents said that they would have supported the government's decision to stop the TBA services. Twenty-two percent said that they would have advised the government to improve the health care system first whilst 21.6% would have preferred that the government empower TBAs and allow them to continue practicing (Table 5.4).

**Table 5.4: Mothers' advice to government on the moratorium on TBAs'
(n=139)**

	N (%)
Do it the way it has done	67(48.2)
Do it slowly	11 (7.9)
Improve the health care system first	31 (22.3)
Empower TBAs to conduct deliveries	30 (21.6)

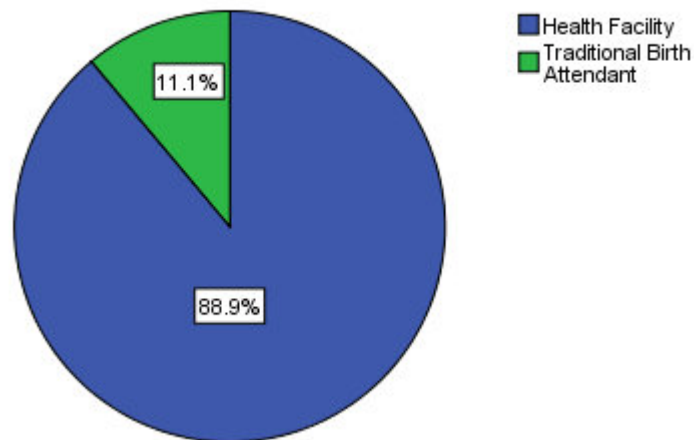


Figure 5.1: Mothers' preference of place of delivery (n=144)

Figure 5.1 illustrates that the majority of the mother respondents (88.9%) would have preferred to deliver at the health facility. There were three main reasons given for this (Table 5.5). The first was that the provider had adequate competence to manage complications (88%); secondly, they would get transport in case of an emergency (61%); and 55% indicated that providers gave better care.

Table 5.5: Mother respondents' reasons for choice of place of delivery (n=144)

	N (%)
Close to where one lived	
Yes	21 (14.6)
No	123 (85.4)
Family/cultural influence	
Yes	14 (9.7)
No	130 (90.3)
Transport available in emergency	
Yes	88 (61.1)
No	56(38.9)
Provider could manage complications	
Yes	127 (88.2)
No	17 (11.8)
Provider gave better care	
Yes	79 (54.8)
No	65 (45.2)

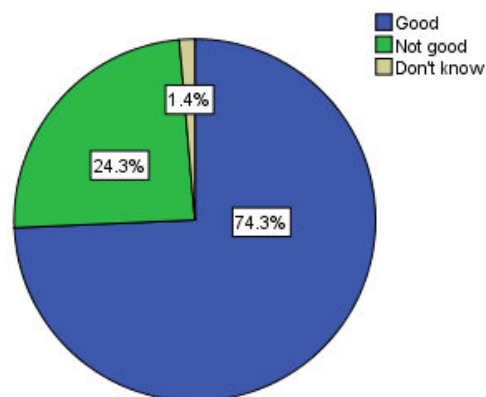


Figure 5.2: Mothers' opinions regarding the moratorium on the TBAs (n=144)

Almost three-quarters (107 = 74.3%) of the mother respondents thought that the ban on TBAs was a good decision (Figure 5.2).

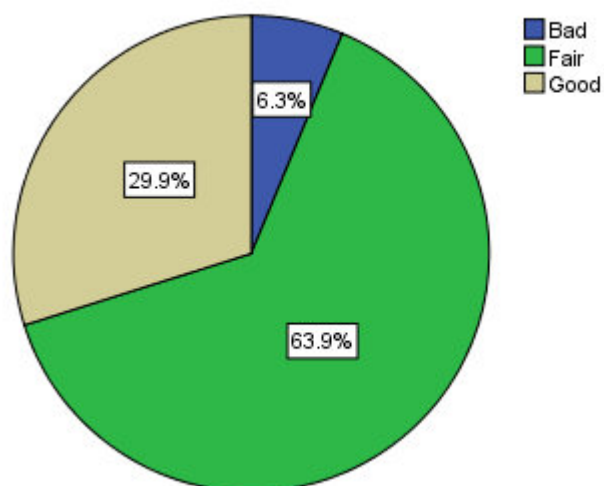


Figure 5.3: Mothers' rating of TBAs' competency (n=144)

The majority (63.9%) of the mother respondents were of the opinion that the TBAs' were fairly competent while only 29.9% perceived their competency to be good (Figure 5.3).

Table 5.6: Mother Respondents' perceptions of TBAs' continued involvement in MNH care services (n=144)

Characteristic	N (%)
Are part of village health Safe Motherhood committee	19 (13.2)
Not active in MNH care anymore	92 (63.8)
Don't know	33 (22.9)

More than half (63.8%) of the mother respondents stated that TBAs were no longer active in MNH care services. However, 22.9% did not know what TBAs were doing after the moratorium (Table 5.6).

5.2.3 Section C: Mother Respondents' Perceptions of the MNH Care System

This section explored mother respondents' perceptions of the health facility's capability to manage all pregnant mothers during labor, adequacy of human and material support for health facility delivery, performance of health facilities and mothers' perceptions of TBAs being replaced by community midwives

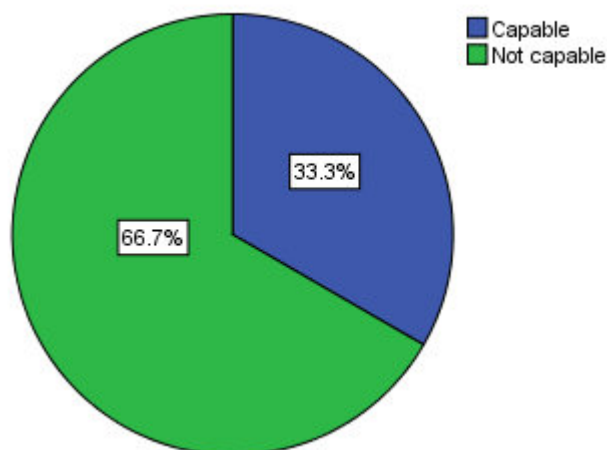


Figure 5.4: Mothers' opinions of the HFs' ability to manage more deliveries (n=144)

Figure 5.4 shows that two-thirds of the mothers (96=66.7%) perceived that health facilities were not capable of managing all the pregnant mothers who accessed skilled birth attendance.

Table 5.7: Availability of resources at the HFs (n= 144)

	N (%)
Adequate drugs and supplies	
Yes	56 (38.9)
No	88 (61.1)
Adequate staff	
Yes	67 (46.5)
No	77 (53.5)
Adequate rooms/space	
Yes	56 (38.9)
No	88 (61.1)

Table 5.7 shows that mother respondents perceived health facilities to be poorly resourced in terms of both human and material resources.

Table 5.8: Mothers' perceptions of HCWs attitudes in providing MNH services (n=144)

Characteristic	N (%)
Bad	0 (0.0)
Fair	67 (46.5)
Good	77(53.5)

Just over half (53.5%) of mother respondents perceived health care worker attitudes to be good, whilst 46.5% felt that health care worker attitudes were fair (Table 5.8).

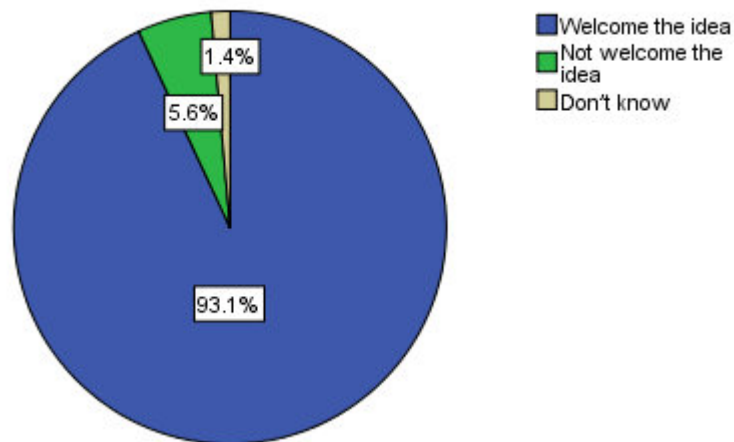


Figure 5.5: Mothers' opinions of TBAs' replacement with CMs (n=144)

Figure 5.5 shows that almost all the mother respondents (134= 93.1%) would support the idea of replacing TBAs with community midwives.

5.3 PHASE TWO

The findings are presented in three sections: characteristics of nurse-midwife respondents, NMs perceptions of the MNH care system and NMs' perceptions of TBAs' changing role.

5.3.1 Section A: Characteristics of Nurse-midwives

This section provides an overview of the characteristics of nurse-midwives who participated in the study. It provides information on the respondents' years of experience and whether they were trained in BEmONC services. Their perceived competency in providing MNH care was also obtained.

Table 5.9: NM respondents' years of work experience (n=55)

Years	N (%)
<1	9 (16.4)
1-2	11 (20.0)
>2	35 (63.6)

Table 5.9 indicates that almost two thirds (63.6%) of the nurse-midwife respondents had more than two years work experience.

Table 5.10: Number of NMs trained in BEmONC (n=55)

Characteristic	N (%)
Trained	31 (56.4)
Not trained	24 (43.6)

Table 5.10 shows that 56.4% of the nurse-midwives were trained in BEmONC.

Table 5.11: NM respondents' perceived competencies in providing MNH services (n=55)

Competent in:	N (%)
Administration of parenteral uterotonics	
Yes	55 (100.0)
No	0 (0.0)
Administration of parenteral antibiotics	
Yes	55 (100.0)
No	0 (0.0)
Administration of anticonvulsants	
Yes	43 (78.2)
No	12 (21.8)
Sometimes	1 (1.8)
Manual removal of placenta	
Yes	17 (30.9)
No	38 (69.1)
Assisted vaginal delivery (vacuum extraction)	
Yes	12 (21.8)
No	43 (78.2)
Resuscitation of new born	
Yes	55 (100.0)
No	0 (0.0)
Manual vacuum aspiration	
Yes	27 (49.1)
No	28 (50.9)

Table 5.11 shows that all the nurse-midwife respondents felt that they were competent in the administration of parenteral uterotonics, parenteral antibiotics, and resuscitation of the newborn. Seventy-eight percent of the nurse-midwife respondents felt that they were capable of administering anticonvulsants, 31% felt that they were able to manage

a manual removal of the placenta while only 21.8% felt competent in conducting vacuum extractions.

5.3.2 Section B: Nurse-midwives' Perceptions of MNH Delivery System

In this section, nurse-midwife respondents were asked to give their perceptions of the MNH system which included mothers waiting time, the number of supportive visits that they had received from management, the availability of resources and how they perceived the performance of the health facility.

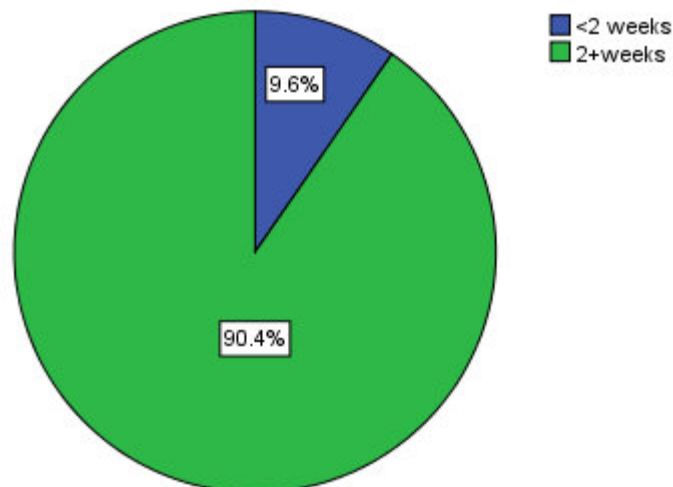


Figure 5.6: NMs perceptions of mothers' waiting time at the HF (N=55).

Nurse midwife respondents (90.4%) reported that mothers spent two weeks or more waiting at the health facilities before giving birth (Figure 5.6).

Table 5.12: District health management team' visits (n=55)

DHMT's visits	N (%)
Yes	16 (29.1)
No	39 (70.9)

Table 5.12 shows that most of the nurse-midwife respondents (70.9%) reported not having received any supportive visits from their district health management teams with only 29.1% reporting to have been visited.

Table 5.13: Availability of resources in health facilities (n=55)

	N (%)
Adequate equipment	
Yes	10 (18.2)
No	45 (81.8)
Adequate drugs and supplies	
Yes	15 (27.3)
No	40 (72.7)
Adequate staff	
Yes	24 (43.6)
No	31 (56.4)
Adequate rooms/space	
Yes	17 (30.9)
No	38 (69.1)
Readily available transport for referral	
Yes	27 (49.1)
No	28 (50.9)

Nurse-midwife respondents indicated that they did not have adequate equipment, space, drugs and supplies. Fifty-one percent perceived that transport for referral was not readily available. (Table 5.13).

Table 5.14: NM respondents' perceptions of their attitudes in providing MNH services (n=55)

Attitudes	N (%)
Bad	0 (0.0)
Fair	9 (16.4)
Good	46 (83.7)

Table 5.14 illustrates that the majority of the nurse-midwife respondents (83.7%) perceived the attitudes of health care workers themselves as good.

5.3.3 Section C: Nurse Midwives' Perceptions of TBAs Changing Role

This section explored nurse-midwife respondents' perceptions of TBAs changing role. Areas of focus included the adequacy of TBA training, TBAs competency in providing MNH care, amount of support TBAs received, reasons why TBAs continue practicing, whether providers were involved in the decision making process on the moratorium and the perceived influence that the moratorium has had on the health facility workload.

Table 5.15: NM respondents' perceptions of TBAs training (n=55)

Adequate	N (%)
Yes	4 (7.3)
No	51 (92.7)

Table 5.15 indicates that 92.7% of nurse-midwife respondents were of the opinion that the TBA training was not adequate.

Table 5.16: NMs’ perceptions of TBAs competency in providing MNH care services (n=55)

TBAs performance	N (%)
Bad	20 (36.4)
Fair	33 (60.0)
Good	2 (3.6)

Sixty percent of the nurse-midwife respondents rated TBAs competency as fair while 36.4% rated it as bad (Table 5.16).

Table 5.17: NM respondents’ perceptions of the amount of support TBAs received (n=55)

Characteristic	N (%)
Equipment	
Yes	3 (5.5)
No	52 (94.6)
Drugs and supplies	
Yes	3 (5.5)
No	52 (94.6)
Refresher courses	
Yes	2 (3.6)
No	53 (96.4)
Supportive supervision	
Yes	6 (10.9)
No	49 (89.1)
Transport for referral	
Yes	3(5.5)
No	52 (94.6)

Table 5.17 shows that the nurse-midwife respondents' perceptions were that the TBAs did not receive adequate support in terms of equipment, drugs and supplies, refresher courses, supportive supervision, and transport for referral .

Table 5.18: NM Respondents' perceptions of TBAs changing role and their continued practice (n=55)

Characteristic	N (%)
TBAs changed role	
Good	52(94.6)
Bad	3 (5.5)
TBAs stopped practicing	
Yes	8 (14.8)
No	46 (85.2)

Table 5.18 illustrates that 94.6% of the nurse-midwife respondents viewed the changed role as good, however 85.2% were of the opinion that TBAs were still conducting deliveries.

**Table 5.19: NM respondents' perceptions of why TBAs were still practicing
(n=46)**

Characteristic	N (%)
Health facility far	
Yes	30(65.2)
No	16(34.8)
TBAs provide better care	
Yes	34(73.9)
No	12 (26.1)
Don't want change	
Yes	23 (50.0)
No	23 (50.0)
Characteristic	N (%)
Source of income	
Yes	22 (47.8)
No	24 (52.2)
Cultural influences	
Yes	22 (47.8)
No	24 (52.2)

Table 5.19 shows that the distance between the health facility and a village and the perception that TBAs provide better care than the health facility were the major reasons why TBAs continued conducting deliveries.

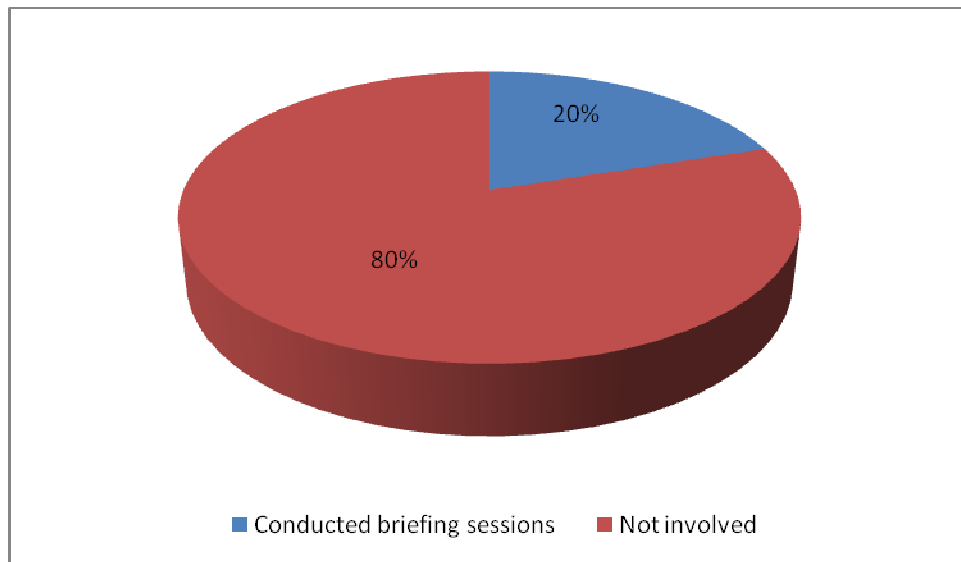


Figure 5.7: NM respondents' involvement in the decision making process on the moratorium on TBAs (n=55)

Figure 5.7 shows that the majority of the nurse-midwife respondents (80%) reported that they were not involved when the government made the decision to stop TBAs from conducting deliveries.

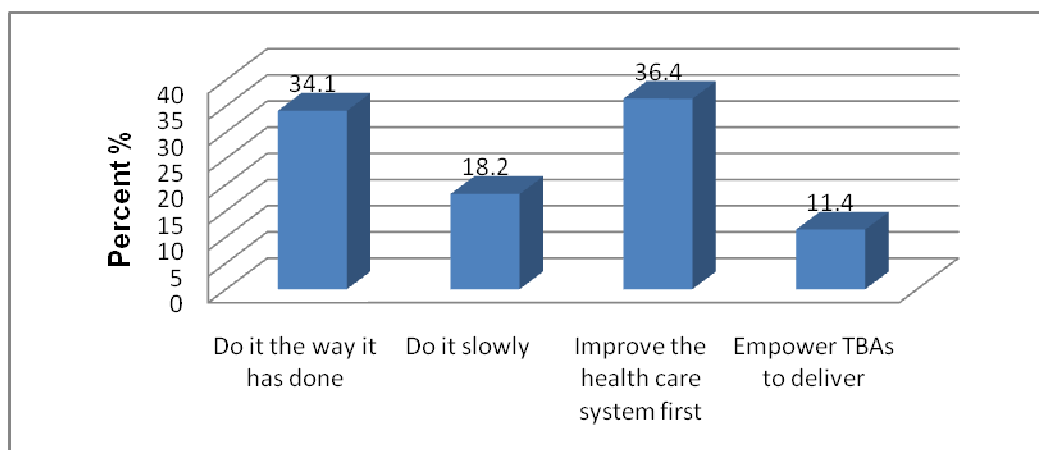


Figure 5.8: NMs advice to government (n= 55).

Figure 5.8 indicates that 36.4% of the nurse-midwife respondents thought that government should have improved the health care system first while 34.1% did not have any problems in the way the government passed the directive on the moratorium on TBAs.

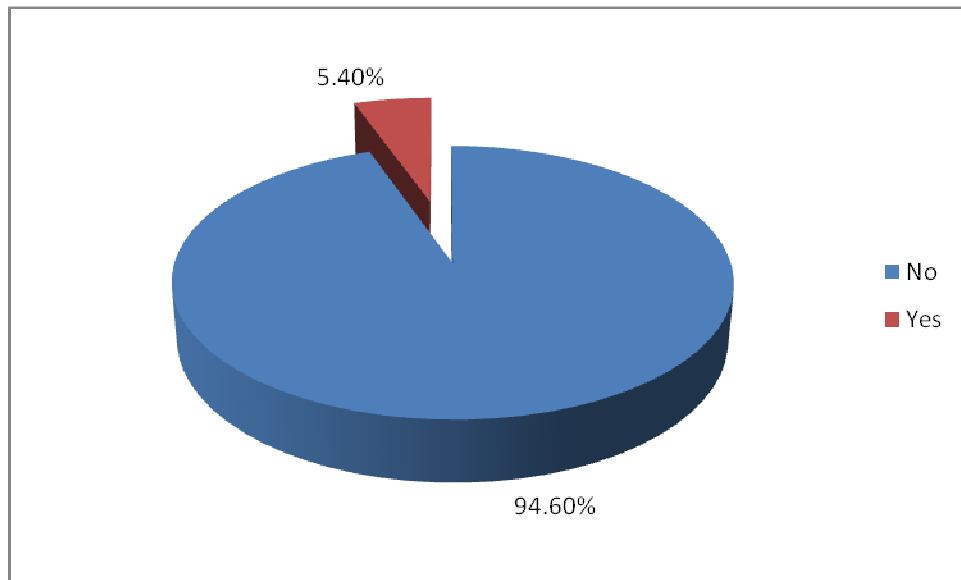


Figure 5.9: NMs perceptions of the HF's capability to manage all mothers after the moratorium on TBAs (n=55)

The majority of the nurse-midwife respondents reported that the health facilities were not capable of managing all of the mothers who sought skilled birth attendance.

Table 5.20: NM respondents' perceptions of challenges encountered by HFs as a result of moratorium (n=55)

Characteristic	N (%)
Increased rate of born before arrival	
Yes	41 (74.6)
No	14 (25.5)
Mothers deliver unattended	
Yes	31 (56.4)
No	24 (43.6)
Mothers use floor beds	
Yes	28 (50.9)
No	27 (49.1)
Increase in seen in second stage	
Yes	39 (70.9)
No	16 (29.1)

Table 5.20 provides information on the challenges health facilities faced following the moratorium. The challenges of the increased rate of “born before arrival” (74.6%) and the increase in the number of mothers seen in the second stage of labor (70.9%) were the two factors that nurse-midwife respondents perceived as main challenges.

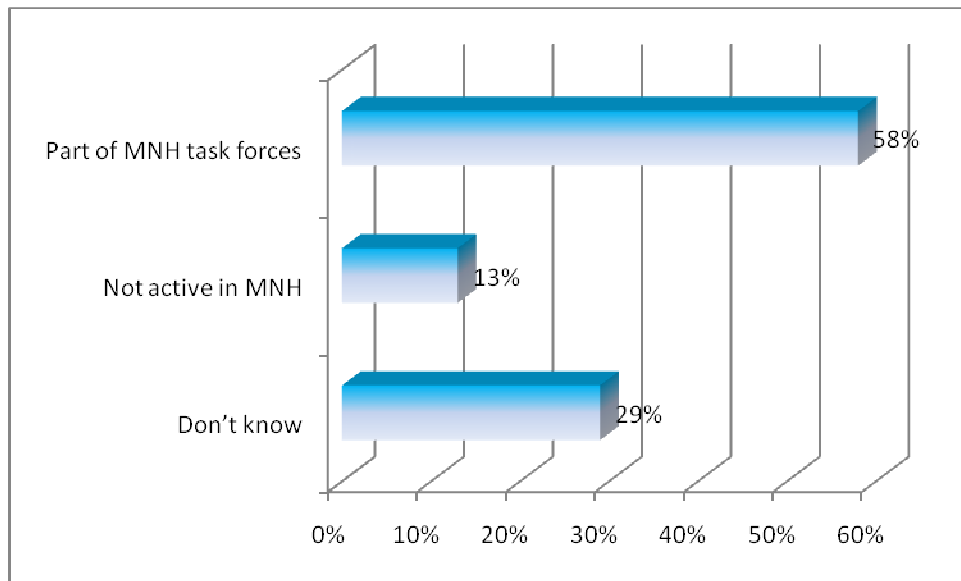


Figure 5.10: TBAs' current involvement in MNH care (n=55)

More than half of the nurse-midwife respondents (58%) said that TBAs were part of the village MNH task force and 13.0% thought that they were no longer active in MNH activities (Figure 5.10).

Table 5.21: NM respondents' opinions on CMs (n=55)

Community midwives	N (%)
Welcome idea	40 (72.7)
Did not welcome idea	15 (27.3)

Table 5.21 indicates that 72.7% of the nurse-midwife respondents said that they would welcome the idea of community midwives.

5.3.4 Health Facility Data: 2010 July – June 2011

Table 5.22: HF's ability to provide FANC services on the day of the visit (n= 24)

District No. HF's	A n=5	B n=9	C n=6	D n=4
	n (%)	n (%)	n (%)	n (%)
Pregnancy test	0(0.0)	2(22.2)	3(50.0)	0(0.0)
Haemoglobin test	0(0.0)	1(11.1)	0(0.0)	1(25.0)
PMTCT	5(100.0)	8(88.9)	6(100.0)	1(25.0)
Urinalysis	0(0.0)	0(0.0)	0(0.0)	1(25.0)
Iron tablets	0(0.0)	3(33.3)	5(83.3)	2(50.0)
Albendazole	4(80.0)	9(100.0)	4(66.7)	3(75.0)
Sulphonamide drug (SP)	0(0.0)	3(33.3)	1(16.7)	1(25.0)
Tetanus Toxoid Vaccine	5(100.0)	8(88.9)	6(100.0)	4(100.0)
Insecticide Treated Nets	5(100.0)	7(77.8)	2(33.3)	4(100.0)
Syphilis	3(60.0)	5(55.6)	0(0.0)	1(25.0)
No. HF's providing full FANC package	0	0	0	0

Table 5.22 shows that in district A only PMTCT, TTV and ITNs services were provided in all the facilities. In district B, only Albendazole tablets were provided in all the facilities. In district C, only PMTCT and TTV services were provided in all the facilities. Lastly, in district D only ITNs and TTV services were provided in all the facilities. Urinalysis was available in only one facility (25%) in district D. Haemoglobin level testing was available in one facility in each of districts B and D only. None of the facilities in district A was able to offer a pregnancy test, haemoglobin test, urinalysis, iron, or antimalarials. None of the facilities in district B was able to offer urinalysis. In district C, none of the facilities was able to do a haemoglobin test, urinalysis or syphilis test and in district D, none of the facilities was able to do a pregnancy test on the day of the visit.

