

https://dspace.org/

Community perceptions of maternal health services in rural areas in Dedza district in Malawi

Divala, Priscilla

2020
https://hdl.handle.net/10539/29958

Downloaded from a DSpace repository. https://dspace.org/

Community perceptions of maternal health services in rural areas in Dedza district in Malawi

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master in Public Health (Rural Health).

Priscilla Divala

Student number: 1131428

Supervisor: Dr Motlatso Mlambo

Co-supervisor: Mr Stephen Pentz

© Johannesburg, May 2020

DECLARATION

I, Priscilla Divala, declare that this Research Report is my own work. It is being submitted for the Degree of Master of Public Health in rural health at the University of the Witwatersrand, Johannesburg. I declare that this work or part thereof has never been submitted for any degree or examination at any other University.

_____

Candidate Signature

Date: 19.06.2020

Ethical Clearance Number: M170867.

DEDICATION

In memory of my mother

Nessie Kanyemba

1945 – 2011

ABSTRACT

Background:

Maternal health services continue to be a challenge in rural areas of Malawi. Understanding this challenge, in the Malawian context, is important in achieving a responsive health system. Maternal health care services are more effective if communities perceive them as reliable and also if there is a shared understanding between the community and the health-care providers.

Aim:

This study aimed to explore community perceptions of maternal health services in rural areas of Dedza District in Malawi.

Methods:

This study employed exploratory qualitative research design. For data collection, three focus group discussions (FGDs) and 15 one-on-one in-depth interviews were conducted. In total, 24 men participated in the FGDs and the 15 one-on-one interviews were conducted on women.Data was collected using Chichewa, a native Malawi language, and were translated to English. Back translation was performed for credibility purposes. Inductive coding of participants' quotations was utilized for thematic analysis. Themes were generated by comparing codes from the in-depth interviews and those from the FGDs. MAXQDA software, version 12, was used both for management and analysis of data.

Results:

Five themes could be generated from the community's perceptions on maternal health service provision. The first three themes report on the available services and users' appreciation of those services. The themes are; 1) Maternal health services package understanding; 2) Community appreciation and preference of health care providers 3) Maternal health services provision barriers and challenges. Themes 4 and 5 expose challenges that are faced by the health system. Respectively, these themes are; 4)

Maternal health sercive patient challenges; 5) Proposals on maternal health service improvement plans.

Conclusion:

In Malawi's rural areas there are available maternal health services. Some of these are appreciated by the users. However, there are challenges that both the health system and respective users face. In order to reduce maternal mortality rate in Malawi's rural areas, it is paramount for people, especially those that are poor, to utilize maternal health services. Access to health services was improved through the introduction of community by-laws. This has since decreased maternal mortality rate in Malawi. However, the ethical implications of the introduction of community by-laws compromise women's autonomy in health care decision making.

Key words:

Malawi, maternal mortality, maternal health services, community by-laws

ACKNOWLEDGEMENTS

- Glory be to God for the unending favours and blessings He always showers on me. I am blessed to be a blessing to others.
- I would like to thank my Supervisors, Dr Motlatso Mlambo and Mr Stephen Pentz for teaching me what it means to be an excellent researcher.
- Very special thanks to Dr Mlambo for always encouraging me to go to the next level. I have learnt so much throughout the years that I have worked with her.
- This study is dedicated to my husband Joseph, my children Shalom and Chikondi. I wish to sincerely thank you all for your love, support and strong belief in me.
- I wish also to thank my long-time friend, Richard Perekamoyo for being there for me time and again.
- Finally, let me recognize all my classmates in the rural health program for the amazing experiences we have had and the knowledge we shared as a team.
- For those not mentioned here but you tacitly or overtly played a critical role in this study, please feel honoured and appreciated.