Table 5.23: Ability of HF's to provide the seven BEmONC functions on the day of the visit (n= 24)

District No. HF's	A n=5	B n=9	C n=6	D n=4
	n (%)	n (%)	n (%)	n (%)
Assisted vaginal deliveries (vacuum extractions)	3(60.0)	4(44.4)	5(83.3)	4(100.0)
Manual Vacuum Aspirations (MVA's)	4(80.0)	6(66.7)	4(66.7)	3(75.0)
Manual Removal of Placenta (MRP)	3(60.0)	9(100.0)	4(66.7)	3(75.0)
Resuscitation of the New Born (RNB)	5(100.0)	9(100.0)	6(100.0)	4(100.0)
Administration of uterotonics	5(100.0)	9(100.0)	6(100.0)	4(100.0)
Administration of magnesium sulphate	2(40.0)	8(89.9)	2(33.3)	3(75.0)
Administration of parenteral antibiotics	5(100.0)	9(100.0)	6(100.0)	4(100.0)
No. HF functioning fully	0	5	0	3

Table 5.23 shows that uterotonics and parenteral antibiotics were provided in all the facilities under study. In addition, all the facilities had the equipment to perform resuscitation of the newborn on the day of the visit. None of the facilities in districts A and C was able to provide all seven BEmONC signal functions on the day of the visit; five out of nine facilities (55%) in district B and three out of four facilities (75%) in district D were able to provide the seven BEmONC functions on the day of the visit.

Table 5.24: Numbers of NMs in BEmONC sites trained in BEmONC

Districts	A	B	C	D
No. HF's	n=5	n=9	n=6	n=4
No. NMs	n=14	n=35	n=44	n=15
NMs trained in BEmONC	10(71%)	15(43%)	26(59%)	9(60%)
Total No. NMs trained in BEmONC		60	(55.5%)	

Table 5.24 shows that district A had the highest proportion of nurse-midwife respondents trained in BEmONC although it ranks third in terms of population size.

Table 5.25: Number of mothers who were waiting onset of labour on the day of visit to the HFs

District No. HFs	A n=5	B n=9	C n=6	D n=4
Range across HFs	1-7	1-18	2-14	6-44
Average number	2	7	8	24

Table 5.25 shows that an average of ten and a range of 1 - 44 mothers across the four districts were waiting the onset of labor in the BEmONC facilities on the day of the visit. District D although it ranks fourth in terms of population size had the highest number of mothers waiting for labor in one of its facilities. There were no waiting homes at any of the study facilities for pregnant mothers to lodge.

Table 5.26: Number of deliveries in 24 hours at the HF

District No. HFs	A n=5	B n=9	C n=6	D n=4
Range across HFs	1-10	1-8	2-5	4-12
Average number	6	5	4	7

Table 5.26 shows that a range of 1- 12 mothers had been delivered in 24 hours across the study facilities in the four districts with an average of six deliveries in 24 hours. District D had the highest average number (seven) of deliveries although it ranks fourth in terms of population size.

Table 5.27: Travelling distance from the farthest village to the facility (n=24)

District No. HFs	A n=5	B n=9	C n=6	D n=4
Longest distance	30kms	33kms	27kms	35kms
Average travelling distance	18.6kms	20.7kms	19kms	26.2kms

Table 5.27 shows that mothers in these rural areas travel a maximum of 35 kms in order to access MNH services with an average of 21kms.

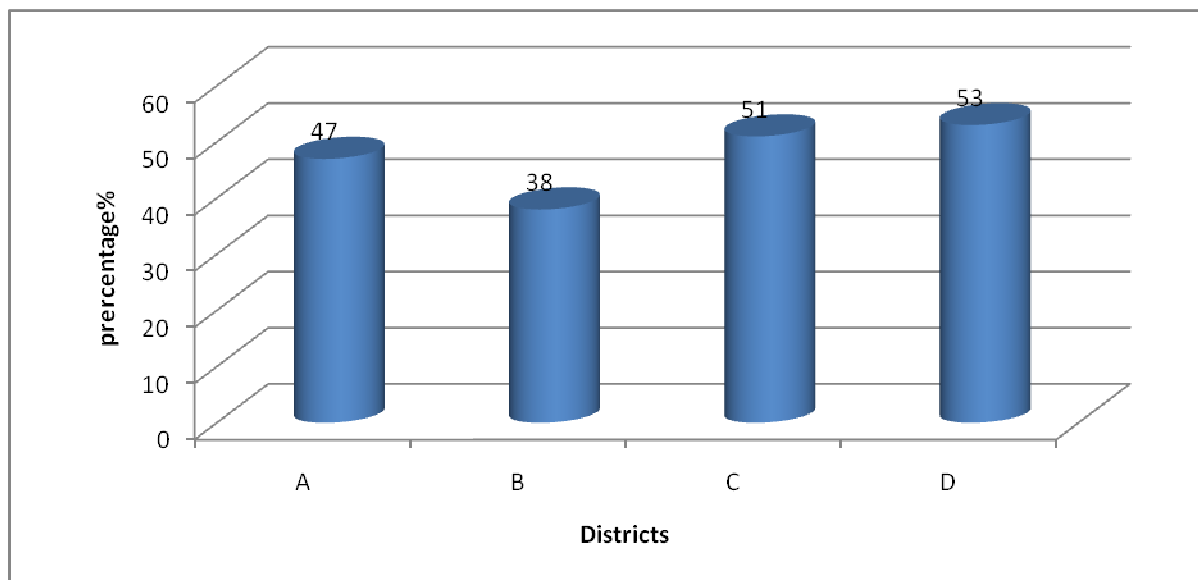


Figure 5.11: SBA rate in BEmONC HFs in rural areas (n=24)

Figure 5.11 shows that all of the rural BEmONC facilities operating in the rural areas functioned below the national average rate of 71% (DHS, 2010) in terms of skilled birth attendance. The 24 health facilities had an average of 47.3% in skilled birth attendance rate.

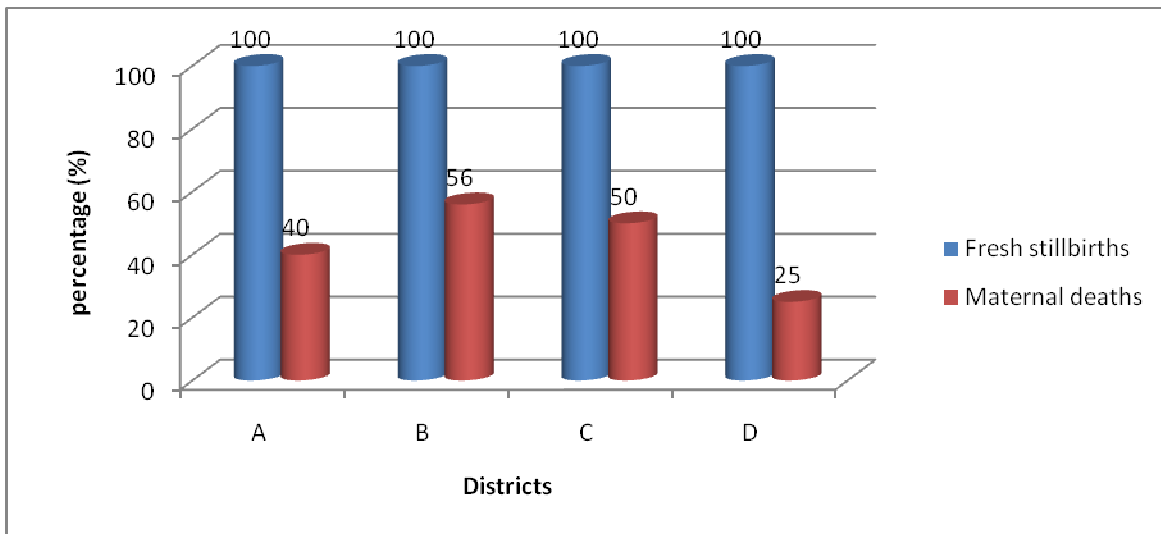


Figure 5.12: Prevalence of FSBs and MDs in the period July 2010 - June 2011 in BEmONC HFs in the four districts

Figure 5.12 shows that all 24 of the health facilities included in the study had recorded stillbirths during the reporting period. A total of 18 maternal deaths were recorded in a total of 11 health facilities. Each district had a facility which reported a maternal death in a period of one year with district B reporting the highest proportion of facilities (56%) which experienced maternal deaths.

5.4 SUMMARY OF QUANTITATIVE FINDINGS

Findings in phases one and two of the study reveal that communities and health care service providers were not consulted on the moratorium on TBAs. However, respondents in both phases agreed that stopping TBAs was a good decision. It was reported that TBA services continued in their communities. Respondents in both phases acknowledged that the health care system lacked capacity to manage every mother who went for a facility delivery, even though mothers perceived that a health

facility delivery was the best option for themselves. Respondents in both phases welcomed the idea of community midwives.

5.5 QUALITATIVE FINDINGS OF THE STUDY

Qualitative data were collected in phases three to five of the study. Data from these phases were integrated in the identification of themes and will be presented together. Pseudonyms or codes have been used in place of real names for participants, locations and institutions.

The following conventions were used in reporting the results of the study: Italics are used to identify direct quotes or direct words spoken by the participants. Capital letters are used to indicate the emphasis made in stressing an issue. Lines --- are used to indicate participants' emotions such as frustration, grief or sadness. Dots (...) indicate that some words have been omitted which were not directly relevant to the point being presented. Where appropriate, participants are quoted word for word.

5.5.1 Identification of Common Themes

Together with a co-coder, the following themes were identified:

Theme 1: Government's commitment to TBA program

Theme 2: TBAs' roles

Theme 3: The moratorium on TBAs and their new roles

Theme 4: Coordination among partners

Theme 5: Mothers' access to skilled birth attendants

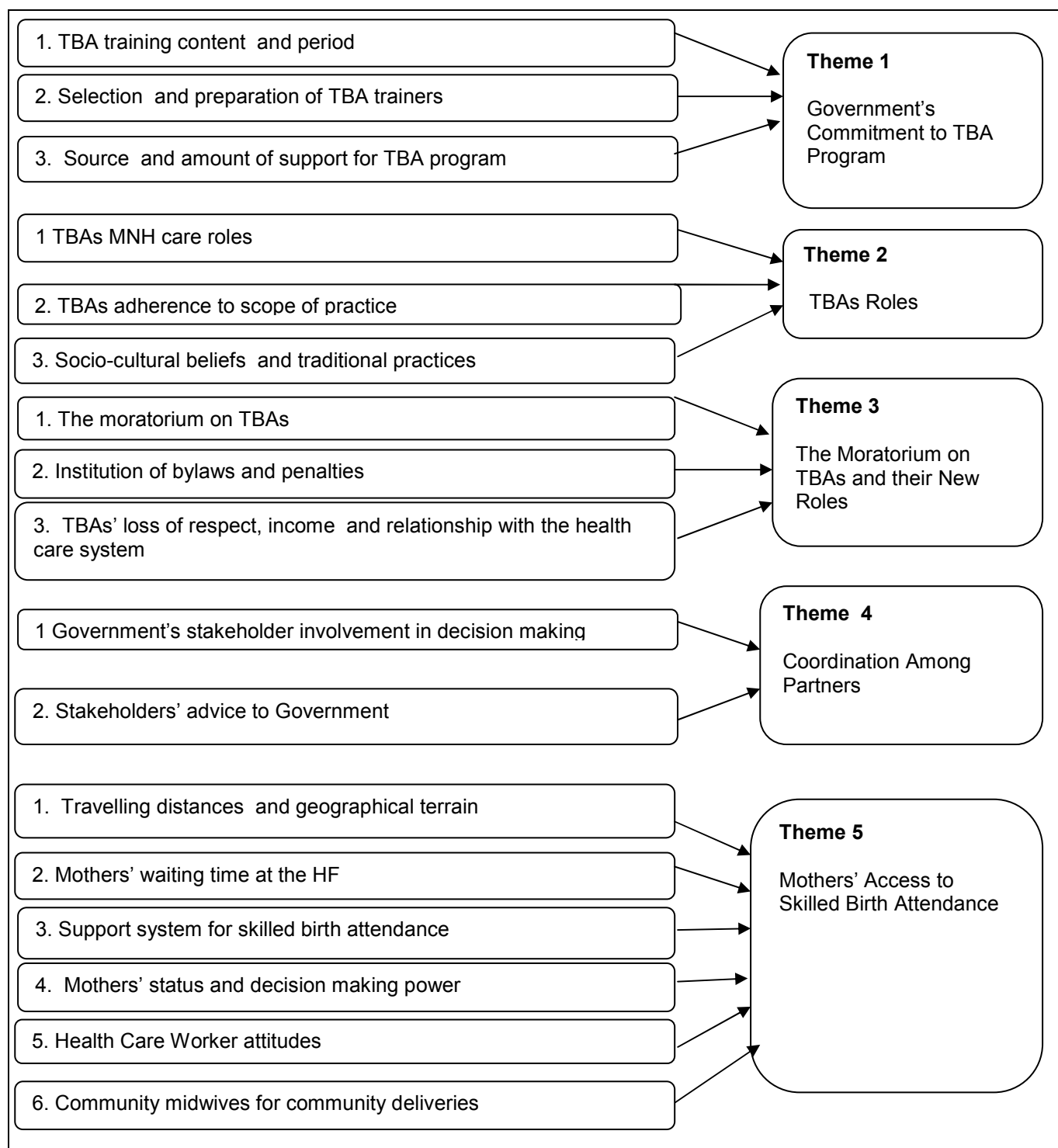


Figure 5.13: Sub-Themes and Themes Identified in Phases 3-5

5.5.1.1 **Theme one: Government's commitment to the TBA program**

This theme describes government's commitment to the TBA program which was demonstrated through the provision of training for trainers and support committed to the program. Sub themes which made up the theme included: TBA training content and period, preparation of TBA trainers and source and amount of support for the TBA program.

5.5.1.1.1 **TBA training content and period**

Participants in the three phases were of the view that there was too much content for the allocated period of training. Most of the TBAs recruited for the training were old and illiterate and this made it difficult for some trainers to complete the content within the short time provided.

It (the content) was too much such that they could not teach us the whole content because the period was short (others agreeing). Moreover, the refresher (course) was sporadic and inconsistent. Sometimes two years would pass by without any refresher (course). They were also taking us in sub groups because there were many TBAs. If they take this TBA this year, next year it will be another TBA and the other group would stay without being refreshed (TBA # 20).

TBAs were perceived as lacking capacity to learn with the majority of them being illiterate and old. Therefore, trainer and health professional participants

were of the view that TBAs should have been given an opportunity for hands on practice in order to internalize the learnt skills.

Therefore, with me I felt the duration was not enough looking at the illiteracy and the age ahah. .. We needed each TBA to practice and then be able to observe her that she was doing the right things. Than just assuming, demonstrating you take it that they have gained something is not enough (Trainer # 2).

What I think its people took advantage of this to say they already know how to conduct deliveries. Therefore, it is as if they were just trying to beef up some gaps... Four weeks I think to me it was an orientation not training (HP # 8).

There was agreement amongst some participants in all phases that the TBA training period was adequate since the TBAs were already practicing.

But one thing with these TBAs it's not that they were women who were very blank. They had very good experience on issues of childbirth (HP # 2).

It was reported that refresher courses, though planned, were not conducted accordingly and some TBAs had more training opportunities than others.

There were some TBAs where colleges would send their students, those TBAs were at an advantage ..., a nursing college would say we go to TBA so and so therefore let us refresh her. So that when our students go, she knows the current issues... Those are the problems that came. However, plans were there (HP # 6).

5.5.1.1.2 Selection and preparation of TBA trainers

Most of the trainer and some health professional participants stated that the trainers' preparation was not adequate for them to teach illiterate, elderly learners.

The content was too much, the duration was too short and TBA trainers were not adequately prepared (Trainer # 6).

Those who mostly experienced problems with managing their time were enrolled nurse-midwife trainers. The registered nurse-midwives and enrolled community health nurse-midwives cited having utilized their previous experience during the training sessions. One health professional cited level of competence to have influenced performance. Another challenge was language for example a trainer of Tumbuka background teaching Yawo TBAs.

Because much as some of the trainers were registered nurse-midwives, some of the trainers were enrolled nurse-midwives. Some were

community health nurse-midwives, because of the levels of qualification it really depended on the competency of the trainer (HP # 1).

May be that is where we had a challenge, two weeks was not enough. I witnessed one occasion, which was very sad. It was a registered nurse from the northern part of the country and she was in the south trying to train Yaos, (another tribe in the country which speaks Yao) I think that was a bit of a challenge because I could see the TBAs - some of them totally lost (HP # 2)!

Some TBA trainers reported not to have undergone any training but were requested to teach. They learnt on the job which might have affected their performance.

I do not know we were just picked to go and teach. What they were doing was that nurse-midwives would be taken from their facilities and you were made to teach a topic, for example second stage, baby care, postnatal. The other would teach another topic having not undergone any ToT (training of trainers; Trainer # 6).

On the other hand, some health professionals and trainer participants were of the view that TBA trainers were well prepared considering that they were practicing midwives.

Yes. I think it was sufficient because at that time we already had knowledge in midwifery, so it was just like now relating to the same knowledge for us to teach the TBAs. Therefore, the Training of Trainers was ok (Trainer # 4).

5.5.1.1.3 Source and amount of support for the TBA program

At the conception of the program, participants generally felt that there was adequate support for the program, but things changed over time when TBAs were not able to get the resources needed for the workload. The TBA program was supported by donors from the beginning of the program and remained so for a *very long time*. The following were participants' perceptions of the amount and source of support for the TBA program.

I remember at the beginning, at least when UNICEF was supporting us, we were having the supplies because we used to have our own supplies for the TBAs. However, later on the support was not enough from the donors (Trainer # 2).

Another participant observed:

TBA services were being supported by partners, government put in very little money. This was an agenda supported by partners for a very long time. If government put in any resources (it) is probably (in the) procurement of a few items. But mostly its staff salaries (HP # 3).

With time, resources became problematic and the TBA services suffered as well.

Sometimes during visits, one would find TBAs using plain hands to deliver mothers. Some would use plastic bags...because they had no gloves, which were also not available at the facility. Therefore, things were not enough. Even ferrous (sulphate) was also in short supply making it impossible for TBAs to give (to) their mothers (Trainer # 3).

Another participant described the implications of not having enough equipment and supplies:

In terms of equipment, they had no (did not have) enough equipment. They were having so many deliveries and little equipment. It was also difficult for them to sterilize the equipment; as a result, they would just clean and reuse it which is not ideal (Trainer # 1).

When a need to refer a mother arose, some TBAs would resort to financing the trip to the facility themselves.

...You know people in the village are living in dire poverty. Because we did not want the mother to die at our place for fear of giving a bad image

to our place. ...so as a result we could even sponsor the trip to the hospital (TBA # 20).

Some TBA participants complained that they could not get supplies from the health facilities because their area HSAs were not supportive enough.

Our HSA was not cooperative therefore, we just stopped asking. He was doing his own things, whether it was drinking beer, selling drugs. Drugs were always out of stock according to him so we simply got tired and stopped asking (TBA # 17).

Problems with finances affected the amount of support given to the TBAs; supervision suffered the most because of transport problems both at the health centre and district levels. Sometimes referred mothers were required to find their own means of transport to get to the health facility.

The problem was the frequency with may be funding ..., they were not able to visit them (TBAs) as frequently as possible. Sometimes they were only following them when something has gone wrong. ... In some cases TBAs were asking the patient saying you are supposed to go to the hospital can you please find transport (HP # 6).

Consequently, HSAs were asked to supervise TBAs. However, HSAs have not had any MNH care training.

We were highly dependent on (the) area Health Surveillance Assistants (HSAs) to assist us supervise these TBAs ...They (TBAs) were given phone numbers for them to call. However..., the TBA would call for an ambulance but due to inadequate numbers of ambulances, no transport would go to fetch the patient. TBAs would therefore resort to using an oxcart, bicycles or even improvised stretchers (Trainer # 1).

Lack of supervision was the case at provider level as well:

Therefore, I think in terms of supervisions they were not done at consistent levels as it was planned. Consider even what is happening now, years go by without DHMTs supervising their people. They would only go if there is a special activity but not for supportive supervision. Facilities that are supervised every quarter are negligible (HP # 10

As a result, participants in the three phases observed that the system did not empower the TBAs in order for them to provide effective services. Consequently, participants concluded that TBAs were actually let down by the health care system.

YES, A BIG GAP, A VERY BIG GAP. If we empower the TBAs and supervise them frequently, they would have been conscientious enough not to keep those (patients) outside their scope (of practice). We were not

there, not available for them, we went quiet and disappeared with the help they so much needed... so she went haywire. ---Our supervision was not intensive (Trainer # 9).

Another health professional, who sounded frustrated, raised more systemic issues:

I think the TBAs in those days, some of them, had a raw deal; they could not refer their patients in time. For them to go and phone for an ambulance it was such a challenge, ---the road terrain was bad (and) they could not get to the facility in time. So that contributed to maybe some of the (maternal) mortality we experienced with the TBAs – not of their own making. ---Yes ...even the TBA supervisor started experiencing challenges, no transport, and no resources for them to even go out and visit the TBAs. ...when the DHO (district health office) had to give priority to transport, they never thought of giving transport for TBAs (HP # 2).

5.5.1.2 Theme Two: Traditional birth attendants' roles

This theme describes how TBAs conducted themselves in performing their duties. During training TBAs were instructed in their roles and responsibilities. However, lack of clear policies and regulations for TBA practice meant that the TBAs' practice depended on individual TBA's conviction of the need to practice within the given scope of practice. The following subthemes made up this

theme: TBAs' MNH care roles, adherence to scope of practice and socio-cultural beliefs and traditional practices.

5.5.1.2.1 **TBAs' MNH care roles**

TBA participants were able to describe the antenatal care roles such as taking social, medical-surgical and obstetric histories.

... we welcome her, ask her, her home village... we should ask her name, the name of her husband, the denomination she belongs to, she should tell us. Thereafter we start asking mother, have you ever suffered from epilepsy? (all agreeing). No. Or migraine headache have you ever suffered from that? No. Or even anemia did you ever have such a problem? No. How about your deliveries before, were they normal deliveries (TBA # 9)?

TBA participants were also able to describe the head to toe examination that they performed during antenatal care.

In Antenatal, we were starting from the head checking if she has lice, so that she should cut her hair, then we go and look at the tongue, if she has inadequate blood (checking for anemia). If it is so, we were sending her to hospital (TBA # 17).

They ably described the signs of labor including signs of second stage of labor and how to conduct a normal delivery and postnatal care.

Yes, if there are really labor pains then we knew that the mother was indeed in labor having signs like discharge with little blood (show)... Then something would break releasing some watery fluid (rupturing of the membranes) if that breaks we knew that the baby was now approaching the exit (TBA # 1).

TBAs demonstrated adequate knowledge of the management of the mother soon after delivery.

After the baby is born, we take it nicely, nicely. We make it lie this way (demonstrating the up and downward delivery motions of the baby) ... Thereafter we take the scissors, which they used to give us earlier, and we clamp and cut the cord... We take those (placenta) and throw away and clean the utensils...Then we check and hold the cord as if we are playing with it (making sideways motion)... until finally it drops down where the baby was also received. Then we go back to the mother to check whether she has tears or not...We check the amount of blood loss, is it too much or not (TBA # 7)?

Another TBA added:

Isn't it that with us after delivery and after she has rested. If she delivers in the morning, it means in the afternoon she will go home. Early in the morning then you go follow up on your mother (TBA # 18).

Participants in all phases observed that TBAs were expected to be able to identify mothers at risk, refer them to the health facility for delivery, and conduct normal deliveries only.

The information was just to make them be able to practice a safe delivery... the most emphasis was to make sure that the TBA identify a risk and refer. Therefore, that needed the actual identification and only deal with normal deliveries (Trainer # 5).

TBAs used to conduct more deliveries than the health facilities. A typical quote from one of the trainers who was also a provider herself alluded to this:

Then it would be possible that at the HF we could deliver about eight deliveries against 30-40 deliveries by just one TBA from within the area (Trainer # 6).

5.5.1.2.2 TBAs' adherence to scope of practice

TBA participants were able to describe their scope of practice and seemed knowledgeable about what they were expected to do with pregnant mothers in their care.

Thereafter the training the government said to us you have been trained, here is your scope (of practice)... (TBA # 7).

Trainers and health professional participants observed that even though TBAs were able to articulate their scope of practice perfectly, they did not abide by those standards once they returned to their place of practice. One trainer observed:

They can tell you everything about their scope (of practice), but for them to follow just that, that is where there is a problem. As a result, we were receiving mothers who were almost dead, posing a big challenge on the system (Trainer # 1).

Participants in the three phases reported that some TBAs encountered complications while managing pregnant mothers.

There is another untrained TBA from the same Kame area. She operates as both a TBA and a herbalist.....She too made a blunder ...Cervical prolapse (TBA trainer # 6).

Sometimes the mother can be ready to deliver but the baby does not come down because of the cord on its neck....I have referred three such cases (TBA # 20).

TBA participants reported having encountered complications they had never seen or heard of before, such as cervical prolapse.

As for me.... I encountered the unthinkable. A certain man came to me in the middle of the night with his wife who had delivered many times - maybe it was her sixth (delivery)... He explained to me that something comes out during delivery. As we were talking the baby was already coming....but something else was also coming like a snake below the baby (TBA # 17)!

TBA participants reported maternal deaths which had occurred at their place or another TBA's place.

I said... you have twins. Go to the district hospital...They went and called madam Mbowe please come, she took her into her house...take these herbs to drink you will deliver normally. The mother did not deliver. The tummy swelled, she went to the grave, Madam Mbowe caused a death of a mother. ...She had a ruptured uterus... (TBA # 8).

Beliefs in witchcraft convinced TBAs that some mothers' deaths were a result of witchcraft:

I too received a mother from Kanverere, during assessment the husband said that the woman vomits during delivery. She vomited, vomited and she was gone---dead. Yet she had been bewitched. Later we heard that she was being seen here and there (TBA # 18).

TBAs were aware of the health facility's staff's concern regarding their (TBAs) reluctance to refer patients outside of their scope of practice. One defended themselves as follows:

What makes us not to abide by the instructions is pity (for the mother) sister. A mother with twins would arrive on your doorstep with the first twin's head visible on the vulva... Therefore, the only thing for us to do is give me your things. If God is with you. You see the baby has come, later you see the other coming as well. When you do that, they (the community) will say oh! The TBA can even deliver twins she knows and yet the time was already over (TBA # 14).

5.5.1.2.3 **Socio-cultural beliefs and traditional practices**

TBAs' and mothers' beliefs in culture and tradition influenced the way they dealt with pregnancies. Some believed that a pregnancy could not be completed successfully without subscribing to traditional medicines. Participants in the

three phases concurred that some TBAs would use herbs in managing pregnancy and labor.

It is even worse with us blacks we do many other things like witch craft, we cast spells on each other for that one not to deliver. If God has revealed it to you in your sleep, a solution to somebody's spell and you give her the concoction on a wooden spoon you find that the mother has been relieved and delivers well. Why should we say that each pregnancy complication the answer is operation; should all of us be scarred? We feel sad about it, now that the government has called us we are happy about it so that they can lead us properly (TBA # 14).

Participants in all the phases concurred that mothers did not comply with referral advice and would go to the TBA in order to subscribe to their cultural beliefs and traditional practices.

I think some had a conflict because they were trying to abide by what the government trainer had told them...they had to leave some of the traditional practices which the women go for...Like a woman who has her first pregnancy and the in-laws are saying we want to prove that this pregnancy is from our brother. Therefore, you are not delivering at any health facility. Obviously, they will go to a TBA because that is where they will do their cultural things (HP # 2).

Participants in all the three phases observed that some TBAs had acquired their skills from their parents and would continue practicing even if it was harmful. In addition, mothers liked to access both TBA services and the health care system services concurrently.

My grandmother started this job... then my mother took over... Now I was doing my work the way the grandmother was telling us. Is not it she was mixing TBA and African herbs. Mothers would say please assist us with herbs to quicken the delivery... That was the grandmother while I was watching, learning. Now when I took over, I started work the way my grandmother was doing... Then she (the pregnant mother) would be asked will you be taking herbs here or not? No, give me the herbs. I will be receiving dual services. She would give her the herbs to drink;... the lower path was sutured by the doctor? Yes. Ok. "Here" make sure you bath three times a day (TBA # 8).

Yes they could hear what they were being taught but once back home they continued doing what they had been doing all along. Some were even claiming to have been directed by the spirits to become TBAs. Therefore, if you tell them to do things differently from what the spirits had directed them to do they would not take that... I was told by the spirits to conduct deliveries, the same spirits will tell me to stop! You did not tell me to become mzamba (TBA) the spirits did! The same will order

me to stop. You simply taught me how to do it. You cannot order me around! I cannot stop (Trainer # 10)!

As a result, participants in the three phases acknowledged that complications occurred due to cultural and traditional practices to which TBAs and mothers subscribe. Yet the TBAs could not be apportioned the blame.

In my case, a certain mother came to me saying our child delivered the day before yesterday, with a newborn in their hands, but she is traumatized. She delivered at a prophet. There goes the tear down to the anus, a big wound. I then put her in a head down position as I was inserting some herbs, because I too deal with herbs, even the doctor knows (TBA # 14).

You and your husband have killed the baby... When you look at the mother here, there is semen all over... Look at the baby it has semen. Therefore, some mothers are killing their babies themselves (TBA # 8).

Participants in all phases expressed a desire for the lifting of the moratorium to allow TBAs to practice. TBAs themselves were looking forward to the day when they would be allowed to recommence conducting deliveries since they strongly believed that it was a calling inherited from their parents.

When we accept the government should consider us, it should come to us TBAs who accepted and find us something to do. ...Because we have not forgotten the fact that we are TBAs, it is still in our minds (mmh, mmh agreeing, ululating) People are crying for us... Therefore, we are requesting the government to plan to select I got my job from my parents, that one it is from her parents as well (TBA # 12).

5.5.1.3 Theme Three: The moratorium on traditional birth attendants and their new roles

In this theme, participants' perceptions of the TBAs changing role were explored. Anecdotal reports and health care workers' sentiments in different fora showed that TBAs were doing more harm than good to the mothers. Therefore, the government issued a directive in which all TBAs were stopped from conducting deliveries. The theme emerged from the following subthemes: The moratorium on the TBAs, the institution of bylaws and penalties and TBAs loss of income, respect and relationship with the health care system.

5.5.1.3.1 The moratorium on TBAs

Even though it was believed that TBAs had not contributed to the reduction of the maternal mortality rate, they were still believed to be of value to the mothers especially those in the rural, remote and hard to reach areas. The following were participants' perceptions of the moratorium on TBAs.

Participants in all phases did not agree with the moratorium on TBAs. They asserted that the current situation in the country is not supportive of skilled birth attendance which is facility based only.

Therefore, I am so passionate about this TBA issue because I feel we gave them a very wrong deal, including the mothers out there who rely on nobody else but a TBA... Some of the policies that we make as senior government officials it is because we are not out there in the dust, out there where women are delivering in the bushes... We are sitting here in our office, air-conditioned, drinking cold water then we say no no no.--- I think these TBAs are killing our women (HP # 2)!

Adherence to the moratorium was difficult because communities received confusing messages on the directive.

My observation is that communication that has come from us to the TBAs it is not very clear. Because first we said stop conducting deliveries, then we said no let them continue, --- then we said no lets redefine the roles... (HP # 8).

Another health professional participant was equally frustrated:

TBAs were actually saying it was government, which trained us, and the government actually gave us certificates, why should you stop us... I

know there was a time when the president (the then state president) had announced that the Ministry of Health should find ways of working with the TBAs. ---Therefore, I think the people misinterpreted it to mean that the president had directed that TBAs should start performing deliveries (HP # 9).

Some people have taken advantage of the suspension of TBAs' training to institute their own training for TBAs. The latter are required to pay for this training. One of the TBA participants revealed:

They came to my house in person telling me that there was a training in Libombwe to be conducted by Mr. Yobanezi- Dr Yobanezi... We are not the same. I simply told them that. ... Nevertheless, he actually charges, they just wanted to convince me... so that I get attracted. (TBA # 14).

TBA participants reported that their role is now that of a counselor, advising mothers to seek skilled birth attendance.

Therefore, when we were told to stop aaa we listened and we are just staying. Now our job is that of a counselor telling people to go (TBA # 7).

However, participants in all the three phases acknowledged government's predicament and supported the government's decision on the moratorium on TBAs.

So let us not cheat you madam. Do what you think is right and just tell us to go and do A B C, we shouldn't cheat you that we do not use herbs, there are others who are using herbs. See someone died, she went to the graveyard walking. ...Madam do what you know is right and tell us what we should do finish (TBA 17).

5.5.1.3.2 Institution of bylaws and penalties

In order to reinforce the directive for stopping TBAs, the government involved traditional leaders who are the gatekeepers to the community. The programmers knew that if they involved the local leaders, they would support the directive and facilitate its implementation in the communities where TBAs worked. Participants in all phases were apprehensive of the bylaws and penalties that had been instituted in the communities by the local leaders. TBA participants said that they had *many tales* to tell but had nowhere to tell their tales.

There are many tales but we did not have anywhere to tell our tales. However, at the hospital they were also threatening that if you deliver any mother it means prison (TBA # 2).

In trying to abide by the laws mothers are left to deliver alone in an inhumane and undignified manner. A TBA participant observed:

You have labor pains and are heavy laden, - go ahead we will come after you. Along the way the mother becomes weary, she does not care who is looking provided she gets relieved. Whether there are goat herders or children just playing, whether there are men she is simply looking for relief, she lays there struggles by herself with no one to cover her nakedness... We have thrown away childbirth... (TBA # 3)!

TBAs were in a dilemma having been compelled to assist the mothers who did not make it to the hospital on time on the one hand and trying to abide by the order on the other hand.

...Away from me! and I closed the door. Therefore, they went to another untrained TBA. ... some parts remained inside. .. She (untrained TBA) knew that she had been stopped from conducting deliveries so she did not have the zeal of telling them lets go to the hospital. So instead of going to the hospital they took her to a herbalist... They went back home and stayed there for a week. Now they went to Mdemba facility where they were fetched by an ambulance and came here where the girl died. They buried her but I feel guilty because I actually got her by her hand and ordered her out of my house. So I said ho! I was tempted by the devil not to assist her. Oh! The goat has killed a mother (TBA # 20)!

Another TBA participant was really concerned:

They come drop the mother by your doorstep--- knock on the door and leave. When you open the door asking with whom have you come? --- Oh, they have gone back. If you tell her lets go to the facility, I cannot manage. What remain is for you to go fetch the mat spread it, ---you peep the head is on the vulva. That is it, you conduct the delivery and finish. In the morning she goes. Later they come, why you conducted a delivery! They say no you have made a mistake! You should have sent her away to the road if she dies let her die on the road! Her people will come and fetch their dead body back home (TBA # 3)!

Participants described how mothers ended up delivering on their own in an unhygienic and traumatic manner for fear of putting the TBA in a dilemma.

Somebody (a pregnant mother in labor) came from Kandame was on her way to the facility. While on the way, the mother delivered. Children were coming from school, there was a dog squatting in front of the mother --- ready to catch the newborn baby (TBA # 20)!

Another TBA participant alluded to the same:

A child is born alone on the way. ---The baby wriggling on the sand on the way (TBA # 2).

Health professionals and TBA trainers agreed with the TBA participants that not all mothers could make it to the facility on time to deliver.

Sometimes they are assisting mothers in deed on the way to the facility, in the bushes; places that are not conducive (to delivery; Trainer # 8).

Participants in all phases concurred that local leaders had instituted penalties for any delivery that took place outside the health facility.

However, if I receive you here, I do not have goats to pay...and maybe you too do not have, where will we get some to pay? Therefore, mother please start off. They ask us where are you going to pay the goats? Firstly the village chief, second the group village and third the traditional authority himself (TBA # 9).

As a result, a gap had been created which had culminated in the mushrooming of untrained TBAs who had seized the opportunity and were delivering mothers 'underground' without being monitored by the health care staff. The trained TBAs, envying their friends, joined their counterparts' 'underground' work.

Because we are still having many born before arrivals, even seen in second stage are also happening in big numbers. Things have not changed (Trainer # 4).

Even in my home area, they say to me your friends are delivering why can't you do the same (TBA # 20)?

A TBA trainer asserted:

THESE TBAs HAVE GONE UNDERGROUND. THEY ARE PRACTICING, but they have gone underground and that is very dangerous. ...on further interviews all she said was you know the women are delivering in the bushessss- around the TBA hut... Therefore, they reach a deal. You do not report that I delivered you... She (TBA) cannot communicate back to the health system to say I am meeting ABC challenges because she is afraid. Therefore, that is putting our mothers even more at risk (HP # 2).

Participants in all phases agreed that in spite of the restrictive laws and penalties TBAs would not let a mother suffer alone whilst they watched but would assist the mother in delivery.

TBAs ARE CONDUCTING DELIVERIES. We do not know where these deliveries are done, whether it is in the TBAs homes or where, but they are delivering... Now with what we are experiencing there is a VERY BIG GAP (Trainer # 9).

TBAs themselves alluded to this:

No, we cannot do that. (All Agreeing)... We help to deliver her and take her to hospital at once. (Mmh all agreeing; TBA # 16).

There is male involvement in the underground operation where husbands are required to accompany the team (the laboring wife and the TBA and others) to the bushes if delivery takes place at night.

I thought with us it was the boy child- husband who went to fetch the water. That is what we are doing in the middle of the night. We say now the husband- who might be some meters away...now go get a bucket and fetch some water (TBA # 3)!

TBAs reported that they still remember that they are TBAs. Theirs is a calling that they accepted.

Because we have not forgotten the fact that we are TBAs, it is still in our minds... that work was instilled in us and we accepted it with all our hearts... I got my job from my parents, that one it is from her parents as well. Some do it as business. We work because we want to help our friends, mmh. We accepted this calling. Yes, we accepted (TBA # 12).

As a result, pregnancy related complications were on the increase and mothers were not checking into health facilities in time for emergency care because they were afraid of being queried about delivering outside of the health facility.

The number of mothers delivering at the TBAs is increasing and when they finally decide to refer, they are just abandoning the mother in a vehicle and tell her to go to hospital to make it look like the mother died in a hospital. Moreover, the number of mothers who are traumatized during childbirth is also increasing very much. In addition, many neonatal deaths are happening there, things have not changed (Trainer # 1).

Ironically, some TBA participants reported that they used to be part of the Safe Motherhood Task Force but decided to withdraw because they believed their involvement was a risk to their own lives.

Recently we (the task force) were doing follow ups. We were asked to go about and investigate mothers who are delivering in the community... Then we observed that things were not ok because people were not happy with us trying to put us in trouble, some even wanted to way lay us. We said to ourselves we will be killed for nothing. Let us leave it. Let them kill themselves (TBA # 15)!

Some health professional participants distanced the health care system from the harsh bylaws and penalties imposed by the local leaders.

Well community leaders – the truth is that we never said as Ministry of Health; we never said that they should punish pregnant women if they deliver at a TBA... As community leaders, they have made their own by laws. We are not part of those by laws. They are made by them (referring to local leaders; HP # 1).

Other health professional participants had varying views.

Because the laws that the traditional leaders have put up; yes they are responding to what we have told them (HP # 6).

However, health professional participants reasoned that the institutionalization of bylaws and penalties had resulted in an increase in the number of mothers seeking a health facility delivery.

However, because the traditional leaders have made the bylaws that is why we are having that high number of pregnant women delivering in facilities. Skilled attendant conducts 71% of deliveries. Therefore, we are talking of about 29% happening at home and TBAs....In 2004; we were having 57% of deliveries happening at a facility. Now we have gone up. Although welfare survey in 2009 indicated 75%. Therefore, we have rather gone down (HP # 1).

5.5.1.3.3 TBAs' loss of respect, income and relationship with the health care System

Participants in the three phases observed that when TBAs had to conduct the deliveries, they used to demand a considerable amount of respect from their communities. One TBA reported on the support she received from the community members in respect of her role:

Most of the clients from whom I hire the oxcart do not ask for payment, they say I will not charge the mother because of you mama, I say thank you and I go with the mother (TBA # 15).

Their word was considered paramount as observed by one trainer participant:

Those of us who were going to the communities know that these mothers would listen to what the TBAs were telling them and they (mothers) had completely changed (Trainer # 5).

The communities considered TBAs part of the formal health system because of the working relationship between them and the health care providers. This accorded TBAs respect as well.

They (patients) were being received properly because after we were trained we had a good relationship with facility staff and they were

attending to us promptly. You had given us resources, receivers we were given.... You had given us weighing scales and this was making us look like we were half of the health facility isn't so? Mmh. Yes or maybe a quarter of a facility – (laughs; TBA # 20).

Some of the TBAs stocked items a mother in labor would need and sold them to mothers who reported to them without these supplies.

Did you take the plastic paper? (TBA asking the mother) No, I did not., If there was one we would take that one and give it to her and inform her that she would pay so much (TBA # 8).

Participants in all phases were concerned about the TBAs loss of income and the fact that there were no immediate plans to compensate them.

You know it was their source of income for these old women, they have so many orphans that they take care of, send them to school and that was their source of income...We have indeed created that big dilemma... Loss of income, loss of respect, I mean what have we done! We know most of them are geriatrics. Have we assessed them psychologically? Ooh no! I think we really made a big blunder! If I may say we are policy makers but we blundered and we need to act and act very fast (HP # 2)!

A TBA disclosed the predicament TBAs have found themselves in

Therefore, I would have lodged my complaint that my husband is dead. I get my help from this work. I do not have children as you see me here all have died finish... we are pleading that if we could start our work again, so that we can get some help from there ...As I am saying, our earnestly plea is we would like to be given the opportunity to practice in the open as before. So that we can be doing our work in the open at ease carefully as we were doing before in a cautious manner, as we would be advised accordingly (TBA # 14).

There are no incentives with the new role:

Even if we are helping the mothers now we are not getting anything out of being an escort. That was our only source of income (TBA # 16).

A health professional participant noted this fact:

I think the TBAs have not been given anything else to replace their income (HP # 6).

Participants in all phases agreed that there is need to explore ways of how TBAs could be compensated for the loss of income.

To me I think the issue of TBAs is an emotive issue. Because we say, some people have lost income and in places where people have lost their

income are very sad. So probably I wish there was a way of supporting these people to earn income other than delivering (HP # 3).

After the TBAs were stopped from conducting deliveries, all the benefits they used to enjoy were lost. Further, they were ridiculed by the very people who used to respect them- the local leaders. As a result, the community members joined in undermining the TBAs.

When they (local leaders) came back, we heard from the group village head (GVH) that TBAs stop working, stop! You do not know your work! You are just killing them (the mothers). You are also just butchering mothers' private parts! Taking a razor and cut? Can we really say that the delivery path is narrow let us cut it? Mhu? Mhu? Now we were made fun of by the people! oooh you have lost, we will see what you will eat! As if we were eating the mothers, or as if we were taking the afterbirths and grappled on them (TBA # 20)!

TBA participants were concerned that the good relationship which had existed between the health facility staff and the TBAs no longer existed. Yet despite the directive, mothers still went to the TBAs for delivery. However, TBAs did not have supplies in order to conduct the emergency procedure safely.

Yes. Lay people do not know how to deliver the placenta. Then they rush back to us, we do not have the supplies. Now because you are

persuaded to save the life of the mother, you go look for empty sugar packets instead of gloves in order to help. Thereafter you take the mother to the facility. Therefore, we feel that doing things this way is risky. It is important to put safe measures in case of an emergency. We need supplies, funerals are not good (TBA # 20).

TBAs felt useless with the new role

Now they completely stopped giving us gloves. Even for use in an emergency,...So they have completely thrown us away, they are looking at us as if we are not useful anymore (TBA # 20).

5.5.1.4 **Theme Four: Coordination among partners**

Policy development calls for consultations among stakeholders to obtain commitment and ownership from those to be influenced by the policy. The theme emerged from the two subthemes which included government's stakeholder involvement in decision-making and stakeholders' advice to government.

5.5.1.4.1 **Government's stakeholder involvement in decision making**

Participants in all phases concurred that key stakeholders were not consulted when the decision to stop TBAs was made. Even though some meetings were held, the purpose was to disseminate the new guidelines rather than debate the

TBA services. The implication is that it is difficult to make an informed decision on whether TBAs needed to be stopped from conducting deliveries or not.

If I remember well it came as a directive informing the TBAs to stop conducting deliveries... They were simply told to stop conducting deliveries. Therefore, even though we were telling them to stop some took heed of the instruction but others did not (Trainer # 1).

Some health professional participants reported that stakeholders received the message through the media.

That one (I) am not sure...Because most of them would say we heard about it from television, radio or our Member of Parliament (HP # 11).

5.5.1.4.2 **Stakeholders' advice to government**

Participants in all three phases felt that there was need for consultation before the decision was made.

Because when you are coming up with a policy; you cannot come up with a policy without consulting the users (HP # 4).

Another health professional confessed:

Probably as a ministry, we needed to have listened one, to the women themselves, the influential people in the communities, the TBAs themselves, the village headmen (HP # 2).

Some trainer participants were very concerned with government's authoritative way of stopping all TBAs' activities at once.

Stopping the TBAs abruptly was not good because up until now they do not know why they were stopped. TBAs are still waiting to be told of the reasons for stopping them. They were just stopped abruptly without warning or explanation. They were simply told that you are required to stop! Therefore, we are still waiting for a response that TBAs will be told why one day (Trainer # 10).

Some health professional and trainer participants felt that TBAs should have been stopped in a 'phased manner'.

Well unfortunately, it is something that already took place, but my position should have been say let it be gradual... We can't simply today or next month say we stopped all TBA deliveries... maybe we need to conduct ... some studies to find out -how are our TBAs coping or how is the community responding to the directive. We actually might find out...that TBAs are proliferating ... (HP # 10).

Considering the lack of debate on the decision, participants in all phases felt that the government needed to reverse the decision.

It wouldn't be a bad idea to actually make a U turn and say no we have seen this and that... let's get together and start talking. You know the satisfaction of a client should be our major concern as policy makers. Are our clients satisfied with all this? Are the TBAs satisfied with the new role we have given them (HP # 2)?

5.5.1.5 Theme Five: Mothers' access to skilled birth attendance

In this theme, participants' perceptions of the mothers' access to skilled birth attendance were obtained. The theme emerged from the following subthemes: travelling distances and geographical terrain, mothers' waiting time at the HF, support system for HF delivery, women's status and decision making power, health care worker attitudes and community midwives for community deliveries.

5.5.1.5.1 Travelling distances and geographical terrain

Participants in the three phases observed that not all mothers in Malawi would be able to go to the health facility even if they wished because of geographical barriers and long distances.

That is not possible. Looking at our geographical terrain; it is not possible...maybe it would be because of some geographical barriers, hills, rivers or long distances...impassable terrains from where people live to the facility (Trainer # 9).

Some areas are very isolated to the extent that even health care providers could not reach the areas for the purposes of supervision. A TBA trainer who was a supervisor recalled:

Even us supervisors when we were going there for supervision sometimes we could not manage to reach where the TBA was staying. Sometimes we could get off the vehicle somewhere because of poor road infrastructure and trekked on foot to the TBA. Sometimes we could even get tired and end up just shouting for the TBA to come to us instead of us reaching up to her home, sometimes with an impassable river between (Trainer # 8).

5.5.1.5.2 Mothers' waiting time at the health facility

Participants in all phases observed that the fact that mothers were not able to predict how long they were going to wait for labor to start at the facility resulted in them postponing the trip to the health facility. Consequently, mothers were depriving themselves of the opportunity of skilled attendance at birth.

Because sometimes dates- since they are required to go and wait at eight months. So all this time the husband will be alone without a wife? With no one to cook for him and maybe they do not have a grown up child to do the household chores. More so, the guardian's husband is also alone. As a result, the husband will go and get infected because men and women differ in the desire for sex. He will even end up

importing AIDS whilst you are at the facility awaiting while he goes hunting... That is why mothers say no I will wait for labor to start and just go there to deliver (TBA # 20).

Absence of a reliable family member for a guardian for both the mother and her family at home compounded the problem.

Some do not have adequate numbers of relatives, just her mother or her mother in-law to look after her family back home. Therefore, she is left to community members' consideration in order to find one as a guardian (Trainer # 6).

Lack of financial and food resources for the waiting mother and the family force mothers to postpone the trip indefinitely:

As for food you do peace jobs in order to get that day's meal. Therefore, those responsible in refilling your consumables at the facility the same have to fend for the family back home (TBA # 20).

5.5.1.5.3 Support system for skilled birth attendance

Participants in all phases inferred that inadequate support for the health facility delivery prevents mothers from accessing skilled birth attendance. Several factors emerged which influence mothers' support systems for facility delivery which included infrastructure and availability of a suitable sleeping accommodation for mothers when they awaited the onset of labor at the health

facility; supervision of facilities in rural areas, adequate material and human resources and availability of MNH services.

In this study, participants in all phases were concerned that although mothers had taken heed of the directive to go and deliver at the facility, the facilities were not equipped to manage the potential influx of mothers to the facilities.

The hospitals are overwhelmed, a room meant for about 20 women was accommodating 60 - 70 women. During the day, they would sit outside and during the night that is when they would come back and sleep... (HP # 9).

A TBA trainer who was a provider was concerned about the inhumane manner in which mothers were being accommodated.

There is a problem of lack of space in most of our facilities...we visited a facility where we found a hut made of logs and thatched with grass and falling on one side where pregnant mothers were sleeping awaiting labor. Therefore, during rains that hut would not be suitable for use. In most facilities space is a problem (Trainer # 1).

Another trainer made the following observation:

In addition, if you were to go to the ward in the evening to see for yourself where these mothers are sleeping--- THEY ARE HEAPED LIKE BAGS OF MAIZE having been heaped one on top of the other (Trainer # 9).

As a result, some facilities sent waiting mothers back home without any guiding policy which confused the communities. A health professional participant was concerned about it:

Otherwise, we are sending two different messages. We are on the radio telling them (mothers) please go and deliver at the facility and when they go to the facility somebody is sending them back (HP # 3).

Upon realization that the situation had gotten out of hand a health professional was really concerned.

No. and if anybody is doing that that is an offence! The hospital is not supposed to send anybody back!... What hospital is that? At central level if somebody is sending a patient away, I will be concerned... Because otherwise if people are making some policies without us knowing we cannot help (HP # 3).

However, some health professional participants acknowledged the dilemma faced by the providers and concurred with them that space is a challenge.

So even now, we are having problems with space. Mothers are sleeping on the floors... because of inadequate space. If the mother wants to go to (a) HF she can but I should be frank that the space is not there. Because

even some antenatal mothers are sleeping in the guardian shelter which is not right (HP # 5).

Participants were concerned with inadequate numbers of skilled birth attendants at the facilities.

Now at times that one midwife will go and attend a meeting or training that means when she (the mother) goes there she will be attended by the female ward attendant or hospital attendant. Therefore, these are some of the things, which will sometimes encourage mothers to go to the TBA because they know that the TBA has more experience than the one whom we will find at the facility (Trainer # 2).

A TBA participant expressed her concern:

Because we from Chiwota we feel sorry for our nurse-midwife. There is only one nurse-midwife, Nabanda... For an individual to be delivering throughout the night, delivering almost 100+ per month! We are feeling sorry and wonder whether she has time to eat ... (TBA # 20)!

Participants reasoned that this deterred mothers from making the effort to go to the facility for delivery.

They are saying because our health centers are so short staffed. It does not matter because when they go to the HC they will still be delivered by hospital attendant or even her own mother and in the HC. The midwife is

not there... she is not there that day... Therefore, the mother ends up being delivered by the hospital attendant (HP # 2).

Health professional and trainer participants reported that health facilities lacked the necessary drugs for pregnant mothers:

Drugs are still scarce in the facilities. Even with us, we are not able to give our mothers ferrous (sulphate) and SP (Sulphurdoxine Pyremethamine) drugs...some (mothers) are completing ANC without receiving a single dose of SP or ferrous (Trainer # 8).

Participants in all phases observed that the community MNH system was still deficient.

Therefore, what we are doing is actually we are taking the women from the community; send them to the HFs where there are inadequate resources, we do not have waiting homes, we do not have resources, and we don't have the midwives... In solving one problem, WE CAME UP WITH ANOTHER BIG PROBLEM. We are seeing a lot of women going to the hospitals but delivering on their own or delivering at the guardian shelter (HP # 8).

Health professional participants were concerned that the consequences of the vacuum would soon manifest itself in the national indicators where a reversal in the gains made would be observed:

Because now the gap is widening and the consequences on our maternal mortality are going to be seen in the few years to come. Instead of us reducing this I do not know, we will even going to climb. ..This policy- I think it was not on time, it was not introduced in a proper manner and we are seeing the consequences (HP # 2).

5.5.1.5.4 Mothers' status and decision-making power

Participants in all phases felt that mothers' low status and lack of power in decision-making prevented them from exercising their right to access health care. It was generally reported that the decision not to go to a health care facility for delivery was made on their behalf by significant others.

People need to discuss first before a decision can be made for the mother to go to the health facility. Our mothers are not empowered enough to make their own decisions to seek care.mmh (Trainer # 1).

Decision making power is often invested in other people likely to provide support at the time.