List of tables

Table 3.1 ……. Demographic information of FGD participants

Table 3.2……Demographic profile of FGD participants

Table 3.2 ……..Demographic profile of IDI participants

Table 3.3 ……. Themes and sub themes for FGDs and IDIs

List of figures

Figure 2.1 …… Map of the study area in Dedza district in Malawi

List of acronyms

AIDS:	Acquired immunodeficiency syndrome
ANC:	Antenatal care
C/S:	Caesarean section
CMS:	Central medical stores
EHP:	Essential health package
EmOC:	Emergency maternal obstetrics care (This is the official usage of the term in Malawi)
EmONC:	Emergency maternal obstetric needs care
EPMM:	Ending preventable maternal mortality
FGDs:	Focus group discussions
HIV:	Human Immunodeficiency Virus
IDI:	In-depth interviews

MDGs:	Millennium Development Goal(s)
MHS:	Maternal health services
MMR:	Maternal mortality rate
PHC:	Primary healthcare
PoW:	Plan of work
PPH:	Post-partum haemorrhage
PMTCT:	Prevention of mother to child transmission
SDGs:	Sustainable development goals
TB:	Tuberculosis
WHA:	World Health Act
WHO:	World Health Organization

Definition of terms/concepts

Maternal health:

The health of women during pregnancy, child birth and up to six weeks after giving birth. It involves tracking down the health of a woman from preconception to postnatal and family planning. This is meant to ensure positive results that reduce maternal morbidity and mortality (1).

Maternal health services:

Health care services with dimensions of family planning, preconception, prenatal and postnatal care. These services aim to ensure a positive and fulfilling experience and reduce maternal morbidity and mortality (1).

Maternal mortality rate:

The "number of registered maternal deaths due to birth- or pregnancy-related complications per 100,000 registered live births"(1).

Malawi:

A landlocked country in the southeast of Africa. It was formerly known as Nyasaland until 1964. It has a population of 18.6 million people. It shares the boarder with Zambia, Tanzania and Mozambique (2).

Community by-laws:

Community rules and regulations (66).

Service package:

A minimum package of services which is made available to communities within a certain period of time. It includes; staff, infrastructure, equipment and financial resources (62) .

Service delivery:

Provision of sufficient, affordable and quality basic services such as maternal health care to the community (62).

Service improvement:

A systemic approach that uses specific techniques to deliver and measure sustained improvement of health care quality (2).

Service outcome:

The changes expected to result from a health service program (3).

Community perceptions:

The way the community understands, regard and interpret information 38).

Community participation:

Voluntary process by which people including the disadvantaged, influence or control the decisions that affect them (38).

TABLE OF CONTENTS

DECLARATION i

DEDICATION ii

ABSTRACT iii

ACKNOWLEDGEMENTS v

List of tables vi

List of figures vi

List of acronyms vi

Definition of terms/concepts viii

CHAPTER ONE 1

INTRODUCTION AND ORIENTATION FOR THE STUDY 1

1.1 Introduction 1

1.1.1 Why are maternal health services needs a key concern? 1

1.1.2 Maternal health problems in Malawi 2

1.2 Problem statement 4

1.5 Justification of the study 6

1.6 Research question 7

1.6.1 Aim 7

1.6.2 Objectives 7

1.7 Literature review 7

1.7.1 Determinants of maternal health services. 8

1.7.1.1 Socio -economic status 8

1.7.1.2 Availability of resources and health services provider's behaviours 8

1.7.1.3 Community participation in maternal health services 8
1.7.1.4 Quality of care 9
1.7.2 Social-cultural determinants in maternal health services 10
1.7.2.1 The use of traditional birth attendants (TBA) or Azamba 10
1.7.2.2 Cultural beliefs 10
1.7.2.3 Level of education and lack of knowledge 11
1.7.2.4 Poor health decision-making 12
1.7.2.5 Community level delays in seeking maternal health services 12
1.7.2.6 Age of a woman 12
1.7.3 Global and local agendas 13
1.7.3.1 Sustainable development goals (SDGs) 13
1.7.3.2 The Safe motherhood initiative 13
1.7.3.3 The role of primary health care in promoting maternal health care access and reducing MMR 14
1.7.3.4 Universal health coverage in Malawi 14
1.7.3.4.1 The role of Health Surveillance Assistants (HSAs)..... 15
1.7.4 Global perspectives on barriers to maternal health care services 15
1.7.4.1 Maternal Mortality rate and access to maternal health services 15
1.7.4.2 Financial and infrastructure barriers 16
1.7.4.3 Cost and distance 16
1.8 Conclusion 17
CHAPTER TWO 18
RESEARCH METHODOLOGY 18
2.1 Introduction 18
2.2 Study design 18