Maybe people are still waiting for the husband to come, or maybe an aunt, an uncle to make the decision for them to go to the hospital (HP # 9).

5.5.1.5.5 **Health care worker attitudes**

Participants in all phases reported that mothers at the health facilities met providers who were bullies, unfriendly, harsh, rude and abusive towards them.

They say very foul language to these women. They have repeated some of the language that the midwives utter. It is really a shame. Some of them are even beaten, scolded, pinched (HP # 2).

A health professional participant said:

When the woman is in labor, they would like to be communicated to. However, it is as if the providers have a sealed mouth. They do not talk to the pregnant women (HP # 1).

When the mothers reported to the health facility at night, the nurse-midwife was not readily available to assist. The process of calling the nurse-midwife on duty was tedious and sometimes intimidating to the guardians involved.

If you follow them (NMs) in the night.....The moment you knock on the door the lamp goes out and all becomes quiet. Why are you coming here alone? Go get the guard. Now you rush back to go and call the guard, the guard will ask you -have the waters broken already... that we should go and call the doctor (nurse-midwife)? As you go with the guard the baby is

being born behind you. They are simply picking up babies already born (TBA # 14).

Trainers and TBA participants reported that mothers seeking care were sometimes turned back from the health facility which resulted in untold miseries.

In my village somebody (pregnant) went to the facility... Did you (NM asking a mother who reported in labor) calculate your days well?... Go back. Upon arrival at home, the pains continued...So I took the knife (kitchen knife). However, when I cut the cord the baby was bleeding so much all over the place... I...called my husband and showed him that this (referring to the placenta) is not coming out of me... My husband started pulling and pulling, luckily it came off... The baby developed yellow fever and the same day the baby died. The mother had a tear, they sutured the tear (at the facility; TBA # 8).

Another TBA said that midwives' unavailability for the laboring mother can put both the mother and baby in danger. Some had their own personal stories to tell.

She (nurse-midwife) assessed her and said I think she will deliver in the morning. I (TBA respondent) went and knocked on the door again, she responded saying I told you that she would deliver in the morning... Then

I heard a definite push, when I peeped, I saw the head I just rushed and caught the baby (TBA # 20).

I (TBA) came to the labor ward with my child mmmh--- iiih---- she was carrying twins... the first baby was in transverse and the second one was lying in normal position... they did not assist her on time until she went into labor, ...I ...pleaded with them to do something with my child... the doctors started shouting at me. You are going to deliver her yourself! Now instead of taking her for operation in time they took her too late. I managed to secure one baby only. The other ended up a stillbirth --- (TBA 22).

Participants in all phases observed that health care workers display negative attitudes as part of their character and not necessarily because of the workload.

We have lost a number of women not because of not having adequate resources, not because we did not have doctors, or maybe we do not have whatever but because somebody's attitude towards that particular patient (HP # 8).

However, health professional and TBA participants observed that these experiences were prevalent among the young health workers who had no experience of what labor is really like and therefore could not be empathetic.

You have trained these new nurses yes? Mmh. You deploy them to HFs. They know pregnancy through a pencil like that one! But the real labor pains they know not"! (Mmmh others agreeing). Now when the mother is lying on the bed in pain, groaning gash, gash, should they ridicule her? Are you groaning? Are you crying? ... They speak real obscene language! Is it me who slept with you (TBA # 20)!

Participants observed that Malawian women continue to bear children to an advanced age and may refrain from using the facilities because of the insults received from younger providers.

Malawi has got a high fertility rate and older mothers are still delivering- (even) at 40... so they (mothers) would not like to face the insults of the younger health workers in the facilities. So they shun away from hospital deliveries (Trainer # 5).

However, some health professional and trainer participants believed that although negative attitudes were prevalent, not all providers had negative attitudes towards the mothers.

But to me its not at the level that the community or media is putting it – I think there are those cases whereby women are ill treated in some cases but not as much as it is being portrayed. ... This scope that we have because when you hear it, its like every time you go to the government

hospital and you are pregnant you will be mistreated I don't believe so
(HP # 10).

Participants observed that all stakeholders were equally responsible for the negative attitudes displayed by young midwives.

These children that we call midwives are coming from the same communities. So some of the bad attitudes are actually coming from them. Therefore, we have to work and assist one another – concerted efforts to change these attitudes (HP # 9).

5.5.1.5.6 **Community midwives for community deliveries**

Participants welcomed the idea of community midwives and inferred that that would be a good idea and a sure way of filling the 'gap' which has been created through the moratorium on TBAs.

My opinion...I could see it in the long run if they are several of them in the community that is the way maybe TBAs would naturally die a natural death (HP # 9).

However, some health professional participants cautioned that these midwives would not fall into the category of skilled birth attendant.

Nevertheless, to add on that because CMs the ones that are being trained now, they may not be skilled in terms of definition by (the) World Health Organization (WHO) and (the) International Council of Midwives standards. Because (the) minimum requirement for the skilled attendant at birth is three years and these are being trained for 18 months. They are well trained but they may not be defined as skilled by WHO standards (HP # 8).

Another HP participant concurred that bringing care to where mothers are is the best feasible option to improve skilled birth attendance.

Am an advocate for bringing the midwives to the community and not the other way round- mothers to the hospital. In addition, those midwives can work with the TBAs, and redefine their roles; I think things can work without any problems. So I think we need to look at that again (HP # 8).

Some trainer participants had advice regarding community midwives:

Provided the women that are chosen are mature enough,... have adequate training, skills, and the equipment that they need; I have no problem... I think mothers would also like it because it will be within their communities. Yes. Most of our Malawian women would like to deliver at least within. Yes. Rather than away- so many kilometers away (Trainer # 2).

Involvement of the chiefs was seen to be paramount.

In addition, if the chiefs select these because they are the ones who know who has been to school, and to consider not taking more people in one village but to consider each village. Yes (Trainer # 3).

Some TBA and trainer participants also warned that they could not see a young, well-trained midwife going to work in the rural, remote and hard to reach areas which are sometimes hostile to live in with no amenities available.

However, I fear that somebody who has undergone such training cannot accept to go and work in the far off villages. You know when people are trained they know that they are empowered, sought of emancipated and may not accept to go to rural areas (Trainer # 7).

5.5.2 Summary of Qualitative Findings

Figure 5.13 summarizes the perceptions of participants in the focus group discussions and in-depth interviews. Those who supported the changing role attested that TBAs did not have the capacity to learn new ways of managing_pregnant mothers due to their advanced age and poor educational background. Furthermore, TBAs continued to practice outside of their scope of practice and subjected mothers to harmful traditional practices despite the training. Moreover, the TBAs were not skilled birth attendants and therefore were frustrating the government's efforts to achieve the MDGs with their substandard care.

The proponents of TBAs on the other hand contended that despite the fact that TBAs were not skilled and were considered not to have contributed towards the reduction in maternal mortality rates, they were still of service to the mothers in underserved, rural, remote and hard to reach areas. They feared that the rushed decision would result in a reversal of the gains achieved this far as TBAs had gone underground and therefore were not supervised. The TBA proponents asserted that the health care system cannot manage every pregnant mother seeking skilled birth attendance and that not all mothers can make it to the health facility even if they wished to do so.

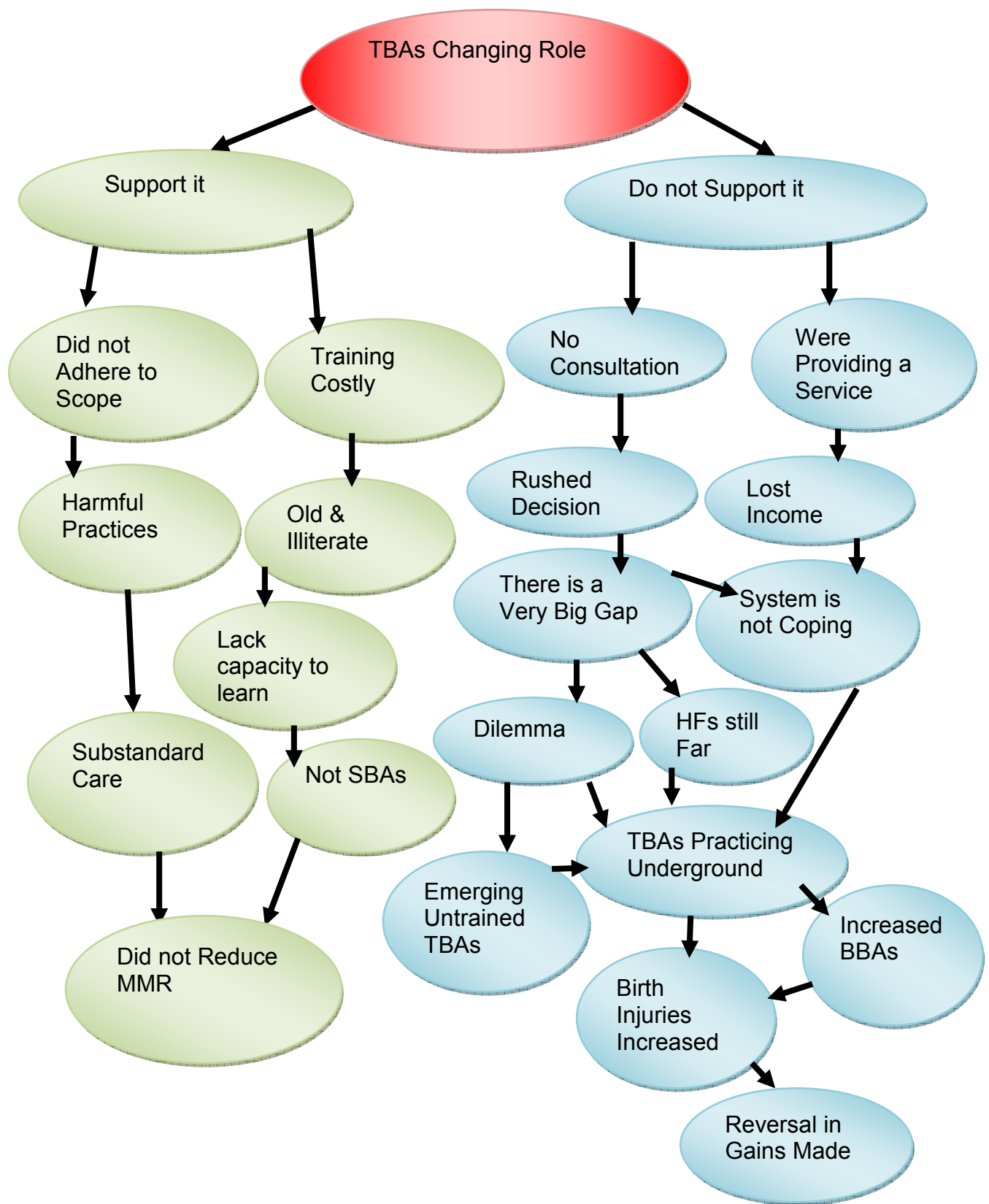


Figure 5.14: A Summary of the in-depth interviews and FGDs on the moratorium on TBAs

5.6 CONCLUSION

It is clear from the findings that there are conflicting views on whether the moratorium on TBA services was the best solution for Malawi. However, both participants and respondents in the study have inferred that TBAs are still practicing although respondents were not happy with the performance of TBAs. The findings show that long distances and lack of preparedness of the system to cope with the sudden demand for skilled birth attendance were some of the reasons why mothers continued to deliver outside health facilities. Findings also show that providers in these facilities were not able to provide all the seven signal functions of BEmONC. Their competency in providing MNH care was also inadequate. Further, findings also show that failure of the TBA services was a failure by the system as well. Because of this, proponents of the TBA service found it difficult to support the instituted moratorium. The findings show the need to review the decision in order to put in place effective mechanisms and systems that will facilitate mothers' access to skilled birth attendance as the current system is failing. The following chapter will present the discussion of both the quantitative and qualitative findings of the study in an integrated manner. Finally, recommendations and limitations of the study and the need for further research will also be presented in the same chapter.

CHAPTER SIX

DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter presents the discussion of both the quantitative and qualitative findings. The mixed method paradigm provided for convergence or divergence of the study findings. Literature has been integrated to determine consistency or divergence. In addition, the chapter presents the summary and the recommendations of the study on perceptions of key stakeholders of the changing role of TBAs in rural areas of CWZ, Malawi. In the discussion, pseudonyms have been used in place of names of people, locations and institutions.

6.2 DEMOGRAPHICS OF THE MOTHERS AND CHARACTERISTICS OF THE NMs RESPONDENTS

The overall picture made was that generally mothers were married (93%), uneducated with 62% having attended lower primary school only. The majority (95%) of the mothers were poor and depended on subsistence farming and 73.6% travelled distances of more than five kilometers to access a skilled birth attendant. Fifty six percent were grand multiparas who are more at risk of developing pregnancy and labor related complications. Notable was the fact that a few (2%) of the mother respondents who had come to the facility awaiting labor reported that they were single. Although the figure is low, it is still unusual in Malawi especially in a rural setting where it is culturally

expected that every pregnant mother must be a married woman. Lack of education is associated with unemployment and therefore poverty (Yakong, 2008). In addition, there is little ability to assimilate health choices in order to effectively negotiate access to an appropriate health care provider. This view was also supported in Bangladesh by Anwar, Killewo, Chowdhury *et al* (2004) who reported that poor mothers tended to seek care from unskilled providers. It has been observed that mothers in these areas were generally poor with no or very little education. Therefore it can be concluded that these mothers were not empowered enough to be able to demand appropriate care from skilled providers. Sicchia and Maclean (2006) contend that 70% of the world's poor are women due to inadequate education. Thus, low educational status coupled with unemployment means women lack negotiating skills and this renders them the most vulnerable in the society, resulting in their dependency on husbands for decision-making (Pindani, 2010; Rath, Basnett, Cole *et al* 2007). In this study mothers depended on aunts, mothers-in-law and uncles to make health related choices. Ensor and Kooper (2004) in their study of low and middle income countries revealed that where a mother has no voice on the state of affairs, it does not make any difference whether she is aware of her need to access care or not.

Sixty four percent of the nurse-midwives had been working in the health facilities for more than two years. This meant that the majority of the nurse-midwives were well conversant with the facilities and their catchment areas. They were also well informed of the available services to the communities and the existing relationships.

6.3. SUPPORT SYSTEM FOR MNH CARE SERVICES

This study has revealed that the health care system failed to support the TBAs when they were conducting deliveries. Ironically, the same system also failed to provide adequate support for skilled birth attendance. The factors contributing to the health care system's failure were multifaceted and included substandard TBA training and over reliance on donor support which made the program unsustainable. Further, health facilities in rural areas continued to experience shortages of drugs and supplies and some BEmONC facilities were not able to provide all of the BEmONC signal functions. There was a lack of supportive supervision to the TBAs by health care providers who in turn were never supervised by their DHMTs. In addition, although the health care system created the demand for skilled birth attendance, inadequate provisions were in place to motivate mothers to seek skilled birth attendance.

6.3.1. TBA Training was Substandard

In this study, 92.7% of the nurse-midwife respondents reported that TBA training was inadequate. Findings show that TBAs' training did not empower them enough to provide competent care for them to make a significant contribution towards reducing the maternal mortality rate. It was reported that the *content was too much, the duration was too short and TBA trainers were not adequately* prepared to deal with an elderly, illiterate learner. Participants contended that TBAs needed extra time to correct their harmful practices before proceeding with the acquisition of the required skills and the four-week training period could not provide for that. Moreover, their training excluded hands on experience in real life situations. Therefore, participants concluded that what took place was actually an orientation to the TBA training.

The majority (96.4%) of the nurse-midwife respondents reported that TBAs were not given refresher courses as was planned. Participants in the qualitative phases who observed that the trained TBAs were taken in small subgroups for refresher courses affirmed this. Further, these refresher courses were inconsistently done and some TBAs who were favored were called more often for refresher course than others. In addition, participants argued that it was wrong to capitalize on the trainers' previous knowledge. Instead, program managers needed to consider trainers' skills and adequate time for TBA training as paramount for the success of the program they asserted. *Moreover, nurse- midwives would just be picked to go and teach TBAs having not undergone any training of trainers.* Therefore, some trainers ended up just copying what others were doing and that also depended on the availability of an experienced trainer in the team. Participants thought that culture, age and the qualification of the trainers should have been considered when selecting TBA trainers.

These findings are consistent with what Izugbara, Ezech and Fotso (2008) in Kenya reported. The authors observed that the TBA training period was too short for them to have been able to contribute to reducing maternal and neonatal mortality rates. UNFPA (1996) also reported that the trainers, given the short training period, were not adequately prepared for their role. The report reasoned that it was erroneous to capitalize on the fact that trainers were already practicing the learning content. Sibley, Sipe and Koblinsky (2004) in their study conducted in eight developing countries concluded that criteria for both trainers and trainees were necessary in order to obtain the desired learning outcomes. In this study, it has been noted that trainers were not

empowered and the training period was too short, therefore even though programmers expected the best from the TBAs the entire program was not suitable for either the context or the type of learners.

6.3.2 TBA Program Depended on Donor Funding

Partners in consultation with the Malawi government initiated the TBA program. After training, TBAs were supplied with delivery kits which contained some drugs, supplies and a limited amount of equipment. However, replenishment of these kits proved problematic. Some TBAs who depended on their area HSAs to refill their kits were disappointed as their HSAs did not cooperate. *Drugs were always out of stock according to him (HSA), so we simply got tired and stopped asking.* Some facility staff were reluctant to refill TBAs' kits because they had neither recognized nor accepted the TBAs. *Sometimes during visits, one would find TBAs using plain hands to deliver mothers.* Supervisors would then advise them to use empty sugar packets to protect themselves and the mothers which was not ideal. UNFPA (1996) reported that TBA programs in developing countries were indeed dependent on donor funding. When the partners shifted their focus from TBA training to the training of skilled birth attendants, the TBA program suffered in terms of resources (WHO, 2002 and Bergstrom & Goodburn, 2001). It can be argued that the study has revealed that TBAs were not given an enabling environment for them to make a significant contribution towards perinatal care.

6.3.3 Lack of Drugs and Equipment for MNH Care

Just as TBAs experienced a lack of resources, 61.1% of mother and nurse-midwife respondents (73%) also reported that facilities did not have adequate drugs and supplies. Eighty two percent of nurse-midwives indicated having inadequate equipment. The lack of resources at the facility compromised quality of care. Mothers were informed that at the facility they would receive the necessary antenatal care they needed but when they went for the services they were told otherwise. *Some are completing ANC without receiving a single dose of SP (antimalarial) or iron.* Moreover, some delivered without knowing their HIV status because of a lack of testing kits. Mothers were told to buy their own supplies for delivery and yet they were told that facility delivery was free.

Participants asserted that even though mothers were assured of skilled birth attendance at the facility what they received was an irony. *Therefore, what we are doing is actually taking the women from the community; send them to the HFs where there are inadequate resources, we do not have waiting homes, we do not have resources, we don't have the midwives.* In corroboration with the above findings, Mbaruku (2005) in Tanzania reported that lack of essential equipment, drugs and supplies contributed to poor quality care that increased the number of maternal deaths in Tanzania. In Kenya, Izugbara *et al* (2008) reported that the poor quality of MNH care was due to chronic shortages of basic equipment, drugs and supplies. Therefore it can be concluded that the reason why there has been no momentum in the reduction of the maternal mortality rates in spite of the moratorium on TBAs is that the health care

system lacks the capacity to provide quality maternal and neonatal care for every mother and newborn in need.

6.3.4 Some BEmONC HFs in Rural Areas did not provide BEmONC Services

The nurse-midwives interviewed (n=55) were only able to provide three (out of seven) BEmONC functions, namely administration of parenteral uterotonics, administration of parenteral antibiotics and resuscitation of the newborn. Although 56.4% of the nurse-midwives interviewed were trained BEmONC providers, only 22% felt competent to conduct vacuum extractions and only 31% felt competent to undertake a manual removal of the placenta. Further 49% of nurse-midwife respondents felt competent enough to conduct a manual vacuum aspiration of the products of conception. This implies that although a trained BEmONC provider would attend some mothers, in these BEmONC facilities they would still not be able to access emergency obstetric care if the need arose. In addition, health facility data showed that only eight of 24 (33%) BEmONC facilities were fully functioning as BEmONC sites. Further, no facility under study was able to provide a full package of focused antenatal services and that included PMTCT services in four facilities.

Similar findings were observed in an assessment done in four countries by Harvey, Ayabaca, Bucagu *et al* (2004) who reported that not everyone with a medical, nursing or midwifery training could be classified as a skilled birth attendant because though trained, providers lacked the skills to competently deal with complications responsible for most of the maternal deaths. Indeed not all trained BEmONC providers in these facilities were competent to provide all

the BEmONC functions. Although all the sites used in this study were BEmONC facilities not all sites were providing BEmONC functions.

6.3.5 Supervision of MNH Services in Rural Areas was Inconsistent

In the study, 89% of the nurse-midwife respondents reported that TBAs were not supervised as planned. In confirming the quantitative data, participants in the qualitative phases observed that TBAs were mostly visited by their supervisors *when something has gone wrong*. TBAs complained of being inadequately supervised or even not at all. Moreover, the few times that TBAs were visited it was without prior notice from the supervisors. As supervisors were striving to provide consistent support to the TBAs they resorted in co-opting the HSAs-*we were highly dependent on area HSAs to assist us supervise these TBAs*. Yet these HSAs were not trained in MNH care, therefore their visits were more of a courtesy call than supervision.

Participants in the study agreed that the problems that TBAs encountered were *not of their own making* but that the system *gave them a raw deal*. Thus, although the policies were progressive the same could not be demonstrated in practice. Therefore, TBAs having been left to operate without any meaningful support from the formal health care system felt detached, unappreciated and unrecognized. As a result, participants concluded that TBAs were failed by the very system they were serving. Moreover, 71% of nurse- midwife respondents reported that like their TBA counterparts in the rural areas they also did not receive adequate supervision from their management teams. Participants in the qualitative phases gauged these findings where they too observed that staff were not supervised by their DHMTs accordingly.

Consider even what is happening now; years go by without DHMTs supervising their people. They would only go if there is a special activity but not for supportive supervision. Facilities that are supervised every quarter are negligible.

The finding is in line with WHO's (2004:8) observations that "It is now generally accepted that one of the main reasons why many TBA based maternity care programs were unsustainable...the program failed to link TBAs to a functioning health care system, ... TBAs did not work within an 'enabling environment". In its report of 1996, UNFPA observed that supervision was acutely limited in almost every country. "The more rural the TBA, the least frequent she reported to have been visited" (UNFPA 1996:5). Such observations are true for the providers as well. WHO (2006a) stated the need for supportive supervision of all providers at all levels of service delivery.

As a result, TBAs continued to practice outside their scope of practice in order to sustain their relationship with the mothers, the only partners who remained with them. This gave room to their returning to old harmful, cultural and traditional practices. TBAs would use herbs in order to treat tears, episiotomies and correct malpositions. Any mishaps that occurred would be attributed to the mother and not the TBA. *You and your husband have killed the baby*; therefore, TBAs free of blame and lack of supervision from the formal system were left to continue their malpractices.

Lack of adherence to the TBA scope of practice was also reported by Peltzer *et al* (2009) in South Africa who inferred that sometimes TBAs operated outside their limits and would assist mothers with complicated deliveries. TBAs in this study also stated

the same however; they quickly defended their actions and blamed it on mothers reporting to the TBA in the second stage of labor. In Nepal, Falle, Mullany, Thatte, *et al* (2009) asserted that although TBAs reported their willingness to refer complicated or at risk mothers, it was evident that decisions to refer these mothers were not forthcoming. UNHCR (2006) emphasized that harmful practices affect women and girl children first and foremost and are an expression of gender violence especially in situations where mothers and girls do not have adequate education. In their report, Bergstrom and Goodburn (2001) warned that no amount of TBA training would alter TBAs' engraved belief systems. Ofili and Okoje (2005) in Nigeria reported that several diseases and conditions affecting mothers and newborns who subscribe to TBA assistance during delivery were a result of TBAs' harmful traditional practices.

6.3.6 Demand without supply

After the moratorium on TBAs, mothers continued to travel long distances in order to access skilled birth attendants. However, in the health facilities there was demand without supply. The more mothers the system beckoned to go for facility delivery the more the system was not coping. This study has revealed that long unpredictable waiting times compounded by unsuitable accommodation deterred pregnant mothers from checking in at the facility in time to await labor. Further, critical staff shortages persist in the health facilities operating in rural areas which force mothers to be delivered on their own, by their guardians or facility cleaners. Moreover, means of referral were not well established.

6.3.6.1 Unpredictable waiting times and unsuitable accommodation

Mothers are required to wait for the onset of labor at the health facility when they are eight months by dates. The expected date of delivery is calculated from the mothers' history of her last menstrual period. If a mother makes a mistake and gives incorrect information, her due date will be inaccurate. As a result, a mother may wait at the facility for two months or more. On the other hand, the mother may go into labor at home because of incorrect calculations. In the quantitative phase 90% of nurse-midwife respondents said that mothers waited at the facility for more than two weeks for the onset of labor. This is a long period if one considers the many responsibilities placed upon the mother in the home.

Waiting at the facility has certain implications participants observed: *So all this time the husband will be alone without a wife? With no one to cook for him and maybe they do not have grown up child to do the household chores.* If they have young children, there will be a need for someone to look after the children. The guardian's family will also have been deprived of a female head. As a result, the husbands of these two homes may end up being unfaithful to their wives as the women continue to wait indefinitely at the facility. Two percent of mother respondents confirmed these fears when they reported that they were single. These mothers reported that news had reached them whilst waiting at the facility that their husbands had taken other wives. Some mothers also do not have adequate numbers of family members; therefore, *she is left to the community's consideration in order to find one as a guardian.* Moreover, those

remaining at home might be required to do *piece jobs in order to get that day's meal. Therefore, those responsible in refilling your consumables at the facility the same have to fend for the family back home.* In addition, the mother is required to take her own utensils, in which food at the facility will be prepared. This deters mothers from going to wait at the facility.

In Tanzania Magoma et al (2010) who revealed that the Watemi and Maasai women refused to leave their families unattended to go and wait for delivery at the facility also reported similar findings. In Nigeria, Salako, Oloyede and Odusoga, (2006) reported that mothers resort to TBA use because of long waiting times at the facility, amongst other reasons. These factors therefore influence mothers' timely reporting to the facility in order to access skilled care at birth.

More than half of both the mother (61.1 %,) and the nurse-midwife (69.1%) respondents reported that there was inadequate space for all mothers seeking skilled birth attendance. Fifty one percent of the nurse-midwives said that mothers used floor beds for delivery. Participants in the qualitative phases corroborated with their counterparts in the quantitative phases when they observed that when mothers go to wait for facility delivery, they are ushered to sleep in the guardian shelter. This is done because other waiting mothers would have filled the small postnatal ward. *Mothers are packed like bags of maize one on top of the other* during the night. A health professional participant finally

declared: *If the mother wants to go to the health facility she can but I should be frank that the space is not there.*

Without a clear policy in place, facilities made their own policies whereby they were selecting mothers who came to wait and would tell them to *go back home and come when labor starts*. Facility data showed that an average of ten mothers waited in these facilities with an average of six deliveries in 24 hours. In one of the study sites, there were two nurse-midwives, two labor beds and they had had 12 deliveries in 24 hours with 44 waiting mothers. Seljeskog *et al* (2006) in Mangochi Malawi made similar observations when they reported that women in labor sat on the floor waiting for a chance to get a bed on which to deliver. Moreover, the labor ward was so hot in the intense heat of Manbochi with only one working fan for the whole labor ward.

6.3.6.2 **Persistent staff shortages in BEmONC facilities in rural areas**

Findings show that the majority of health facilities in the study areas had an inadequate number of skilled birth attendants. Among those available, there were inadequate numbers of BEmONC trained providers. The findings revealed that of the 55 nurse-midwives who were interviewed only 31 (56.4%) were trained in the provision of BEmONC services. Facility data showed that there were a total of 108 nurse-midwives in the 24 BEmONC facilities but only 60 (55.5%) were trained BEmONC providers. Fifty six percent of nurse-midwife respondents admitted that mothers delivered unattended at the facilities.

The qualitative data confirmed that the critical shortage of midwives continued to haunt some facilities including the BEmONC sites in the rural areas. *We are seeing a lot of women going to the hospitals but delivering on their own or delivering at the guardian shelter.* Respondents and participants in all phases observed that understaffing in the health facilities is de-motivating mothers from seeking skilled birth attendance at birth. *They are saying because our health centers are so short staffed. It does not matter because when they go to the HC they will still be delivered by hospital attendant or even her own mother and in the HC. The midwife is not there... she is not there that day...* The implication is the quality of care. Reported self-deliveries and assisted deliveries by unskilled people cannot attract mothers if they can have an assisted delivery at the TBA who has some knowledge and skills.

Titaley, Hunter, Dibley *et al* (2010) in Indonesia reported similar concerns where it was observed that in some villages the only village midwife frequently travelled leaving the facility unmanned. WHO (2008b) observed large within-country differences between the poorest and the wealthiest of the population. Inequalities between population groups were particularly high for maternal and neonatal care, which included antenatal care and the presence of a skilled attendant at delivery.

6.3.6.3 **Inefficient referral system**

All respondents and participants were concerned that mothers in the study areas lived in far, rural, remote and hard to reach areas. In the study area, 74%

of mothers travelled a distance of more than five kilometers in order to access MNH care. Data from health facilities confirmed these findings. Mothers in the study areas could travel a distance of up to 35 Kms with an average distance of 21 Kms in order to access MNH care. Trainer participants who were supervisors said that sometimes when they went to supervise, they would get off the vehicle at some point and continue on foot. Sometimes supervisors would *end up just shouting for the TBA to come to us instead of us reaching up to her home* after getting exhausted because the roads were nonexistent or in disrepair, *sometimes with an impassable river* without a bridge between them. During the rainy season, when the waters have swelled even if a vehicle waited on the other side of the river, the mother would not make it on time to the health facility.

The majority (94.6%) of the nurse-midwife respondents reported that TBAs did not have a reliable means of transport for referral of their patients. Given the poor terrain and nonexistent road infrastructure and geographical barriers in areas where TBAs operate, it was a challenge for TBAs to refer mothers to the health facility when the need arose. Most of the times TBAs, with the help of the community, would resort to the use of *oxcarts, bicycles, improvised stretchers* and wheelbarrows to take the mother to the facility and this was very slow. Sometimes the mother's family would be required to pay for the transport if it was hired. *In order to avoid giving a bad image of their place* if the mother died TBAs offered *to sponsor the trip to the hospital* by hiring the available means of transport to the facility should the family not be able to afford it.

Chitsa Banda (2003) in South Africa reported that respondents were dissatisfied with the transport system because of delays in response to an emergency call. Thus, distances and inefficient transport systems coupled with poor terrain and geographical barriers force mothers in the study areas to deliver outside of health facilities. In Nepal, Thatte *et al* (2009) observed that the TBA referral system did not function efficiently because TBA referral was not included during the planning of the TBA program. Similar observations were also made in Bangladesh by Anwar *et al* (2004) who said that home deliveries had no links with efficient transport to emergency obstetric care and therefore home deliveries proved ineffective. The implication of these findings is that the moratorium on the TBAs in Malawi would still not be effective if an improved transport system was not one of the integral components of the national plan.

6.3.7 MNH care services in rural areas are deficient

When the moratorium on TBAs was being decided upon, no preparations for a likely increase of clients to the facilities were planned for. As a result, the health facilities were not coping in providing skilled care for every pregnant mother coming to access skilled birth attendance. Two thirds (66.7%) of the mother and the majority (95%) of the nurse-midwife respondents alluded to the fact that the facilities were not capable of managing the number of mothers who sought care at the health facilities after TBAs were stopped from delivering. Participants in the qualitative phases concurred with their counterparts when they observed that mothers in the rural areas received contradictory messages. *We are on the radio telling them (mothers) please go and*

deliver at the facility and when they go to the facility, somebody is sending them back because they cannot cope.

Participants reasoned that *the gap is widening and the consequences on (for) our maternal mortality are going to be seen in the few years to come* when we shall register a reversal in gains that have been made this far. TBAs registered some maternal deaths in their areas due to a lack of adherence to their scope of practice. Ironically, health facilities had also recorded perinatal deaths. Health facility data showed that all of the facilities under study had experienced fresh stillbirths in a one-year period. A total of 18 maternal deaths occurred in 11 of the 24 health facilities studied. This shows that referral systems in these areas were still deficient as mothers with complications are expected to be referred to a hospital in time where they would obtain comprehensive emergency obstetric and neonatal care. No mother is expected to die at this level of service delivery. WHO (2008b) advised governments to institute strategies that are feasible and sustainable in bringing every mother for skilled birth attendance. WHO therefore recommended a phased in approach to skilled birth attendance at every birth.

In this study, it is inferred that accessing the health facility did not guarantee skilled birth attendance at birth. Neither did it guarantee complete antenatal care for mothers. The study has revealed that when complications arose, not all mothers in need were able to access BEmONC services in these facilities. Transport for referral to district hospitals was uncertain. Safe delivery in these facilities remained uncertain. There was a strong view from mothers that it did not really matter where they delivered, whether

at home with a TBA or at the health facility with unskilled and untrained hospital cleaner.

6.4 TBAs' CHANGING ROLE

Findings of the study show that some TBAs were members of the MNH task forces and Safe Motherhood Committee. However, mothers (64%) reported that TBAs did not carry out that role. TBA participants having misunderstood their new role, confirmed the mothers' observations with discontentment and said that *when we were told to stop aaa we listened. Now our job is that of a counselor telling people (mothers) to go for a facility delivery*. As a result, TBAs did not consider themselves active – *we are just staying*. Therefore, perceptions of the people in the community were that with the moratorium, TBAs were no longer active in MNH activities.

Despite the controversy about the abrupt way in which TBAs were stopped in rendering their services, most respondents and participants agreed with the opponents of the TBA model that having moved away from the TBAs it might not be proper to revert to them. Mother (74%) and nurse-midwife (94.6%) respondents concurred with some of the participants in the qualitative phases that it was good to ban TBAs from conducting deliveries. It is worth noting that respondents in the study, especially mothers themselves, realized that a facility delivery with assistance from a skilled provider is a mother's best option.

The MDG report (UN, 2010) stated that the TBA is a sad reminder of the low status accorded to women especially the poor, rural and remote mothers in many societies.

Pregnancy and delivery needs to be everyone's business. "Let us keep the promise" Ban Ki-moon is reported to have said (UN, 2010:3). WHO (2006a) has stated that skilled care at birth should be a non- negotiable national priority. However, the socio-cultural context of most of the developing countries supports home deliveries and yet skilled providers are not available at that level. Ebuehi and Akintujoye's (2012) study in Nigeria is not consistent with the findings of this study. They reported that only 17% of the respondents were of the view that TBAs should be banned from assisting mothers during labor. This divergent view could be due to the fact that in Osun State, Atakumoja muslims and Christians Apostolic Church (CAC) members constitute the majority of the population. CAC members are not allowed to access health facilities for health care services (Olowe, 2003). This means that mothers from this religion deliver at home. Therefore, a combination of muslims (who would rather get assistance from a female provider such as a TBA) and the CAC members would influence the results in the observed direction.

6.4.1 TBAs received contradictory messages

In Malawi TBAs continued to practice without legislation or clear policies. As a result, the herbalist who heads the association of herbalists encouraged TBAs to continue delivering against the order. He even proceeded to initiate and implemented a TBA training program; *they came to my house in person telling me that there was a training in Libongwe to be conducted by Mr. Yobanezi...* This gave opportunists a chance to take advantage of the gap created by the moratorium on TBAs and to start practicing in place of the trained TBAs. Later the former national president also announced that TBAs should not have been stopped and needed some empowerment so that they

could continue delivering. However, the former first lady continued to encourage mothers to seek skilled attendance at birth. Participants agreed that TBAs had received divergent messages. *We said stop conducting deliveries then we said no let them continue then we said lets redefine the roles.* Therefore, participants in all phases reasoned that it has been difficult for the TBAs to comply with the directive because they had received conflicting messages and were confused.

These findings echo what was reported earlier by the MoH (2007a) where it was noted that TBAs lacked support from the health care system, a problem which was compounded by a lack of clear policy for the TBA program and this resulted in creating confusion in the communities. The same confusion continues regarding TBA practice five years after TBAs were banned. In Kenya, Izugbara *et al* (2008) stated that lack of clarity on policy led to ambiguities with TBAs' roles, which resulted in TBAs not being respected by the health workers and their activities could therefore not be integrated into the health care system. Lack of integration culminates in lack of support in order to make any meaningful contribution towards achievement of the MNH goals.

6.4.2 Bylaws and Penalties Resulted in a Dilemma

Local leaders in responding to the directive, used their authority to institute by laws which required mothers to deliver at the facility. Those mothers and TBAs who did not comply were fined in either cash or kind. In some cases, offenders would be asked to pay up to three goats; *firstly to the village chief, second the group village head and third the traditional authority.* Some mothers and TBAs were threatened with imprisonment if they were found delivering or assisting with delivery outside the health

facility. Leaders had also instituted task force teams which investigated home and TBA deliveries. In some communities, cases were heard in the presence of the health facility staff who guided the local leaders in making the final verdict.

Both respondents and participants observed that the passing of the moratorium on TBAs by the Ministry of Health and the institution of bylaws by traditional leaders at community level had resulted in an increase in the number of mothers seeking skilled birth attendance. The skilled birth attendance rate increased from 57% in 2006 (MICS 2006) to 75% in 2009 (Ministry of Development & Planning, 2010). This was a result of harsh bylaws and penalties instituted by local leaders which were exacting and non-negotiable. TBAs were penalized even if they assisted in managing the third stage of labor.

As a result, while trying to reach care, having delayed in making a decision to access care on time, mothers often delivered on the way to the facility in an undignified, unhygienic and traumatic manner. TBA participants were concerned with the loss of dignity that childbearing used to demand; *She lays there, struggles by herself with no one to cover her nakedness – we have thrown away childbirth!* Mothers could be delivered by their own mothers, husbands or even strangers who had no knowledge of how to conduct a delivery. Sometimes they delivered alone on the way to the facility. Children on their way to or from school witnessed mothers struggling to deliver alone and jeered at them. Whilst trained TBAs complied with a change of policy and instituted bylaws, mothers went through untold miseries. Babies were *born wriggling on the sandy, muddy ground*. A TBA participant reported that a laboring mother delivered

alone on her way to the facility, *a dog was squatting waiting to devour the newborn baby!*

TBA participants reported of the dilemma they found themselves in because of the moratorium. They reported that *sometimes they come drop the mother by your doorstep, knock on the door and leave in the night while the TBA was sleeping. Upon opening the door the TBA would be greeted by a mother in established labor, if the TBA enquired with whom the mother had come she would say oh they have gone back, if the TBA said lets go to the facility the mother would say I cannot manage. When the TBA assessed the mother, she would see the head already on the vulva. What remains is for the TBA to conduct the delivery and in the morning the mother goes back home.* Nevertheless, later the TBA would be summoned by the chief to answer charges of having conducted a delivery. *No! You have made a mistake, you should have sent her away, if she dies let her die on the road, her people will come and fetch their dead body back home!*

The findings also show that some TBAs who complied with the moratorium were repentant and regretted having refused mothers who reported to them with an imminent delivery. A TBA participant reported that a mother whom she sent away from her home for fear of paying a fine ended up in the hands of an untrained TBA who discouraged the mother from going to the facility when a complication occurred. As a result, the mother died after visiting other herbalists and avoiding the health facility for fear of punishment. The TBA therefore felt remorseful for the death of the mother- *Oh! I was tempted by the devil not to assist her. Oh! The goat has killed a mother!*

Similar observations were reported in Zambia by Corey and Andes (2011) who reported that TBAs were caught in a dilemma because they were expected to abide by the policy on the one hand and on the other hand were being pushed by mothers coming to them in established labor for assistance. Yet their delivery kits had been retrieved by the system. It is important to consider that TBAs operated among their own people with whom they had a special relationship; some were even their next of kin. TBAs would therefore find it difficult to refuse assisting their own relation if the mother reported to her with an imminent delivery.

Moreover, some TBA participants reported that they had withdrawn from the task force in their village. This happened because these task force members observed that their role of investigating mothers who deliver outside the facility was causing animosity between themselves and the community. Community people were planning to way lay them, afraid of being harmed physically they no longer served on these committees.

6.4.3 TBAs Practiced Underground

This study has revealed that both untrained and trained TBAs continue to practice. Ninety two percent of mother respondents acknowledged that TBAs were available in their village or nearby villages. Of these, 42% were certain that TBAs were still practicing. The majority of the nurse-midwives (85%) who encountered the aftermath of TBA activities were sure that TBAs were still conducting deliveries. The proportion of mothers who alluded to the fact that TBAs were still practicing is also an important

finding considering that mothers may not have been open to revealing TBAs continued practice since these are their own people.

Participants in the qualitative phases confirmed the findings that untrained TBAs were mushrooming and practicing having taken advantage of the gap created by the moratorium on trained TBAs. Some trained TBAs reported being persuaded by their communities to recommence services since their untrained counterparts were also delivering. *Even in my home area, they say to me your friends are delivering why can't you do the same?* TBAs asserted that they still remember that they are TBAs and that theirs was a calling: *Because we have not forgotten the fact that we are TBAs, it is still in our minds... that work was instilled in us and we accepted it with all our hearts...*

Respondents and participants in all phases observed that many TBAs having gone underground were slowly but surely practicing - whether it means assisting the mother on *the way to the facility, in the bushes*, bathrooms, vegetable gardens, around the TBA hut or under the bridge. Ironically, the so much sought for male involvement in MNH was also gaining momentum in the underground practice where husbands were required to accompany the team (the laboring wife, the TBA and others) to the bush if delivery occurred in the night; *with us, it was the boy child- husband who went to fetch water. That is what we are doing in the night. We say now to the husband who might be some meters away- go... fetch some water.* Since it is in the night and were operating in the bush presence of a male guardian was inseparable. Trainer participants and the majority of the nurse-midwife respondents (75%) alluded to this development. Respondents and participants observed that there was an increase in

the number of babies who were being born outside the facility and the number of mothers who were reporting to having had traumatic deliveries was also increasing. TBAs did not refer on time for fear of punishment. *When they finally decide to refer they are just abandoning the mother in a vehicle to make it look like the mother died in a hospital, things have not changed.*

Kumar (2007) predicted in his report on Malawi, that stopping the TBAs from delivering would promote their practice especially in the rural, remote and hard to reach areas where access to the health facility is improbable, and as a result maternal deaths in the communities would be underreported. CWZ (2010) confirmed the fears of Kumar (2007) in its annual report of 2010. In the report, it was stated that since the moratorium on TBAs, all four districts under study had failed to follow up the maternal deaths which had occurred in the communities and therefore these deaths were not reported to the Zone. Moreover, TBAs' activities were not reported and referrals by TBAs were not recorded or reported. With no data available, one may argue that the nurse- midwives' observations (58%) that TBAs were still active in MNH activities could be true only that TBAs may not have been active with their new role (that of advising mothers to go for HF delivery) but with their old role (conducting deliveries).

It is therefore not surprising to note the decline in the skilled birth attendance rate to 71% (DHS, 2010) from 75% in 2009 (Ministry of Development & Planning, 2010). The facility data showed that skilled birth attendance in the study facilities was 47.3% on average which is far below the national rate of 71%. The decline is an important observation. This might be an indication of the reversal in gains achieved to date in

reducing the maternal and mortality rate in Malawi as was feared by the study participants. It can be concluded that despite the moratorium on TBAs, mothers continue to deliver outside the health facilities even in the catchment areas of BEmONC facilities, where bylaws and penalties have been instituted, implemented and reinforced. These findings are consistent with those from rural Tanzania where lower rates of skilled birth attendants were also registered in rural areas compared to their national rate (Kruger, 2009). Therefore, it can be concluded that total elimination of TBA services, by sidelining them and the use of force, such as the institution of bylaws in Malawi, will not facilitate the realization of skilled birth attendance for all. There is need to include TBAs as active players in MNH if countries are to achieve the goal of bringing every pregnant mother to the skilled birth attendant (Replogie, 2007). In the MDG report, the UN (2012) observed that the skilled birth attendance rates were as high as 78% in the urban areas and as low as 41% in the rural areas of East Africa and Southern Africa where Malawi belongs.

6.4.4 Policy Makers Detached from Reality

Findings show how disconnected the policy makers were with the implementers and other stakeholders. There were contradictory views over bylaws instituted by traditional leaders. Some reported that the harsh bylaws that were implemented had nothing to do with the ministry. While other health professional participants felt that traditional leaders were only implementing what the ministry had instructed. Participants asserted that policy makers whilst in their *air conditioned* comfort zones sipping *cold water* had distanced themselves from reality and made decisions meant to cut off the poor, rural, disempowered mother from the only source of help she had in her harsh

environment. However, WHO (2005b) has cautioned countries that each country would need to consider its unique situation when developing policies on skilled birth attendance. WHO (2005b) reminded stakeholders that this goal was not achieved overnight in developed countries. Malawi therefore needed to consider all at stake when implementing a blanket policy on TBA deliveries.

6.4.5 The Cost of the Moratorium on the TBAs

TBA respondents observed that their communities used to respect them as part of the significant others in their communities. Some TBAs' clients would not pay for transport to the facility –*they say I (owner of the transport) will not charge the mother because of you mama* (meaning the TBA) because of respect accorded to the TBA. Trainer participants also alluded to the fact that mothers used to listen to TBAs' advice. Because of that mothers' health related behavior changed because of the TBA's instruction on health related issues. With the moratorium, TBAs were accused by their leaders of lacking delivery skills: *You do not know your work! You are just killing them* (the mothers). *You are also just butchering mothers' private parts!* TBAs were ridiculed in public meetings when the moratorium was announced. Community members joined the leaders in undermining the TBAs. *Now we were made fun of by the people!* TBA participants inferred that they were no longer respected, since they were now considered just like any other ordinary community member and had become a laughing stock. *So they have completely thrown us away, they are looking at us as if we are not useful anymore.*

Supervisors who visited TBAs made the TBA feel more like a health worker and a colleague, which boosted the TBAs' morale. The few supplies the supervisor brought along with her made their relationship stronger. *You had given us resources... and this was making us look like we were half of a health facility...* Despite the moratorium however, mothers sometimes went to the TBA for delivery in an emergency but the TBAs did not have any supplies to conduct the delivery safely. TBAs reasoned that they needed supplies for emergency use because *funerals are not good*.

These findings are consistent with what Corey and Andes (2011) in Zambia reported that TBAs used to receive resources from the government but unknown to them their kits were withdrawn. WHO (1975) noted that TBAs enjoyed respect from their community. Because of her advanced age and experience, community members used to consult them on all issues of village life including health; her opinions and advice were therefore paramount.

Just under half (48%), of the nurse- midwife respondents felt that TBAs continued to practice in quest for an income for their survival. Participants inferred that delivering mothers was the TBAs' only way of getting some form of income whether in cash or kind. Some TBAs stocked supplies a mother would need during delivery and sold those items to mothers who did not bring the supplies along with them. TBAs observed that *escorting mothers to a health facility* was done for *free* and yet the TBA might have been withdrawn from her household chores to go with the mother to the facility. If delivery occurred on the way to the facility TBAs assisted the mother and took her to the facility but did not receive any payment or recognition. Moreover, health

professional participants stated that there were no plans to replace TBAs' loss of income and inferred with concern that the issue was very *emotive*, hence the need to act fast because the system made a *big blunder*.

Chalo, Nabukera, Salihu *et al* (2005) in Uganda, advised that providing feasible alternatives to the TBAs for the loss of their clients should be given attention. The authors contend that there is need for practical solutions to be put in place such as money given to the TBA for referral to the district hospital level. In Pakistan TBAs were allowed to remain with the woman upon referral to the facility, focusing on the role of the TBA as a companion for the woman in labor (Fatmi, Gulzar & Kazi, 2005).

6.5 LACK OF CONSULTATION IN DECISION MAKING

Findings reveal that the moratorium on TBA services lacked ownership, commitment and acceptance among stakeholders. The majority of both mothers (96.5%) and nurse-midwife (80%) respondents reported that they were not involved when the government made the decision to stop TBAs from practicing. These findings are consistent with the qualitative data where participants concurred that there was no consultation with stakeholders including policy makers, service providers, the traditional leaders, the TBAs and mothers themselves. Participants reported that the moratorium came as a *directive informing the TBAs to stop conducting deliveries* through the traditional authorities who empowered their *group village heads down to their village chiefs* to institute the bylaws and the penalties. *Now if anyone dares to assist, there they are on your doorstep goat!* Participants said that *most of them would say that we heard about it from television, radio or our member of parliament*.

Stakeholders observed that policies need to be driven by effective and contextually relevant evidence about what works best and is safest - *when you are coming up with a policy; you cannot come up with a policy without consulting the users*. They alone only know the burden, the passion and the urgency that emanate from living with the results of disability due to maternal and neonatal complications and seeing those they care for suffer (Chitsa Banda, 2003). Therefore, stakeholders especially mothers and the TBAs did not own the decision and could not commit themselves to its implementation. If consulted stakeholders reported that they would have proposed a phased in approach to allow establishment of alternatives before passing the moratorium. The authoritative approach taken by the ministry in implementing the decision may affect the efforts towards attainment of the MDGs 4 and 5. Stakeholders seem not to object to the policy but the process followed in instituting it.

This finding is consistent with what WHO (2004) observed in the WHO African region. It was reported that there was poor coordination among partners on implementing the WHO resolution on TBAs. Seattle (2010) in Mozambique reported similar findings because of insufficient engagement of the right people, such as mothers themselves, from the onset of policy change. In Kenya Dietsch (2010) stressed the importance of acknowledging the opinions and preference of mothers, providers and experiences of traditional midwives (TBAs) when policies are being made. Daire and Khalil (2010) in Malawi recommended that mother and child health policies be driven by beneficiaries and providers in order to obtain commitment and ownership.

6.6 HEALTH CARE WORKERS' NEGATIVE ATTITUDES

This study has revealed that mothers met providers who were harsh, rude and arrogant when they went to the health facility. Findings show that providers shouted at mothers, sometimes *slapped them, pinched, scolded and used obscene language*. Mothers in labor were not informed about the progress of labor. It was also reported that mothers in labor were left alone while the provider went home to do her household chores. At night, guardians were required to be in the company of the facility guard to call the nurse-midwife from her home. The guards also asked whether the *waters were broken* so that they should *go and wake up the doctor* (midwife). Sometimes a provider would intimidate guardians and mothers not to call again until morning. CPAD and ORC Macro (2006) in Kenya reported similar observations where it was noted that service providers in public facilities were frequently unfriendly to mothers and failed to answer their queries. Neither did they advise mothers about important routine information, nor were mothers counseled during antenatal consultations. Similar findings were also reported in Zambia by MacKeith, Chingaya, Ahmed *et al* (2003) who reported that 21% of the mothers remembered someone who had treated them badly during labor.

Participants in this study revealed that health workers kept on postponing interventions which would facilitate good outcomes of pregnancy. If a guardian was knowledgeable and tried to reason with them, they got angry and ordered the guardian to manage her patient herself. Because of nurse-midwives' negligence, mothers were sent back if they reported in the latent phase of labor. One mother delivered alone at home after she was sent back from the health facility when she reported in the latent phase of labor.

Upon arrival at home, the pains continued...So I took the knife (kitchen knife). However, when I cut the cord the baby was bleeding so much all over the place. The placenta was 'pulled out' by her husband - My husband started pulling and pulling, luckily it came off...The mother had a tear, they sutured the tear at the facility and the baby died the same day.

Some health professional participants sadly acknowledged that *we have lost a number of women not because of not having adequate resources, not because we did not have doctors, or maybe we do not have whatever but because somebody's attitude towards that particular patient.* In corroborating with the health professionals, 47% of mother respondents and 16.4% of nurse-midwives stated that there was still room for improvement in the way providers handle pregnant mothers. Respondents therefore agree that the negative attitudes of health care workers remain one of the challenges pregnant mothers encountered as they tried to access skilled birth attendants in these facilities.

Yakong (2008) reported similar findings in Ghana where it was reported that negative attitudes of health care workers affected on the mothers' health seeking behavior. In Kenya, Dietsch (2010) observed that traditional birth attendants were concerned because of the poor attitudes health care providers displayed to the TBAs and the mothers whom they referred for emergency care. Buttiens, Marchal and De Brouwere (2004) observed two major challenges in accessing skilled birth attendants - staff attitudes and inadequate skilled providers. They stated that both these factors needed to be addressed otherwise skilled birth attendance will not move beyond the rhetoric.

In contrast, TBAs were friendly to mothers and as such, mothers in Indonesia continued subscribing to TBAs, despite government's efforts to make trained midwives available within the communities (Titaley *et al* 2010). In Uganda, Sheikh (2010) stated that despite the ban on TBAs mothers continued seeking TBA assistance for delivery. TBAs on the other hand had stated that they would not refuse a mother who sought their services. The author therefore inferred that there is need to create user friendly and accessible MNH services in order to enhance facility delivery rates.