2.2.1 Study site 18
2.2.2 Study population and sampling 20
2.2.3 Inclusion and exclusion criteria 21
2.3 Data collection 22
2.3.1 Focus group discussion with men 22
2.3.2 In-depth interviews with women 23
2.4 Data preparation and analysis 24
2.4.1 Ethical consideration 24
2.4.2 Data preparation 25
2.4.3 Trustworthiness and credibility 26
2.4.4 Dependability 26
2.4.5 Transferability 27
2.4.6 Confirmability 27
2.5 Reflexivity 27
2.6 Risks and Benefits 28
2.7 Conclusion 28
CHAPTER THREE 29
RESEARCH RESULTS 29
3.1 Introduction 29
3.2 Demographic profile of the FGD participants 29
3.3 Demographic characteristics for IDI participant 30
3.4 Presentation of the FGDs and IDIs Findings 31
3.4.1 Theme one: Mother and child health services 33
3.4.1.1 Vital signs and general screening of diseases 34
3.4.1.2 Maternal testing of HIV and partner recruitment to ANC 35

3.4.1.3 Foetal monitoring 36
3.4.1.4 Introduction of Safe motherhood and incentives 37
3.4.1.5 Hospital referrals 38
3.4.1.6 Administration of chronic disease medication 38
3.4.2 Theme two: Appreciation and preference of health care providers 38
3.4.2.1 Hospitable healthcare providers 39
3.4.2.2 Hospitable Traditional birth attendants 40
3.4.2.3 Health Surveillance Assistants (HSAs) mobile services 40
3.4.3 Theme three: Health service provision and health system challenges 41
3.4.3.4 Longer waiting time 42
3.4.3.5 Lack of and mismanagement of resources 42
3.4.3.6 Negative attitude of health care providers and lack of efficient communication 44
3.4.4 Theme four: Maternal health services patients challenges 45
3.4.4.1 Health facility location preference and health care provider preference 45
3.4.4.2 Myths, beliefs, magic and traditional medicines 47
3.4.4.3 Costs and distance 48
3.4.4.4 Poor skills by the health care providers 49
3.4.4.5 Confusion and feeling hopeless 50
3.4.4.6 Dissatisfaction with the status quo 51
3.4.4.6.1 Dissatisfaction with the introduction of maternal health services by-laws 52
3.4.4.6.2 Sanctions for delivering babies out of a health facility 52
3.4.5 Proposals on improving maternal health services 53
3.4.5.1 Training and community health education 54

3.4.5.2 Introduction of clinic committee 55
3.4.5.4 Infrastructure improvement 56
3.4.5.5 TBAs service termination 56
3.5 Conclusion 57
CHAPTER FOUR 58
DISCUSSION OF RESEARCH FINDINGS 58
4.1 Introduction 58
4.2 Demographic characteristics and the utilization of maternal health care services in rural areas 58
4.2.1 Age 58
4.2.2 Marital status 59
4.2.3 Education 59
4.2.4 Occupation 60
4.3. Theme one: Maternal health services package understanding 61
4.3.1 Vital signs and general screening of disease 61
4.3.2 Maternal HIV testing and partner recruitment to ANC 62
4.3.3 Foetal monitoring and referral to hospital 64
4.3.4 Introduction of the safe-motherhood program and its incentives 64
4.4 Theme two: Community appreciation and preference of Health care providers 65
4.4.1 Hospitable TBAs 66
4.4.2 HSAs mobile health services 67
4.5 Theme three: Maternal health service provision barriers and challenges 68
4.5.1 Longer waiting time 69
4.5.2 Mismanagement of resources and lack of resources 69
4.5.3 Negative health care provider attitude 71