6.7 **MOTHERS IN RURAL AREAS WERE NOT EMPOWERED**

The study has revealed that skilled birth attendance in these facilities is below the national rate which means that mothers continue to deliver outside health facilities. Lack of mothers' empowerment to make decisions regarding their own health independently results in mothers not accessing MNH care in time the study has revealed. Participants reasoned that mothers were limited by the fact that before a mother could go for a facility delivery whether planned or in an emergency, a decision for her to do so must be decided upon by her significant others who might be the husband, uncle, mother in-law or an aunt. *Mothers are not empowered enough to make their own decision to seek care* despite the education they might have received at the facility during the antenatal period. Mother respondents (89%) said that they would prefer to deliver at the health facility. The mothers' choice was not because facilities were close to where they lived (15%); neither did they (10%) receive support from their families. Their choice was first and foremost because they (88.2%) knew that the provider was able to manage complications which may arise during labor and

delivery. In addition, they (61.1%) also believed that they could get transport if referral was required even though nurse-midwife respondents said that they had problems with transport. It is possible that transport is more readily attainable in an emergency at a facility than from home. It is inferred therefore that despite the challenges that mothers encountered both at the facility and at home, mothers in the rural areas would rather deliver at the facility with a skilled provider than at home.

These findings are consistent with Berer's (2003) study which revealed similar findings in developing countries, women are inclined to use formal health care services where these are available. This is very crucial to capitalize on. Gloyd, Floriano, Seunda *et al* (2001) in Mozambique noted similar trends where mothers with good proximity to TBAs preferred delivering at the facility for the same reason that facilities have the capability to deal with complications if they arise. Also Anwar *et al* (2004) in Bangladesh stated that if mothers were given a choice they would rather deliver with skilled attendants. Malawi needs to take advantage of this finding and consult extensively nationally, as well as internationally, in order to develop a model which will promote skilled birth attendance. WHO (2005b) stated that there is a need for strategic planning for making skilled birth attendants available and for strengthening referral systems. Therefore, WHO (2008b) advised countries to embark on long term phased-in interventions.

6.8 COMMUNITY MIDWIVES INITIATIVE IN MALAWI

Findings show that both respondents and participants support the community midwife initiative for Malawi. Community midwives are better trained than TBAs but are below the WHO and International Council of Midwives definition of skilled birth attendant. This

poses a policy challenge as much as it appears to bridge the gap. The initiative is however consistent with Andemichael, Haile, Kosia *et al's* (2010) report in Eritrea. Taking MNH care close to where mothers live rather than taking mothers to where MNH care is, may seem the best way if countries are to achieve MDGs 4 and 5. Sibley and Sipe (2006) on the other hand stated that another way of improving the situation is to transform the capable TBAs into more skilled attendants through formal quality training, approved by a regulatory body with close supervision. In Kenya (MoH, 2005) the Ministry of Health reported that there was need for local government assemblies to be more involved in TBA activities in order to be able to protect the lives of its people. Active involvement of local assemblies would work for Malawi, to reinforce the changed role of TBAs and retain providers in rural areas. Ebuehi and Akintujoye (2012) in Nigeria recommended establishing a partnership between TBAs and the health system to foster a healthy collaboration between partners in improving MNH care outcomes. While Nabudere, Asimwe and Amandua (2012) recommended the need for midwives working in health centers to partner with other attendants (such as TBAs) and work together as a team.

6.9 SUMMARY OF THE DISCUSSION OF THE FINDINGS

The question that needed to be answered in this study was: What are the perceptions of key stakeholders of the changing role of TBAs, and what are the reasons why mothers in the rural areas of CWZ continue to deliver at home despite the directive to go and deliver at the facilities? Inferring to the arguments presented in the discussion of the findings, the following is the summary of stakeholders' perceptions of the TBAs

changing role and the reasons why mothers in these areas continue to deliver outside health facilities in spite of the moratorium on TBAs.

6.9.1 The Moratorium on TBAs was not Consultative

The study has revealed that the decision on the moratorium on TBA services was not consultatively made with the relevant stakeholders. As a result, stakeholders had varying perceptions of the TBA's changed role. Firstly, stakeholders were of the opinion that the moratorium was too abrupt, ill timed and did not take into consideration the prevailing challenges rural mothers face when accessing MNH care.

Secondly, the by-laws and penalties instituted by local leaders were exacting and non-negotiable. In addition, participants thought that TBAs had received confusing messages therefore, it was difficult for them to comply with the directive. Moreover, participants in the study perceived that the moratorium had created a gap putting both the TBAs and mothers in a dilemma. As a result, untrained TBAs have emerged and are practicing underground together with some trained TBAs.

Thirdly, participants reasoned that TBAs had lost the income they used to get from conducting deliveries which saw them through the financial difficulties rural people encounter. Supervisors' visits to TBAs created the impression that the TBAs were part of the formal health care system. This impression has disappeared with the imposition of the moratorium and has created a negative image of the TBAs. Both respondents and participants in the study agreed that having moved away from the TBAs as a

country, there was no need to revert to using them but they indicated the urgent need to consider compensating TBAs for their new role.

6.9.2 MNH Care Delivery System is Deficient

Participants in the qualitative phases and respondents in the quantitative phases inferred that TBAs were still practicing. The reasons given for TBAs continued practice were the multifaceted challenges that mothers encounter when trying to access skilled birth attendants. These included long travelling distances, poor terrain, nonexistent road infrastructure and inefficient transport system which hinder mothers from making it to the health facilities on time.

Secondly, lack of adequate sleeping facilities resulted in mothers sleeping in a guardian shelter with guardians. In addition, not all of the BEmONC facilities were able to provide the full FANC package including PMTCT services. Drugs and supplies for MNH care services were also in short supply which resulted in some mothers completing ANC without receiving a single dose of antimalarials.

Thirdly, not all BEmONC trained nurse-midwives felt competent to provide the seven BEmONC signal functions and only a few facilities were fully functioning as BEmONC facilities. This meant that not all mothers in need of BEmONC services were able to receive the services. Some BEmONC facilities were still run by one nurse-midwife. It was not unknown for mothers to deliver alone in these health facilities. Negative health care worker attitudes exacerbated the situation. Both respondents and participants therefore agreed that going to the health facility in these areas did not guarantee safe

delivery. As a result, participants in the qualitative phases observed that it did not matter where a mother delivers whether at home with a TBA who has some training, or at the facility alone, or with a guardian or a cleaner who has no knowledge about labor and delivery.

All participants and respondents agreed that community midwives would be a good initiative for Malawi. However, participants observed that the system needs to ensure that these are indeed deployed to the communities in remote areas. Health professional and TBA participants suggested that TBAs should be incorporated into the system, given an active role in MNH care and that incentives be provided for their role. Others observed that TBAs could be attached to the community midwives to work together with them. Stakeholders emphasized the need to identify appropriate selection criteria for community midwives and to institute functional retention systems so that migration of these workers from rural to urban areas is controlled.

6.10 RECOMMENDATIONS FOR THE PROMOTION OF MNH CARE SERVICES IN RURAL AREAS OF CWZ

Based on the discussion and the summary of the study findings it is hereby inferred that stakeholders need to appreciate that pregnancy and its outcomes are no longer a family affair alone. It is a concern of the whole community, and there is need for everyone to keep the motto “one maternal death is one too many”. Stakeholders at all levels need to demonstrate their commitment and agree on a realistic and feasible plan

for MNH care. The following recommendations for an efficient and effective MNH service in the rural areas are therefore made:

Since the country had already moved away from the TBA model, there is no need for the country to revert to using them. Reverting to using them would mean continuous subjection of mothers to TBAs' substandard care. This would affirm mothers' low position in society as second-class citizens. It has been argued that primarily mothers and girl children are the victims of harmful traditional and cultural practices. Therefore, stakeholders need to recognize that allowing TBAs to continue practicing means subjecting mothers to these harmful traditional and cultural practices. Further, continued TBA practice would undermine the government's efforts to improve skilled birth attendance an indicator for MDG number five. It is therefore recommended that the RHU undertake an analysis of its potential key stakeholders in MNH. This will facilitate the mobilization and / or strengthening of the partnership for an effective sector wide response to the challenges mothers encounter in trying to access skilled birth attendance.

6.10.1 There is need to empower mothers and other stakeholders in the communities

- RHU needs to coordinate with the Ministry of Education to institute a policy on minimum educational qualification levels for girl children and monitor adherence. Involvement of local leaders to institute strategies that will ensure that all school aged girl children in their jurisdiction go to school would be paramount.

- Formation of a community level MNH task force to educate mothers to seek health care in their first trimester needs to be emphasized. There is need to encourage and motivate TBAs to be members of the MNH task force so that they can remain active in MNH activities and retain their position in the society. Local leaders through the MNH task forces should monitor TBA activities and home deliveries. The MNH task forces should provide HSAs with MNH information to facilitate rewarding TBAs who refer the highest proportion of mothers for skilled delivery. The TBAs' new role needs to be disseminated widely so that everyone becomes aware of what TBAs are expected to do. It is important for the health care system to consider TBAs who are younger and have attained an acceptable level of education to be included in the training as community midwives.
- Effective incorporation of the presidential initiative activities in the communities by empowering local leaders to motivate their people to develop health-seeking behavior should be considered important. Continuous training of the local leaders in community MNH activities so that the leaders could impart the right information to their people. There is need for these leaders to participate in MNH meetings at traditional authority as well as district levels.
- The health care system needs to empower communities so that communities could provide some of the material resources for the construction of delivery huts for community midwives. There is need for the structures to be cost effective, at a price communities can afford and as simple as they can be just to provide for the basic amenities. The District Commissioners (DC) could contract with the communities for the provision of some of the material resources communities can ably mobilize. This

could be a criteria for selecting and training of a midwife from that particular community. The DCs could then mobilize the rest of the resources from district partners.

- RHU need to review the three week integrated MNH course to emphasize skill acquisition for nurse-midwives and other providers so that providers are competent to conduct BEmONC services. There is need to advocate with partners for the provision of the necessary equipment after in-service training of providers in integrated MNH. This will facilitate commencement of service provision by providers once they get back and therefore do not lose their skills whilst waiting for equipment.
- Pre-service training needs to include modules in customer care services so that service provision is responsive to the needs of service users. In-service training in customer care for providers in service should also be considered. This will assist providers get a paradigm shift in which they could view service users as their customers on whom the security of their job rests upon.
- The RHU in consultation with the Nurses and Midwives Council of Malawi needs to consider strategies relating to upgrading CMs to skilled birth attendants. This will enhance mothers' accessibility to skilled birth attendants close to their home.

6.10.2 There is need to institute functioning client feedback systems

- District teams need to strengthen the health care user feedback system where they exist and institute these where there are none. This will keep the institutions informed of users' perceptions of MNH care and providers' attitudes ascertained on a regular

basis for necessary action. The clientele should be given efficient means of communicating with authority in case of an urgent need. Instituting an ombudsman office where clients can go or call in order to get immediate assistance will transform the health care system into an empathetic and responsive system. This could be complemented by introducing suggestion boxes which should be marketed regularly to the service users. These boxes should be emptied of their contents for analysis according to schedule. Periodical client exit interviews will also inform the system of the stakeholders' perceptions of the way services are being provided. Findings from the client feedback system should be implemented so that the clientele should be able to see the changes they have recommended being implemented.

6.10.3 There is need for an establishment of an enabling environment for skilled birth attendance

- RHU in collaboration with the presidential initiative on Safe motherhood need to mobilize resources as a matter of urgency for construction of waiting homes in the facilities so that mothers who go to wait for labor can be accommodated in suitable accommodation.
- The system need to effectively engage the TBAs in MNH activities in order to obtain their commitment and ownership to the MNH program in their communities. It has been stated that mothers fail to go to wait for labor because they do not have a reliable guardian. TBAs could be used as labor companions and guardians (apart from the other new roles) for mothers on a rotational basis (the same way the HSAs do) and

given a stipend for their work. This will assure mothers of a guardian and or a companion to support them when they go to wait for labor at the facility.

- Shortage of staff in the rural areas is critical yet the ministry's human resource emergency plan was instituted in order to solve human resource problems in these areas. Therefore, RHU needs to facilitate information dissemination on the purpose of the ministry's human resource emergency plan to nurse-midwives during pre-service training. There is also need to advocate for the development of effective strategies to retain providers in rural areas. Periodical rotation of providers in hard to reach areas would ensure availability of staff in these underserved areas. There is also need for district management teams to conduct opinion surveys for its providers as a means of getting feedback from service providers on their opinion regarding the way they perceive service provision to their clientele.
- Lack of food for mothers who go to wait for labor at the facility is yet another challenge which prevents mothers to go and wait at the facility. The system need to provide food for mothers who go to wait just as it is done at the district hospital level. Communities could be motivated to mobilize food resources for mothers' use at the facility with the help of community level Safe motherhood task forces.
- There is need to create demand away from the TBAs. District management teams need to provide transport for mothers residing in far, rural and remote areas. In collaboration with other sectors at the district level transport could be mobilized to ferry mothers who are due to go to the facility on designated dates and venues. RHU and district management teams need to actively advocate for MNH drugs, equipment and supplies. Provision of full package of antenatal care (FANC) will motivate mothers to

seek facility care. Mothers who go to wait for labor should have their ANC record updated so that they get the maximum benefits of coming to wait for labor.

- RHU needs to advocate with the Ministry to consider delegating the responsibility of employing community midwives to the district assembly and giving them working conditions similar to those of the chiefs whose positions are not transferable. This is a community initiative and therefore needs to be treated as such to ensure retention of these workers within their communities. There is need to ensure that community midwives are deployed in the community especially the hard to reach areas so that those mothers who fail to make it on time for facility delivery can be ably assisted closer home. RHU therefore need to advocate for recruitment of CMs from these areas first. Further exploration of the community midwives initiative at both national and international levels is required in order to develop an informed plan of action on how best the community midwives can be recruited, trained, employed and deployed.

6.10.4 There is need to strengthen community ownership and stakeholder accountability

- Negative attitudes from young providers need to be addressed because such attitudes deter mothers who in turn seek TBA services. It is important to promote stakeholder accountability at both facility and community levels in order to make everyone accountable for their actions and omissions. RHU need to advocate with the directorate of human resources in the Ministry for the institutionalization of the staff appraisal system that government has introduced. There is need to monitor provider performance and employ effective remedial actions in order to improve service

delivery. Rewarding of providers whose performance is outstanding will also encourage them to improve their performance.

- There is need to monitor current TBA practices. While the chiefs should be encouraged to promote health facility delivery, mothers who fail to make it to the facility should be allowed to access TBA assistance especially in areas which are far, rural, remote and hard to reach and have no community midwife. We can reward the good behavior without having to punish the bad behavior - TBAs who deliver the lowest proportion of mothers but refer the highest proportion of mothers in a period should be acknowledged and rewarded. DHMTs therefore need to incorporate TBAs' incentives into their annual plans. This will motivate TBAs to desist from providing care to mothers in labor.
- There is need to actively involve the herbalist association president in MNH committees. This will promote ownership of the MNH program and its outcomes by his office and facilitate transmission of right messages to the communities.
- Use of media in disseminating maternal deaths data so that everyone gets informed on a daily basis where, when and why a maternal death has occurred. This will promote accountability among the stakeholders. Prompt reporting of a maternal death to the Zone by the district health officer will also facilitate active involvement of management in dealing with maternal deaths.
- RHU need to take advantage of the socioeconomic activities going on in the rural communities. Activities such as social cash transfers whereby cash is given to families, which are poor, could be used to improve health facility deliveries. The RHU could advocate for inclusion of mothers' health seeking behavior as one of the criteria for the

potential beneficiaries. This will facilitate pregnant mothers' attendance of antenatal care in the first trimester and skilled birth attendance for these mothers.

- There is need to strengthen DHMT- HF supportive supervision to providers working in rural and remote areas. This will boost providers' morale and capacity to perform. Zonal offices should monitor DHMTs conduct of facility supervision and strengthen this where it is not happening. Rewarding of DHMTs whose performance is outstanding should be considered. Media could also be used to disseminate outstanding performance of district management teams in the Zone.

6.10.5 There is need to strengthen or establish effective coordination mechanisms at all levels of service delivery

- There is need to strengthen coordination mechanisms in MNH care at national level and institute strong coordination mechanisms at zonal, district and community levels. Figure 6.1 provides a coordination framework for building strategic partnerships for renewed commitment in order to promote women empowerment, the establishment of functioning client feedback systems, the creation of an enabling environment for skilled birth attendance and community ownership and stakeholder accountability.

The recommended MNH coordinating framework had been designed to facilitate communication from the Ministry of Health to the communities as well as from the communities to the Ministry of Health. Whilst the reproductive health unit has instituted a national coordinating framework these systems are non- functional or absent altogether at zonal, district and community levels. The bi-directional flow of communication endeavors to include all the stakeholders in MNH care at all levels of

service delivery. The framework has four main coordinating levels. These are the Reproductive Health Unit, the Zonal level, the District level and the Community level. The framework will be described under each of these headings.

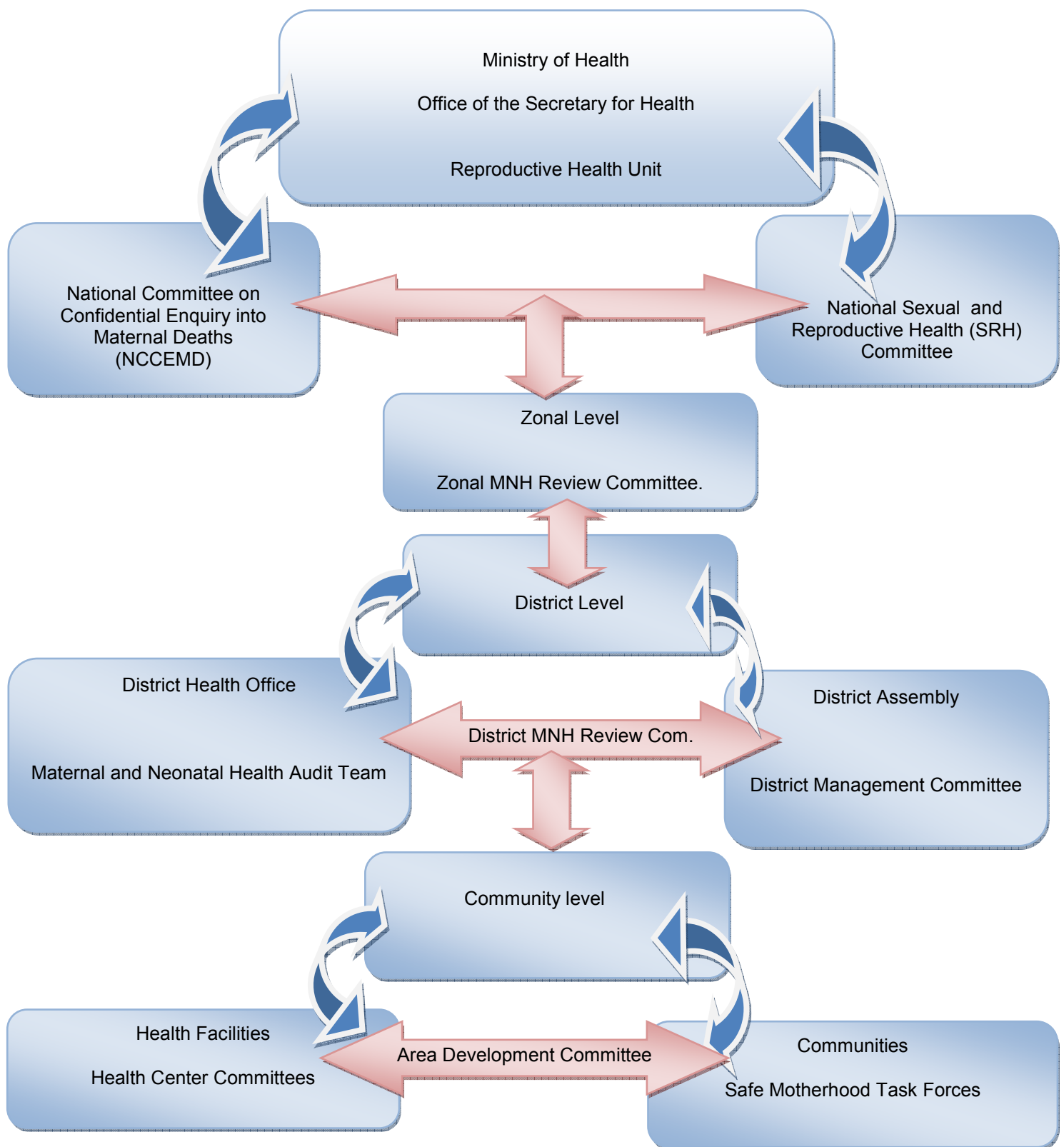


Figure 6.1: The Recommended MNH Coordinating Framework

6.10.5.1 **The Reproductive Health Unit**

This level is responsible for developing MNH policies in coordination with the relevant stakeholders at national level. The RHU should strengthen the National Committee on Confidential Enquiry into Maternal Deaths so that stakeholders meet regularly to discuss maternal deaths in the country. It should also strengthen the National committee on Sexual and Reproductive Health so that it develops informed MNH policies and guidelines.

6.10.5.1.1 **National committee on confidential enquiry into maternal deaths (NCCEMD)**

In this forum stakeholders need to deliberate the incidences of maternal deaths, main causes and challenges that districts encounter in providing MNH care and generate an annual report on the same. The Zonal officers as part of the NCCEMD are to inform this committee of issues relevant to MNH. Detailed information relevant to every maternal death should be made available to this committee. Information should include detail relating to place of delivery, cause of maternal death, and measures taken immediately prior to death.

Decisions made in the NCCEMD must be referred to the National SRH Committee for policy development.

6.10.5.1.2 **The national SRH committee**

This committee is advised by the NCCEMD. It is also responsible for deliberating policy issues and policy development in MNH care delivery. This committee also provides feedback to the NCCEMD accordingly.

6.10.5.2 **The Zonal Level**

The Zones are new structures developed in the context of the Program of Work 2004-2010 strategy. Activities for the Zones are being discovered or experimented progressively. Currently there is no MNH review committee at this level whose officers are members of both the NCCEMD and the SRH. If Zones were empowered to inform the above mentioned two committees of the MNH activities taking place in the Zones then the national committees would be kept abreast of the issues at the local level.

Some of the responsibilities of the Zones include assisting the districts to establish systems and structures for efficient and effective delivery of MNH services. In addition, the officers interpret policies and guide district teams in the implementation thereof. The Zones need to conduct situational analyses of their stakeholders in order to mobilize the relevant players in MNH. There is need to institute Zonal MNH reviews where district management teams and program coordinators meet at this level and provide information to the NCCEMD.

6.10.5.2.1 **Zonal MNH review committees**

Each district in the Zone must submit data relating to the incidence and cause of maternal deaths, skilled birth attendance, main obstetric complications, number of home deliveries and the impact of the three –four delays. Initiatives taken to improve skilled birth attendance, strategies to reduce the incidence of maternal and neonatal deaths and challenges encountered must also be reported. Sharing of best practices should be encouraged.

6.10.5.3 **District Level**

The district health office needs to involve members from the assembly so that other sectors become aware of the challenges the health sector faces in the implementation of the MNH care. Through involvement of the district assembly, the health sector can be linked with traditional leaders, political leaders and other government sectors thereby forming adequate representation in decision making regarding MNH issues. Currently there is no such involvement.

At this level the District Health Officer and his/her management team (comprising heads of sections which includes the District Nursing Officer as the head of MNH care delivery) are responsible for the assessment, planning, implementation and evaluation of MNH care services. The district is responsible to the Zone for submission of all information required in relation to maternal deaths, skilled birth attendance and the implementation of policies. District management teams need to institute functioning maternal and neonatal health audit team which will be responsible for monitoring the provision of MNH care services.

6.10.5.3.1 **Maternal and neonatal health audit team**

This team will be responsible for the following tasks: Auditing maternal and neonatal deaths as they occur with the aim of identifying gaps in the system that need correction. The team will also be responsible for auditing of near miss cases by collecting information from the patient herself as well as from the records in the facility in order to document the event of the near death. The report should identify factors that led to the near miss event and strengths of the system which facilitated recovery of the mother. The team will counsel providers

who participated in providing care to a mother who died. The purpose is not to blame or punish but to create opportunity for learning. This may assist in identifying learning needs for the various levels of health care providers.

The team must inform the district MNH review committee of its activities and outcomes.

6.10.5.3.2 District MNH review committee

District management teams and their stakeholders must conduct periodical MNH reviews in which the analyzed causes of maternal deaths are presented. Periodical reviews must include data on: district statistics relating to number of deaths; statistics relating to number of mothers delivering at the facilities and in the communities. Analysis of the main obstetric complications, Cesarean section rates and the availability of support services such as transport and blood transfusion services should be deliberated in this committee.

6.10.5.3.3 The district management committee

The District Health Officer will be responsible for updating the district management team at the district assembly on MNH activities. Information from the district periodic review will be disseminated and discussed in this committee.

6.10.5.4 **Community Level**

The safe motherhood committee currently does not coordinate with the health center committee which is the main body dealing with health issues at the community level. There is a need for the task force to recognize the importance of coordinating with the health center committee (HCC) so that their activities are coordinated with other community structures. Even though the government has instituted area development committees in the community, health representatives do not participate in these forums. Their role is perceived as one that deals with development issues and stakeholders do not consider health as part of development. The HCC needs to become an active player in these committees so that communities can own the health initiatives being carried out in their areas.

At this level, district management teams remain responsible for monitoring the implementation of MNH care. Management therefore needs to institute functioning health center committees and assist communities to establish Safe Motherhood Task Forces in the communities. Representation of both the Safe Motherhood Task Force and the Health Center Committee should be members of the Area Development Committee.

6.10.5.4.1 **Safe motherhood task force**

Task force members are responsible for encouraging pregnant women to seek ANC early and plan for facility delivery, record pregnancies and its outcome.

Members of this team are to inform the health center committee on their activities.

6.10.5.4.2 Health center committee

This committee is responsible for monitoring health care service provision including MNH at the health center. This committee is responsible for obtaining information from the Safe Motherhood Task force members for record keeping and follow up.

6.10.5.4.3 Area development committee

In this forum, several developmental issues are discussed and there is need to include MNH services. The committee will be responsible for the following: monitoring of TBAs activities; involving TBAs in Safe Motherhood Task Force; mobilization of community resources and dealing with MNH issues at community level which need further investigation and management.

6.11 LIMITATIONS OF THE STUDY

In accordance with a broader contextual significance, the limitations of this study should not be over looked. Even though the researcher was introduced to the mother participants as a researcher it is conceivable that some gave responses feeling that they were dealing with an authority and may have viewed the researcher as part of the system anyway. In such cases, they might not have expressed their true feelings.

The researcher did not obtain the perceptions of mothers in the community who might continue to rely on TBA services. The majority of the mothers would have preferred a facility delivery. However, the mothers interviewed had already come for a facility delivery which may have meant that they were convinced of their option as the best. This may be interpreted to mean that their choice was not representative of all mothers.

The study targeted BEmONC facilities operating in rural areas only, this resulted in the exclusion of district hospitals which are referral institutions of the facilities under study. Their inclusion would have provided the number of mothers referred, the reasons for referral and the outcomes. Inclusion of the district hospitals would have informed the system of the effectiveness of the hospitals in providing support to the lower level facilities and the efficiency of the system in responding to the obstetric emergencies referred from these facilities. The study focused on the rural areas and yet the moratorium on TBAs is for both urban and rural areas. Their inclusion would have assisted in exploring perceptions of mothers who had easier access to MNH care. It may be argued that an urban population would have given divergent views from what was obtained in the rural areas. Therefore, recommendations derived may not reflect the views and needs of the urban population.

The study design had some limitations in that the use of a survey may have inhibited some mothers, such that they did not express their true feelings. The fact that they were being interviewed alone may have been a contributory factor. Although the researcher assured them that their name would not be indicated on the form, nor would they be punished in any way mothers, gave an impression that the attitudes of the

health workers were fine even though this is not the picture which is generally portrayed.

Data were collected during the rainy season and the number of mothers seeking care during this time is generally low. This could also mean that mothers who reside in areas with poor geographical terrain might not have come to the facility therefore those interviewed could have been at an advantage geographically hence their choice of facility delivery. It has been shown that in this study context that 95% of mother respondents were subsistence farmers. This finding was supported by the facility staff who noted that the time of data collection coincided with farming time. As such most mothers do not access health facilities for MNH services during this season because they are busy working in the farm.

The retrospective review of the records met with some challenges in that in one facility one could get two different figures on the same indicator for the same month but from different documents. Therefore, it was difficult to ascertain the correct figure for the indicator. This could have had an influence on the correct number of mothers who had actually accessed skilled birth attendance. Moreover, in the majority of the facilities all deliveries which had happened in the facility were recorded as having been assisted by a skilled birth attendant yet some mothers could have been delivered by their guardians or have delivered alone whilst a good number could have been delivered by the facility cleaners who are not trained in MNH at all.

6.12 FURTHER RESEARCH

Further research is needed on the perceptions of mothers who still access TBAs' services despite the moratorium. This would assist in a more understanding of the

drivers for mothers' continued access of TBA services. The study could inform the policy makers of the extent of influence that TBAs still exert on mothers. Therefore a more inclusive and participatory strategy for TBAs could be developed. Further research is also needed on the perceptions of NMs and mothers in urban and semi urban areas on the moratorium on the TBAs. This will assist in exploring perceptions of women who have better access to MNH care. Findings from such a study could inform policy makers of the salient drivers for TBA services despite women having an easier proximity to health facilities. Another study could be conducted on the type of complications referred from BEmONC facilities in the rural areas in order to obtain empirical evidence of the functionality of BEmONC facilities in hard to reach and remote areas. Such a study may assist in developing policies that would emphasize the need for thorough planning and resource mobilization before training providers from a new site. Similar studies need to be conducted at a national level in order to obtain views from more stakeholders with varying cultural and social backgrounds.

6.13 CONCLUSION

In this chapter, findings from the five phases of the study were discussed. It has been inferred that the moratorium on TBA services was not a consultative process and therefore stakeholders had varying perceptions of the TBAs changing role. Moreover, even though mothers took heed of the directive and went to the facility for delivery, the MNH system is still deficient as mothers found themselves experiencing inadequate services as well as unsuitable accommodation. Mothers were often assisted by their own guardians and sometimes delivered alone. Given these experiences, mothers did

not see the value in a facility delivery. Recommendations for improvement of MNH system have been presented.

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ANNEXURES

ANNEXURE A

INTERVIEW SCHEDULE FOR MOTHERS

Date of interview----- Health Facility Code-----

Code # of participant-----

Section A: Respondent's Demographic Data

1 How many pregnancies have you had?

	Please tick where appropriate (√)	Code
2-4		01
5+		02

2 What is the total number of your living children?

	Please tick where appropriate (√)	Code
1-5		01
6+		02
I have no living child		03

3 How old are you?

	Please tick where appropriate (√)	Code
< 18 yrs		01
18-35 yrs		02
36+ yrs		03

4 How far did you go with your education?

	Please tick where appropriate (√)	Code
Never attended school		01
Lower primary (standard 1-4)		02
Senior primary (standard 5-8)		03
Junior secondary (form 1-2)		04
Senior secondary (form 3-4)		05
MSCE		06

5 What is your occupational status?

	Please tick where appropriate (√)	Code
Full time employment		01
Unemployed		02
House wife		03
Subsistent farmer		04
Small scale business		05
Do piece jobs (laborer)		06

6 What is your marital status

	Please tick where appropriate (√)	Code
Married		01
Single		02
Divorced		03
widowed		04

7 What is the name of your village.....Km.....

Distance in kilometers

	Please tick where appropriate (√)	Code
0-5Kms		01
5+ Kms		02

Section B: Mother's Perceptions of Changing Role of TBAs

8 Is there a TBA in your home village or near your village?

	Please tick where appropriate (√)	Code
Yes		01
No		02
I don't know		03

9 If yes; has the TBA stopped conducting deliveries?

	Please tick where appropriate (√)	Code
Yes		01
No		02
I don't know		03

If yes go to question 11

10 If no, why have the TBAs continued conducting deliveries? (Read out the answers to the respondent).

	Tick (√)	Code
Health facility is far		01
Cultural influences		02
TBAs provide good care than health workers		03
People don't want change		04

11 How was your community involved when the government was making the decision to stop TBAs from conducting deliveries?

	Please tick where appropriate (√)	Code
They conducted meetings		01
We were not involved		02
I don't know		03

12 If not involved or you don't know, suppose you were involved, what advice would you have liked to give the government concerning TBAs and their role of conducting deliveries?

	Please tick where appropriate (√)	Code
To go ahead and do it the way it has done		01
Do it slowly		02
To improve the health system first		03
Empower TBAs and let them continue to deliver		04

- 13 You have delivered at the TBA before. Suppose the Government allows the TBAs to conduct deliveries again, where would you prefer to go for a delivery?

	Please tick where appropriate (√)	Code
The health facility		01
The TBA		02

- 14 Why would you prefer to go and deliver at that service provider? (Read out the answers to respondent).

	Please tick (√)	Code
They are close to where I live		01
My family /cultural influence		02
It is easy to get transport to hospital in case of emergency		03
They know how to manage complications		04
They provide better care		05

- 15 What is your opinion of the TBAs changed role?

	Please tick where appropriate (√)	Code
It is good		01
It is not good		02
I don't know		03

- 16 How do you rate TBAs competency?

	Please tick where appropriate (√)	Code
Bad		01
Fair		02
Good		03

- 17 How are TBAs involved in maternal and neonatal health care in your community nowadays?

	Please tick where appropriate (√)	Code
Are part of village health safe motherhood committee		01
Are not active in maternal and neonatal health anymore		02
I don't know		03

Section C: Mother's Perceptions of the MNH Care System

- 18 Do you think that this health facility is able to cope with the number of mothers who are coming to deliver?

	Please tick where appropriate (√)	Code
Capable		01
Not capable		02
I don't know		03

- 19 Do you think the facility has the following

	Please tick where appropriate (√)	Yes	No
		01	02
1	Adequate drugs and supplies		
2	Adequate staff		
3	Adequate rooms/space		

- 20 How do you rate the attitude of providers in providing MNH care?

	Please tick where appropriate (√)	Code
Bad		01
Fair		02
Good		03

- 21 If the Government decides to replace TBAs with trained community midwives, what would your stand be?

	Please tick where appropriate (√)	Code
I would welcome the idea		01
I would not welcome the idea		02
I don't know		03

- 22 Are there any other comments you would like to make regarding the government's decision to stop TBA's from conducting deliveries?

.....

.....

.....

Thank you very much for your participation.

This marks the end of our discussion

ANNEXURE B

INTERVIEW SCHEDULE FOR NURSE-MIDWIVES

Date of interview----- Health Facility Code-----

Code number of participant-----

Section A: Characteristics of Nurse-midwife respondents

1 How long have you been working at this facility?

	Please tick where appropriate (√)	Code
Less than a year		01
1-2 years		02
>2 years		03

2 Are you a trained BEmONC / Integrated maternal and neonatal health care provider?

	Please tick where appropriate (√)	Code
Yes		01
No		02

3 As a provider do you perceive yourself as a competent provider in conducting the following BEmONC signal functions?

		Yes	No	Sometimes
		01	02	03
1	Administration of parenteral uterotonics			
2	Administration of parenteral antibiotics			
3	Administration of anticonvulsants			
4	Conducting manual removal of placenta			
5	Conducting assisted vaginal delivery (vacuum extractions)			
6	Resuscitation of the new born			
7	Manual vacuum aspiration of retained products of conception			

Section B: Respondent's Perceptions of the MNH Care System

- 4 In your own opinion what is the average length of stay for waiting mothers at this facility?

	Please tick where appropriate (√)	Code
<2 weeks		01
>2 weeks		02

- 5 Do you think that you receive adequate supportive visits from your District Health Management Team?

	Please tick where appropriate (√)	Code
Yes		01
No		02

- 6 Do you think that the facility has the following?

		Please tick where appropriate (√)	
		Yes	No
		01	02
1	Adequate equipment		
2	Adequate drugs and supplies		
3	Adequate staff		
4	Adequate rooms/space		
5	Readily available transport for referral		

- 7 How do you perceive providers' attitudes in providing maternal and neonatal health care?

	Please tick where appropriate (√)	Code
Bad		01
Fair		02
Good		03

Section C: Nurse midwife's Perceptions of TBAs Changing Role

- 8 Do you perceive TBAs' training adequate for them to perform their role effectively?

	Please tick where appropriate (√)	Code
Yes		01
No		02
I don't know		03

- 9 How would you rate TBAs competency in providing MNH care?

	Please tick where appropriate (√)	Code
Bad		01
Fair		02
Good		03

- 10 Do you think TBAs received enough of the following in order to perform their role more effectively?

		Please tick where appropriate (√)		
		Yes	No	Don't know
		01	02	03
1	Equipment			
2	Drugs and supplies			
3	Refresher courses			
4	Supportive supervision			
5	Transport for referral			

- 11 What is your opinion of the TBAs changed role?

	Please tick where appropriate (√)	Code
It is good		01
It is bad		02
I don't know		03

- 12 Do you think TBAs in your area have stopped conducting deliveries?

	Please tick where appropriate (√)	Code
Yes		01
No		02
I don't know		03

If “yes” or “I don’t know” go to question 15.

- 13 If no, why do you think that TBAs in your area have not stopped conducting deliveries?

(Read out the answers to the respondent).

	Tick (√)	Code
Health facility is far		01
TBAs provide better care		02
People don't want change		03
It is TBAs' source of income		04
Cultural influences		05

- 14 How were service providers involved when the government made the decision to restrict TBAs from conducting deliveries?

	Please tick where appropriate (√)	Code
They conducted briefing sessions		01
We were not involved		02
I don't know		03

- 15 If “no” or you “don’t know”, suppose you were involved in the decision making process, what advice would you have liked to give the government?

	Please tick where appropriate (√)	Code
To go ahead and do it the way it has done		01
To do it slowly		02
To improve the health care system first		03
To empower TBAs and let them continue delivering		04

- 16 Since TBAs stopped conducting deliveries is the facility capable of managing all the mothers coming for deliveries?

	Please tick where appropriate (√)	Code
Yes		01
No		02
I don't know		03

If “yes” go to question 19.

- 18 if no, what are the challenges you encounter as a result of the increase in number of pregnant mothers coming to deliver at this facility? (Read out the answers to respondent).

	Tick (√)	Code
Rate of “born before arrival” has increased		01
Some mothers deliver unattended because of work load		02
Some mothers use floor beds for delivery		03
Number of mothers seen in second stage has increased		04

- 19 How are TBAs in your area involved in maternal and neonatal health care nowadays?

	Please tick where appropriate (√)	Code
Are part of village health safe motherhood committee		01
Are not active in MNH anymore		02
I don't know		03

- 20 If the Government decides to replace TBAs with trained community midwives, what would your stand be?

	Please tick where appropriate (✓)	Code
I would welcome the idea		01
I would not welcome the idea		02
I don't know		03

- 21 Are there any other comments you would like to make regarding the government's decision to stop TBA's from conducting deliveries?

.....

.....

.....

.....

Thank you for your participation.

This is the end of our discussion.

ANNEXURE C

HEALTH FACILITY DATA

Code of Health facility-----District-----Date-----

1 Distance of the farthest village receiving MNH care-----kms

2 Total number of Nurse Midwives -----

3 Number trained in BEmONC/ Integrated MNH-----

4 Total number of facility deliveries in the last 24 hours-----

5 Total number of mothers waiting today-----

6 Waiting home for pregnant mothers available yes-----no-----

Maternal and Neonatal Health Care Services

7 Type of focused ante-natal care (FANC) services the facility was able to offer on the day of the visit (√)

		Yes	No
		01	02
1	Pregnancy test		
2	Haemoglobin test		
3	PMTCT		
4	Urinalysis		
5	Iron		
6	Albendazole		
7	Intermittent Preventive Treatment of malaria in pregnancy		
8	Tetanus Toxoid Vaccine		
9	Insecticide Treated Nets		
10	Syphilis screening		

8 Type of BEmONC signal functions the facility was able to offer on the day of the visit

		Yes	No
		01	02
1	Vacuum extraction		
2	Breech deliveries		
3	Manual vacuum aspiration		
4	Manual removal of placenta		
5	Removal of retained products of conception		
6	Resuscitation of the new born		
7	Administration of parenteral uterotonics		
8	Administration of magnesium sulphate		
9	Administration of parenteral antibiotics		

9 Other MNH data

	Data for the past 1year	Jun 2010-Jul 2011
1	Number of new ANC attendees	
2	Number of facility deliveries	
3	Number of fresh stillbirths	
4	Number of maternal deaths	

ANNEXURE D

FOCUS GROUP INTERVIEW GUIDE WITH TBAs

The purpose of this interview is to determine traditional birth attendants' lived experiences of the effectiveness of their training in relation to caring for pregnant mothers during antenatal, labor and postnatal periods.

Main question

Tell me about your experiences when caring for pregnant mothers during pregnancy, labor and after the birth of the child? Do you think that your training prepared you adequately for the care of these women?

Probing questions

- Tell me why you think that TBAs' training was adequate or not adequate in empowering TBAs to perform their MNH roles?
- Tell me the amount of support in relation to equipment, drugs, supplies, supportive supervision and transport for patient referral TBAs received when they were conducting deliveries?
- Do you think it is possible for the government to achieve its goal of facility based skilled attendant deliveries?
- What was the extent of TBAs involvement in the Government's decision to stop TBAs from conducting deliveries?
- What is your advice on the government's decision to stop TBAs from conducting deliveries?

Wrap up

In other countries even in developed countries mothers have an option of delivering at home with the help of a skilled attendant. What is your opinion of having skilled attendants right in the community?

Any other comment

Thank you very much for your participation.

This is the end of our discussion

ANNEXURE E

IN-DEPTH DEPTH INTERVIEW GUIDE WITH TBA TRAINERS

The purpose of this interview is to determine traditional birth attendant trainers' perceptions of the effectiveness of TBA training in relation to the TBAs role of caring for pregnant mothers during antenatal, labor and postnatal periods.

Main question

What are your perceptions of TBAs training and whether that prepared them adequately for their role of caring for pregnant mothers during antenatal, labor and after birth of the child?

Probing questions

- What is your perception of the quality of TBAs training in relation to training content, duration and the quality of TBA trainers' preparation
- How were TBAs' knowledge and skills reinforced after training?
- Can you tell me about the amount of support provided to TBAs in terms of equipment, drugs, supplies, supportive supervision and transport for patient referral?
- Why are some TBAs still conducting deliveries?
- What was the extent of communities' and service providers' involvement in the Government's decision to stop TBAs from conducting deliveries?
- What is your advice on the government's decision to stop TBAs from conducting deliveries?

Wrapping up

In other countries even in developed countries mothers have an option of delivering at home with the help of a skilled attendant. What is your opinion on having skilled attendants right in the community

Any other comment

Thank you very much for your participation.

This is the end of our discussion

ANNEXURE F

IN-DEPTH INTERVIEW GUIDE WITH MINISTRY LEVEL HEALTH CARE PROFESSIONALS

The purpose of this interview is to determine Ministry level Health Care Professionals' perceptions of the TBAs' maternal and neonatal health care roles in relation to the quality of training and amount of support TBAs received..

Main question

What are your perceptions of TBAs training? In your opinion did it prepare them adequately for their role of caring for pregnant mothers during antenatal, labor and after birth of the child?

Probing questions

- what is your perception of the quality of TBAs training in relation to training content, duration and the quality of TBA trainers' preparation
- Were there any plans to reinforce the TBAs knowledge and skills after training? If so, please describe these plans
- Was support given to TBAs in terms of equipment, drugs, supplies, supportive supervision and transport for patient referral?
- As you know, many TBA's are still conducting deliveries. Why do you think this is so?
- What was the extent of communities' and service providers' involvement in the Government's decision to stop TBAs from conducting deliveries?
- Have other jobs been established to assist/compensate TBAs for their loss of income?
- What is your advice on the government's decision to stop TBAs from conducting deliveries?

Wrapping up

In other countries even in developed countries mothers have an option of delivering at home with the help of a skilled attendant. What is your opinion of having skilled attendants right in the community

Any other comment

Thank you very much for your participation.

This is the end of our discussion

ANNEXURE G

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL) CLEARANCE FORM

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Ms E Banda/Prof P McInerney

CLEARANCE CERTIFICATE

M110416

PROJECT

The Perceptions of Key Stakeholders of
Changing the Role of Traditional Birth
Attendants in Rural Areas of Central West

Zone, Malawi

INVESTIGATORS

Ms E Banda/Prof P McInerney.

DEPARTMENT

Department of Nursing Education

DATE CONSIDERED

06/05/2011

DECISION OF THE COMMITTEE*

Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 15/07/2011

CHAIRPERSON 
P/(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Prof P McInerney

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10004, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress report.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

ANNEXURE H

APPROVAL FROM FACULTY OF HEALTH GRADUATES COMMITTEE



Faculty of Health Sciences
Medical School, 7 York Road, Parktown, 2193
Fax: (011) 717-2119
Tel: (011) 717-2076

Reference: Ms Salamina Segole
E-mail: salamina.segole@wits.ac.za
30 August 2011
Person No: 346452
TAA

Mrs EW Chitsa Banda
C/O Malawi Army Medical Services
Po Box 43
Lilongwe
Malawi

Dear Mrs Chitsa Banda

Doctor of Philosophy: Change of title of research

I am pleased to inform you that the following change in the title of your Thesis for the degree of has been approved:

From: **The implications of changing the role of traditional birth attendants in rural areas of Central West Zone, Malawi**
To **Perceptions of key stakeholders of the changing role of traditional birth attendants in rural areas of Central West Zone, Malawi**

Yours sincerely

A handwritten signature in black ink, appearing to read 'S Benn'.

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

ANNEXURE I

MALAWI NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE APPROVAL FORM

Telephone: + 265 789 400
Facsimile: + 265 789 431
e-mail doccentre@malawi.net
All Communications should be addressed to:
The Secretary for Health and Population



In reply please quote No. MED/4/36c

MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

14 November 2011

Evelyn Chitsa Banda
Ministry of Health

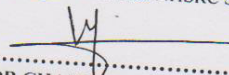
Dear Sir/Madam,

RE: Protocol # 954: Perceptions of key stakeholders of the changing role of traditional birth attendants in rural areas of central west zone, Malawi

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER** : NHSRC # 954
The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : 14/ 11/2011
- **EXPIRATION DATE** : This approval expires on 13/11/2012
After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** : All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS** : Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY** : On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS** : Please contact the NHSRC on Telephone No. (01) 724418, 0999218630 or by e-mail on moh@gmail.com
- **Other:**
Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.


.....
FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: Dr.C.Mwansambo (Chairman), Prof. Mfutso Bengo (Vice Chairperson)
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00003905 FWA00005976)

ANNEXURE J

LETTER OF APPROVAL FROM REPRODUCTIVE HEALTH UNIT

Telephone: + 265 1 756 869
Facsimile: + 265 1 756 869

All Communications should be addressed to: The
Secretary for Health and Population



In reply please quote No.

MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

29th August 2011

Ref #: MED 4 /RHU/94

Attention: Mrs Chitsa Banda

**RE: Permission To Conduct Research Titled Perceptions Of Key Stakeholders Of
The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West
Zone, Malawi**

Reference is made to your letter dated 23rd August 2011 in which you requested for a permission to conduct a research study titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi as part of your requirement for a PhD with Witwatersrand University.

I am pleased to inform you that your request has been granted provided you get approval from the National Health Sciences Research Committee. As requested you are allowed to conduct the study in Lilongwe, Dedza, Mchinji and Ntcheu in Central West Zone. The office hopes that the study will assist in the improvement of maternal and neonatal health care services in the country.

Good luck,

A handwritten signature in black ink, appearing to be 'F. Kachale'.

F. Kachale

Deputy Director, RHU

ANNEXURE K

LETTER OF APPROVAL FROM CHRISTIAN HEALTH ASSOCIATION OF MALAWI



CHAM CHRISTIAN HEALTH ASSOCIATION OF MALAWI

P.O. Box 30378, LILONGWE 3, Malawi.
Telephone Office: 01-775 180/404, 01-771 258 Fax: 01-775 406
E-mail: chamsec@cham.org.mw

Ref: CHAM/2011

25th November 2011

The Hospital Administrator
Mtendere Health Centre
P O Box 38
MALIRANA

Attention: Mrs E. Chitsa Banda

Dear Madam,

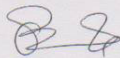
CLEARANCE TO GAIN ENTRY INTO HEALTH FACILITIES TO COLLECT DATA FROM CHAM HEALTH FACILITIES

This letter serves to approve Mrs Evelyn Chitsa Banda to gain access to collect data from Kapiri Hospital, Mtendere and Kasina Health Centres for her research.

Christian Health Association of Malawi understands that Mrs E. Chitsa Banda is a Zonal supervisor for Central West Zone and is an PHD student studying with Reach Trust in the country. CHAM Secretariat is aware and has proof that her research protocol has been approved by the National Health Sciences Research Committee (NHSRC) under the Ministry of Health (refer attached).

We therefore have no doubt that her research is ethically acceptable and safe. Cham Secretariat therefore advises that you give her clearance and the support from your institution.

Yours Sincerely,


PP Rose Kumwenda Ng'oma
EXECUTIVE DIRECTOR

ANNEXURE L

LETTER OF APPROVAL FROM NURSES AND MIDWIVES COUNCIL OF MALAWI

NURSES AND MIDWIVES COUNCIL OF MALAWI

All correspondence to be addressed to The Registrar



P.O. BOX 30361
CAPITAL CITY
LILONGWE 3
MALAWI
TEL: 01 772 044/772 730
Fax: 01 773 932
E-mail: nmcm@nmcm.org.mw

Ref. No. NC/A/RGR/26 VOL. I

5th September 2011

Ministry of Health
Nursing Section
P.O. Box 30377
LILONGWE 3

Dear Mrs Chitsa Banda,

**RE: PERMISSION TO CONDUCT INTERVIEWS IN THE DEPARTMENT OF
NURSING EDUCATION IN THE NURSES AND MIDWIVES COUNCIL OF
MALAWI**

Please refer to your letter dated 23rd August 2011 in relation to the above subject.

The Nurses and Midwives Council has granted you permission to conduct in-depth interviews with the Directorate of the Nursing Education as part of the Health Care Workers.

Please be advised that you may contact the Nursing Officers and make arrangements for the interviews.

We wish you all the best in your studies.

Yours sincerely,

 Martha Mondwa (MScN, MRNM)
REGISTRAR

ANNEXURE M

LETTER OF APPROVAL FROM NTCHEU DISTRICT COUNCIL

Telephone: + 265 235 431/411
Facsimile: + 265 235 462

All Communication should be addressed to: The
Secretary for Local Government



In reply please quote No. MED/18/115

MINISTRY OF LOCAL GOVERNMENT
NTCHEU DISTRICT COUNCIL
P. BAG 1
NTCHEU
MALAWI

29th August 2011

Attention: Mrs Chitsa Banda

**RE : Permission To Conduct Research Titled Perceptions Of Key Stakeholders Of
The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West
Zone, Malawi**

Reference is made to your letter dated 23rd August 2011 in which you requested for a permission to conduct a research study titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants. In some selected health facilities in Ntcheu District, Central West Zone, Malawi as part of your requirement for a PhD with Witwatersrand University.

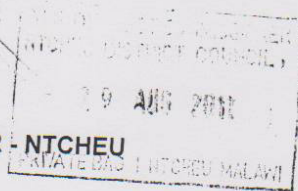
I am pleased to inform you that your request has been granted provided you get approval from the National Health Sciences Research Committee. As requested you are allowed to conduct interviews and focus group discussions with mothers, Nurse Midwives, Traditional Births Attendants (TBAs) and TBA trainers from Katsekera, Bilira, Kapeni, Kasinje and Lizulu Health Centers in Ntcheu district, Central West Zone. The

office hopes that the study will assist in the improvement of maternal and neonatal health care services in our district.

Good luck,

Macloud Kadam'manja

DISTRICT COMMISSIONER - NTCHOU



ANNEXURE N

LETTER OF APPROVAL FROM DEDZA DISTRICT COUNCIL

Telephone: + 265 1 223 379
Facsimile: + 265 1223 379

All Communications should be addressed to: The
Secretary for Local Government



In reply please quote No.

MINISTRY OF LOCAL GOVERNMENT
DEDZA DISTRICT ASSEMBLY
P.O BOX 140
DEDZA
MALAWI

Ref No. Re/No DDC/ADM/1/39/22

Attention: Mrs Chitsa Banda

RE: Permission To Conduct Research Titled Perceptions Of Key
Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural
Areas Of Central West Zone, Malawi

Reference is made to your letter dated 23rd August 2011 in which you requested for a permission to conduct a research study titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants. In some selected health facilities in Ntcheu District, Central West Zone, Malawi as part of your requirement for a PhD with Witwatersrand University.

I am pleased to inform you that your request has been granted provided you get approval from the National Health Sciences Research Committee. As requested

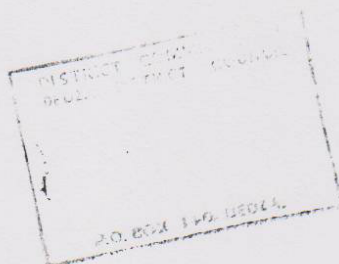
you are allowed to conduct interviews and focus group discussions with mothers, Nurse Midwives, Traditional Births Attendants (TBAs) and TBA trainers from Kasina, Mtendere, Kaphuka, Chitowo, Chikuse, Mayani, Golomoti, Lobi and Mtakataka Health Centers in Dedza district, Central West Zone. The office hopes that the study will assist in the improvement of maternal and neonatal health care services in our district.

Good luck,



Sphiwe. Mauwa

DC Dedza



ANNEXURE O

LETTER OF APPROVAL FROM LILONGWE DISTRICT COUNCIL



LILONGWE DISTRICT COUNCIL

DISTRICT HEADQUARTERS, P.O. BOX 93, LILONGWE

All communications to be addressed to:

The District Commissioner

TEL: +(265) 1 756 110/ 759 730

FAX: +(265) 1 759 730

REF

DATE : 30th August, 2011

Attention: Mrs Chitsa Banda

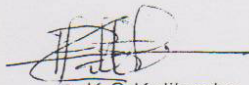
RE: Permission To Conduct Research Titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi

Reference is made to your letter dated 23rd August 2011 in which you requested for a permission to conduct a research study titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants. In some selected health facilities in Ntcheu District, Central West Zone, Malawi as part of your requirement for a PhD with Witwatersrand University.

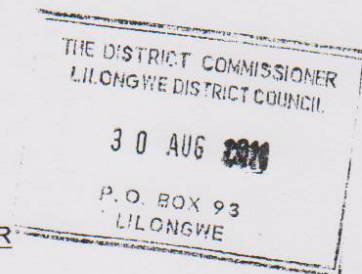
I am pleased to inform you that your request has been granted provided you get approval from the National Health Sciences Research Committee. As requested you are allowed to conduct interviews and focus group discussions with mothers, Nurse Midwives, Traditional Births Attendants (TBAs) and TBA trainers from Chileka.

Chitedze, Nathenje, Mlenthara, Matapira and Nsaru Health Centers in Lilongwe District, Central West Zone. The office hopes that the study will assist in the improvement of maternal and neonatal health care services in our district.

Good luck,


P.K.C Kalilombe

DISTRICT COMMISSIONER



ANNEXURE P

LETTER OF APPROVAL FROM MCHINJI DISTRICT COUNCIL

Telephone: + 265 124 2901
Facsimile: + 265 124 2442

All Communications should be addressed to: The
Secretary for Local Government



In reply please quote No.

MINISTRY OF LOCAL GOVERNMENT
MCHINJI DISTRICT COUNCIL
P.O. BOX 1
MCHINJI
MALAWI

Ref # MGT.22/04/310

Attention: Mrs Chitsa Banda

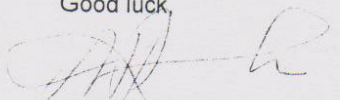
**RE: Permission To Conduct Research Titled Perceptions Of Key Stakeholders Of
The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West
Zone, Malawi**

Reference is made to your letter dated 23rd August 2011 in which you requested for a permission to conduct a research study titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants. In some selected health facilities in Ntcheu District, Central West Zone, Malawi as part of your requirement for a PhD with Witwatersrand University.

I am pleased to inform you that your request has been granted provided you get approval from the National Health Sciences Research Committee. As requested you are allowed to conduct interviews and focus group discussions with mothers, Nurse Midwives, Traditional Births Attendants (TBAs) and TBA trainers from Mkanda, Mikundi, Kochilira and Kapiri Health Centers in Mchinji district, Central West Zone. The office

hopes that the study will assist in the improvement of maternal and neonatal health care services in our district.

Good luck,



A Phiri

15 SEP 2011

DC Mchinji

ANNEXURE Q

LETTER OF APPROVAL FROM NTCHEU DISTRICT HEALTH OFFICE

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

All Communications should be addressed to: The
Secretary for Health and Population



In reply please quote No.

MINISTRY OF HEALTH
P. BAG 5
NTCHEU
MALAWI

29th August 2011:

Ref #: NU/DHO 15

Attention: Mrs Chitsa Banda

RE: Permission To Conduct Research Titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi

Reference is made to your letter dated 23rd August 2011 in which you requested for a permission to conduct a research study titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants. In some selected health facilities in Ntcheu District, Central West Zone, Malawi as part of your requirement for a PhD with Witwatersrand University.

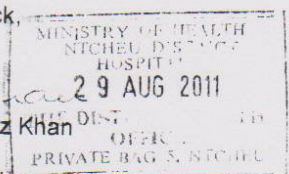
I am pleased to inform you that your request has been granted provided you get approval from the National Health Sciences Research Committee. As requested you are allowed to conduct interviews and focus group discussions with mothers, Nurse Midwives, Traditional Births Attendants (TBAs) and TBA trainers from Katsekera, Bilira, Kapeni, Kasinje and Lizulu Health Centers in Ntcheu district, Central West Zone. The

office hopes that the study will assist in the improvement of maternal and neonatal health care services in our district.

Good luck,

Dr. Shiraz Khan

DHO Ntcheu



ANNEXURE R

LETTER OF APPROVAL FROM DEDZA DISTRICT HEALTH OFFICE

Telephone: + 265 1 223 522
Facsimile: + 265 1 223 523

All Communications should be addressed to: The
Secretary for Health and Population



In reply please quote No.

MINISTRY OF HEALTH
P.O. BOX 136
DEDZA
MALAWI

31st August 2011

Ref #: DZ/DHO 17

Attention: Mrs Chitsa Banda

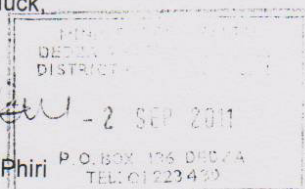
RE: Permission To Conduct Research Titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi

Reference is made to your letter dated 23rd August 2011 in which you requested for a permission to conduct a research study titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants. In some selected health facilities in Ntcheu District, Central West Zone, Malawi as part of your requirement for a PhD with Witwatersrand University.

I am pleased to inform you that your request has been granted provided you get approval from the National Health Sciences Research Committee. As requested you are allowed to conduct interviews and focus group discussions with mothers, Nurse Midwives, Traditional Births Attendants (TBAs) and TBA trainers from Kasina,

Mtendere, Kaphuka, Chitowo, Chikuse, Mayani, Golomoti, Lobi and Mtakataka Health Centers in Dedza district, Central West Zone. The office hopes that the study will assist in the improvement of maternal and neonatal health care services in our district.

Good luck,



B. Phiri P.O. BOX 126 DEDZA
TEL: 01223430

Dedza DHO

ANNEXURE S

LETTER OF APPROVAL FROM LILONGWE DISTRICT HEALTH OFFICE

Telephone: + 265 1 727 060
Facsimile: + 265 1 725 142

All Communications should be addressed to: The
Secretary for Health and Population



In reply please quote No.

MINISTRY OF HEALTH
P.O BOX 1274
LILONGWE
MALAWI

30th August 2011

Ref #: LL /DHO 11

Attention: Mrs Chitsa Banda

**RE: Permission To Conduct Research Titled Perceptions Of Key Stakeholders Of
The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West
Zone, Malawi**

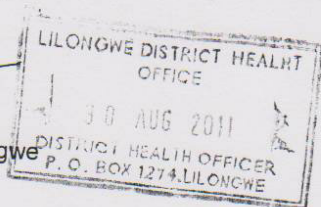
Reference is made to your letter dated 23rd August 2011 in which you requested for a permission to conduct a research study titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants. In some selected health facilities in Ntcheu District, Central West Zone, Malawi as part of your requirement for a PhD with Witwatersrand University.

I am pleased to inform you that your request has been granted provided you get approval from the National Health Sciences Research Committee. As requested you are allowed to conduct interviews and focus group discussions with mothers, Nurse Midwives, Traditional Births Attendants (TBAs) and TBA trainers from Chileka, Chitedze, Nathenje, Mtenthera, Matapira and Nsaru Health Centers in Lilongwe district,

Central West Zone. The office hopes that the study will assist in the improvement of maternal and neonatal health care services in our district.

Good luck,


M Mwale
DHO Lilongwe



ANNEXURE T

LETTER OF APPROVAL FROM MCHINJI DISTRICT HEALTH OFFICE

Telephone: + 265 1 242 310
Facsimile: + 265 1 242 235

All Communications should be addressed to: The
Secretary for Health and Population



In reply please quote No.

MINISTRY OF HEALTH
P.O. BOX 36
MCHINJI
MALAWI

31st August 2011

Ref #: MC/ DHO 13

Attention: Mrs Chitsa Banda

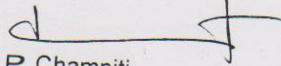
**RE: Permission To Conduct Research Titled Perceptions Of Key Stakeholders Of
The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West
Zone, Malawi**

Reference is made to your letter dated 23rd August 2011 in which you requested for a permission to conduct a research study titled Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants. In some selected health facilities in Ntcheu District, Central West Zone, Malawi as part of your requirement for a PhD with Witwatersrand University.

I am pleased to inform you that your request has been granted provided you get approval from the National Health Sciences Research Committee. As requested you are allowed to conduct interviews and focus group discussions with mothers, Nurse Midwives, Traditional Births Attendants (TBAs) and TBA trainers from Mkanda, Mikundi,

Kochilira and Kapiri Health Centers in Mchinji district, Central West Zone. The Office hopes that the study will assist in the improvement of maternal and neonatal health care services in our district.

Good luck,



P Champiti

DHO Mchinji

ANNEXURE U

SUBJECT INFORMATION SHEET FOR MOTHERS PARTICIPANTS

Good morning/afternoon -----

My name is Evelyn Chitsa Banda and I am conducting a research titled “Perceptions of Key Stakeholders of Changing the Role of Traditional Births Attendants in the Rural Areas of Central West Zone. I would like to collect information from mothers who once delivered at a TBA and have now come to deliver, or are already delivered at this facility. I would like to request you to participate in the study as a participant. If you are willing to be interviewed I will ask you to give consent to participate in the study. Participation in this study is voluntary and you are not obliged to finish the interviews if you don’t feel like it. Confidentiality will be ensured as far as possible. Your name will not be filled in on the interview form ensuring confidentiality. The name of the facility will also not be indicated on the form. Instead codes will be used in case there is need for some clarification from you. All information divulged will be kept in locked cupboards.

The interview is a series of questions in a questionnaire which will be filled by the researcher. The process will take up to 20 minutes and it will take place here at the facility. Information provided by you will assist the health care system on how to provide services in a more efficient and effective manner. Even though there is no direct benefit to you for your participation in the study, your contributions will provide for a more acceptable service provision for others in the future. There is no penalty for refusing to participate in the study now or at any other given time. Data collected will be in custody of the researcher up to 2 years after publication of a journal article.

If there are any questions or areas that need clarification I am willing to respond to your questions.

Thank you for your time,

Evelyn Chitsa Banda.

ANNEXURE V

CONSENT FORM: MOTHERS PARTICIPANTS

I _____ hereby agree to voluntarily participate in the study by Evelyn Chitsa Banda on “Perceptions of Key Stakeholders of Changing the Role of Traditional Births Attendants in Rural Areas of Central West Zone.”

I understand that my choice to participate in this interview or not, will not influence the way I will receive services at this facility in any way now or in the future. I have been informed that am not obliged to complete the interview if at one point I change my mind not to complete the activity.

I understand that my name or the name of this facility will not be mentioned in the study findings and the report and that any information given by me in this study will be treated in confidence by the researcher.

Signed_____

Witness_____

Date_____

ANNEXURE W

INFORMATION SHEET FOR GUARDIANS OF MINORS WHO ARE MOTHERS PARTICIPANTS

Good morning/afternoon -----

My name is Evelyn Chitsa Banda and I am conducting a research titled “Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi”. I am expected to collect information from mothers who once delivered at a TBA and have now come to deliver or are already delivered at this facility. I would like to request you to allow your minor to participate in the study as a participant. If you are willing, I will ask you to assent for her to participate in the study.

Participation in this study is voluntary and she is not obliged to finish the interviews if she doesn't feel like it. Confidentiality will be ensured as far as possible. Your name or that of your ward will not be filled in on the interview form ensuring confidentiality. The name of the facility will also not be indicated on the form. Instead codes will be used in case there is need for some clarification from her. All information divulged will be kept in locked cupboards.

The interview is a series of questions in a questionnaire which will be filled by the researcher. The process will take up to 20 minutes and it will take place here at the facility. Information provided by her will assist the health care delivery system on how to provide services in a more efficient and effective manner. Her participation in the study will provide for a more acceptable service provision for mothers in future. There is no penalty for refusing to participate in the study now or at any other given time. Data collected will be in custody of the researcher up to 2 years after publication of a journal article.

If there are any questions or areas that need clarification I am ready to provide such.

Thank you for your time,

Evelyn Chitsa Banda.

ANNEXURE X

CONSENT FORM: GUARDIANS OF MOTHERS PARTICIPANTS WHO ARE MINORS

I _____ hereby allow my ward to voluntarily participate in the study by Evelyn Chitsa Banda on “Perceptions of Key Stakeholders of Changing the Role of Traditional Births Attendants in Rural Areas of Central West Zone.

I have been informed and understand that my choice to allow my ward to participate in this interview or not will not influence the way she or I will receive services at this facility in any way now or in the future. I have been informed that she is not obliged to complete the interview if at one point she doesn't feel like completing the activity.

I understand that my name, her name or the name of this facility will not be mentioned in the study findings and the report and that any information given by my ward in this study will be treated in confidence by the researcher.

Signed_____

Witness_____

Date_____

ANNEXURE Y

SUBJECT INFORMATION SHEET FOR MOTHERS PARTICIPANTS WHO ARE MINORS

Good morning/afternoon -----

My name is Evelyn Chitsa Banda and I am conducting a research titled “Perceptions of Key Stakeholders of Changing the Role of Traditional Births Attendants in the Rural Areas of Central West Zone. I would like to collect information from mothers who once delivered at a TBA and have now come to deliver, or are already delivered at this facility. I would like to request you to participate in the study as a participant. If you are willing to be interviewed I will ask you to give consent to participate in the study. Participation in this study is voluntary and you are not obliged to finish the interviews if you don’t feel like it. Confidentiality will be ensured as far as possible. Your name will not be filled in on the interview form ensuring confidentiality. The name of your guardian and that of the facility will also not be indicated on the form. Instead codes will be used in case there is need for some clarification from you. All information divulged will be kept in locked cupboards.

The interview is a series of questions in a questionnaire which will be filled by the researcher. The process will take up to 20 minutes and it will take place here at the facility. Information provided by you will assist the health care system on how to provide services in a more efficient and effective manner. Even though there is no direct benefit to you for your participation in the study, your contributions will provide for a more acceptable service provision for others in the future. There is no penalty for refusing to participate in the study now or at any other given time. Data collected will be in custody of the researcher up to 2 years after publication of a journal article.

If there are any questions that need clarification I am willing to respond to your queries.

Thank you for your time,

Evelyn Chitsa Banda.

ANNEXURE Z

ASSENT FORM: MOTHERS PARTICIPANTS WHO ARE MINORS

I _____ hereby agree to voluntarily participate in the study by Evelyn Chitsa Banda on “Perceptions of Key Stakeholders of Changing the Role of Traditional Births Attendants in Rural Areas of Central West Zone.”

I understand that my choice to participate in this interview or not, will not influence the way I will receive services at this facility in any way now or in the future. I have been informed that am not obliged to complete the interview if at one point I change my mind not to complete the activity.

I understand that my name, the name of my guardian, or the name of this facility will not be mentioned in the study findings and the report and that any information given by me in this study will be treated in confidence by the researcher.

Signed _____

Witness _____

Date _____

ANNEXURE AA

SUBJECT INFORMATION SHEET FOR NURSE MIDWIVES PARTICIPANTS

Good morning/good afternoon -----

My name is ----- and I am assisting a student who is registered with the University of the Witwatersrand in RSA as a PhD student in Nursing. Her study topic is "Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi". As a requirement of the study; she is expected to collect information from nurse midwives providing Maternal and Neonatal Health care to mothers and their newborn.

The purpose of this letter is to ask your permission to participate in the study as a participant. If you agree to assist, I will ask you to give consent to participate in the study. Participation in this study is voluntary and you are not obliged to finish the interviews if you don't feel like it. Confidentiality will be ensured as far as possible. Your name will not be filled in on the interview form ensuring confidentiality. The name of the facility will also not be indicated on the form. Instead codes will be used in case there is need for some clarification from you. All information divulged will be kept in locked cupboards.

The interview is a series of questions in a questionnaire which will be filled by the researcher. The process will take up to 25 minutes and it will take place here at the facility. Even though there is no direct benefit for your participation in the study, your contributions will provide for a more acceptable service provision for mothers you are caring for. There is no penalty for refusing to participate in the study now or at any other given time. Data collected will be in custody of the researcher up to 2 years after publication of a journal article.

If there are any questions or areas that need clarification I am ready to provide such.

In case you need some assistance regarding our discussion you can contact the Human Research Ethics committee (Medical) on the address provided below.

Thank you for your time,

Contact: The Secretary, Human Research Ethics Committee (Medical), University of the Witwatersrand, East Campus, Senate House, 10th Floor
Private Bag 3, Wits, 2050, Republic of South Africa
Tel 0027 11 717-1234 Fax 0027 11 717 1265
Email: anisa.keshav@wits.ac.za

ANNEXURE BB

CONSENT FORM: NURSE MIDWIVES PARTICIPANTS

I _____ hereby agree to voluntarily participate in the data collection process done by _____ for a study topic on “Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi”.

I understand that my choice to participate in this interview or not will not have any implications as to how I provide services at this facility now or in the future and that I am not obliged to complete the interview if at one point I change my mind not to complete the activity.

I understand that my name, names of my patients or other staff and the name of this facility will not be mentioned in the study findings and the report and that any information given by me in this study will be treated in confidence.

Signed _____

Witness _____

Date _____

ANNEXURE CC

SUBJECT INFORMATION SHEET FOR TRADITIONAL BIRTHS ATTENDANTS PARTICIPANTS

Dear Potential Participants,

Good morning/good afternoon. My name is Evelyn Chitsa Banda and I am conducting a research titled “Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi.” As part of my study I wish to conduct focus group interviews with Traditional Births Attendants in your area.

I would like to request your participation in this focus group interview as study participants. If you agree to assist me, I will ask you to give consent to participate in the study. Participation in this study is voluntary and you are not obliged to finish the interviews if you don't feel like it. Confidentiality will be ensured as far as possible on the part of the researcher. You will be asked to choose a pseudonym by which I will address you during the discussion and which will enable me to know who made comments when I analyze the data. Your name will not be filled in on the interview form ensuring confidentiality. The name of the facility or your village will also not be indicated on the form. Instead I will use codes for my own use in case I need some clarification from you. All information divulged to me will be kept in locked cupboards. However it cannot be ensured that other members in the group will not break confidentiality.

The process will take up to 40 minutes and it will take place here at the facility. I will also request for your permission to allow me to use tape recorder during our discussion in order to assist me remember everything that will transpire in this discussion. The recorded information will be kept in a locked cupboard in my own office and will not be accessed by anyone else but me. The tape will be destroyed after the report has been accepted. If you feel like you do not want to be recorded or in the course of our discussion you happen to change your mind on the use of the tape recorder let me know and I will write your responses on paper. I will be taking notes to help me remember what you said during our discussion. Even though there is no direct benefit for your participation in the study, your contributions will provide for a more acceptable service provision for mothers in future. There is no penalty for refusing to participate in the study now or at any other given time. You will be reimbursed for travel costs. Data collected will be in custody of the researcher up to 2 years after publication of a journal article.

If there are any questions or areas that need my clarification I am ready to provide such.

Thank you for your time,

Evelyn Chitsa Banda.

ANNEXURE DD

CONSENT FORM: TBAs PARTICIPANTS

I _____ hereby agree to voluntarily participate in the study by Evelyn Chitsa Banda on “Perceptions of Key Stakeholders of Changing the Role of Traditional Births Attendants in Rural Areas of Central West Zone”.

I understand that my choice to participate in the focus group discussions is voluntary and that I am not obliged to complete the discussions if at one point I change my mind not to complete the activity.

I understand that my name, name of my village or the name of this facility will not be mentioned in the study findings and the report and that any information given by me in this study will be treated in confidence by the researcher.

Signed _____

Witness _____

Date _____

ANNEXURE EE

SUBJECT INFORMATION SHEET FOR TBA TRAINERS PARTICIPANTS

Good morning/good afternoon Potential Participants

My name is Evelyn Chitsa Banda and I am registered with the University of Witwatersrand in RSA as a PhD student in Nursing. My study topic is “Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi”. As a requirement of my study; I am expected to conduct in depth interviews with Nurse Midwives who were certified to train TBAs.

The purpose of this letter is to ask your permission to participate in this in depth interviews as a study participant. It is very important that you understand that this study is aiming at obtaining your perceptions on the effectiveness of TBA services and results will not have any bearing on your performance as a nurse midwife.

If you agree to assist me, I will ask you to give consent to participate in the study. Participation in this study is voluntary and you are not obliged to finish the interviews if you don't feel like it. Confidentiality will be ensured as far as possible. Your name will not be filled in on the interview form ensuring confidentiality. Instead I will use codes for my own use in case I need some clarification from you. All information divulged to me will be kept in locked cupboards.

The process will take up to 30 minutes and it will take place here at the facility. I will also request for your permission to allow me to use tape recorder during our discussion in order to assist me remember everything that will transpire in this discussion. The recorded information will be kept in a locked cupboard in my own office and will not be accessed by anyone else but me. The tape will be destroyed after the report has been accepted. If you feel like you do not want to be recorded or in the course of our discussion you happen to change your mind on the use of the tape recorder let me know and I will write your responses on paper. I will be taking notes to help me remember what you said during our discussion. Information provided

by you will assist the health care delivery system on how to provide services in an efficient and effective manner. Even though there is no direct benefit for your participation in the study, your contributions will provide for a more acceptable service provision for mothers. There is no penalty for refusing to participate in the study now or at any other given time. Participants will be reimbursed for their travel costs. Data collected will be in custody of the researcher up to 2 years after publication of a journal article.

If there are any questions or areas that need my clarification I am ready to provide such.

In case you need some assistance regarding our discussion you can contact the Human Research Ethics committee (Medical) on the address provided below.

Thank you for your time,

Evelyn Chitsa Banda.

Contact: The Secretary, Human Research Ethics Committee (Medical), University of the Witwatersrand, East Campus, Senate House, 10th Floor

Private Bag 3, Wits, 2050, Republic of South Africa

Tel 0027 11 717-1234 Fax 0027 11 717 1265

Email: anisa.keshav@wits.ac.za

ANNEXURE FF

CONSENT FORM: TBA TRAINERS PARTICIPANTS

I _____ hereby agree to voluntarily participate in the study by Evelyn Chitsa Banda on “Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi”.

I understand that my choice to participate in in-depth interviews or not will not impact on the way I provide services as an MNH care provider. I understand that proceedings from this discussion will not have a repercussion on me as a MNH provider but that only my views on TBA services are the ones being sought.

I understand that am not obliged to complete the discussions if at one point I change my mind not to complete the activity.

I understand that my name or the name of my district will not be mentioned in the study findings and the report and that any information given by me in this study will be treated in confidence by the researcher.

Signed _____

Witness _____

Date _____

ANNEXURE GG

SUBJECT INFORMATION SHEET FOR HEALTH CARE PROFESSIONALS

Good morning/good afternoon-----

My name is Evelyn Chitsa Banda and I am registered with the University of Witwatersrand in RSA as a PhD student in Nursing. My study topic is “Perceptions Of Key Stakeholders Of The Changing Role Of Traditional Birth Attendants In Rural Areas Of Central West Zone, Malawi”. As a requirement of my study; I am expected to conduct interviews with Health Care Professionals.

The purpose of this letter is to ask your permission to participate in the study as a participant. If you agree to assist me, I will ask you to give consent to an interview at a venue and date of your choice in the month of January 2012. The interview will last for about 45 minutes. With your permission, the interview will be audio tape recorded. Participation in this study is voluntary and you are not obliged to finish the interviews if you don't feel like it. Confidentiality will be ensured as far as possible. Your name will not be filled in on the interview form ensuring confidentiality. The name of the department/ directorate will also not be indicated on the form. Instead I will use codes for my own use in case I need some clarification from you. All information divulged to me will be kept in locked cupboards.

The process will take up to 30 minutes and it will take place here at the facility. I will also request for your permission to allow me to use tape recorder during our discussion in order to assist me remember everything that will transpire in this discussion. The recorded information will be kept in a locked cupboard in my own office and will not be accessed by anyone else but me. The tape will be destroyed after the report has been accepted.. If you feel like you do not want to be recorded or in the course of our discussion you happen to change your mind on the use of the tape recorder let me know and I will write your responses on paper. I will be taking notes to help me remember what you said during our discussion. Information provided by you will assist the health care delivery system on how to provide services in an efficient and effective manner. Even though there is no direct benefit for your participation in the study,

your contributions will provide for an informed decision making for a more acceptable and effective service provision for mothers. There is no penalty for refusing to participate in the study now or at any other given time. Data collected will be in custody of the researcher up to 2 years after publication of a journal article.

If there are any questions or areas that need my clarification I am ready to provide such. My contact number is indicated below. In case you need some assistance regarding our discussion you can contact the Human Research Ethics committee (Medical) on the address provided below.

Thank you for your time,

Evelyn Chitsa Banda.

Cellphone number: 0999936937

Office number: 01706206 email: chitsabandaeve@yahoo.com

Contact: The Secretary, Human Research Ethics Committee (Medical), University of the Witwatersrand, East Campus, Senate House, 10th Floor

Private Bag 3, Wits, 2050, Republic of South Africa

Tel 0027 11 717-1234

Fax 0027 11 717 1265

Email: anisa.keshav@wits.ac.za

ANNEXURE HH

CONSENT FORM: MINISTRY LEVEL HEALTH CARE PROFESSIONAL PARTICIPANTS

I _____ hereby agree to voluntarily participate in the study by Evelyn Chitsa Banda on “Perceptions of Key Stakeholders of the Changing Role of Traditional Birth Attendants in Rural Areas of Central West Zone, Malawi”.

I understand that my choice to participate in the in-depth interviews is completely voluntary and does not necessarily reflect on my work. I have also been informed that I am not obliged to complete the interview if at one point I change my mind not to complete the activity.

I understand that my name will not be mentioned in the study findings and the report and that any information given by me in this study will be treated in confidence by the researcher.

Signed _____

Witness _____

Date _____

ANNEXURE II

CONSENT FORM FOR USE OF TAPE RECORDER

I _____ hereby allow the researcher to use a tape recorder for purposes of recording our discussion. I understand that the equipment may be switched off at any point if I change my mind on its use during our discussion.

Signed _____

Witness _____

Date _____