4.6 Theme four: Maternal health service patient challenges 73
4.6.1 Health facility location preference 73
4.6.2 Myths, beliefs and traditional medicine 75
4.6.3 Costs and distance 78
4.6.4 Confusion and feeling hopeless 79
4.6.5 Maternal health service by-laws 80
4.6.5.1 Dissatisfaction with by-laws 80
4.7 Theme five: Proposals on improving maternal health service programs 81
4.7.1 Training and community health education 81
4.7.2 Introduction of clinic committees 82
4.8 Conclusion 84
CHAPTER FIVE 85
STUDY CONCLUSIONS AND RECOMMENDATIONS 85
5.1 Introduction 85
5.2 Conclusions 85
5.3 Recommendations 86
5.3.1 Government should review recruitment strategies for ANC 86
5.3.2 Policymakers and program managers' focus on maternal health care content programs 88
5.3.3 Infrastructure improvement 88
5.4 Recommendations for future research 89
5.5 Study limitations 89
REFERENCES 91

APPENDICES 101
APPENDIX One: Plagiarism declaration 101
APPENDIX A: Information letter for participants -FGD Discussion 102
APPENDIX B: Consent form for FGD discussion 104
APPENDIX C: Consent form for audiotaping in a FGD discussion 105
APPENDIX D: Information letter for participants – in-depth interview 106
APPENDIX E: Consent form for audio taping in an in-depth interview 108
APPENDIX F: Consent form for in-depth interview……..110
APPENDIX G: FGD interview guide 111
APPENDIX H: In-depth interview guide 112
APPENDIX I: Malawi Protocol approval form 113
Appendix J. Human Research Ethical Committee Clearance Certificate 114
Appendix K. Coding Framework 115

CHAPTER ONE

INTRODUCTION AND ORIENTATION FOR THE STUDY

1.1 Introduction

This study aimed to explore community perceptions of maternal health services in rural areas in Dedza District, in the central region of Malawi. Understanding community perceptions is important in informing health system responsiveness in the context of Malawi. In providing the study context, this chapter will present the sudy's; background, problem statement, justification, the research question, aim, objectives and a literature review. The literature review focuses on the supply of maternal health services and service users' health-seeking behaviours, among other things. These will be discussed in relation to Malawian as well as global context.

1.2 Background

1.1.1 Why are maternal health services needs a key concern?

Maternal mortality rate (MMR) refers to the annual death of women per 100,000 live births during any gestation of pregnancy and within 42 days of terminating a pregnancy due to various causes (1). The introduction of the Millennium Development Goals (MDGs) in 2000 helped to reduce MMRs globally by at least 44% in 2015 (3). Although there has been some improvement in the general global MMR, it fell short of the 75% reduction rate that was envisaged, by the 1990 WHO baseline survey, for the year 2015 (4).

The Sustainable Development Goals (SDGs) that were introduced in September 2015, and came into effect on the 1st of January 2016 set the target of 2030's maternal deaths to be less than 70 per 100,000 live births (5). Despite this target, an estimated 830 maternal deaths occurred everyday globally and out of this figure 550 deaths occurred in the Sub Saharan Africa (4). The MMR in Sub Saharan Africa is higher than the estimated 546 deaths per 100,000 births (4). In the developing countries, including those in the Sub-Saharan Africa region, one out of every 36 women is at risk of dying from pregnancy complications, compared to developed countries where one in every 4900 women can die (4).

Literature show that for every maternal death that occurs in Sub Sahara Africa, there is an estimated 13 to 17 other women who suffer from pregnancy-related complications (6). According to WHO, these ratios might be higher because not all countries provide accurate data, especially on statistics from rural areas. Additionally, not all deaths are reported to the authorities (6).

The introduction of SDGs to reduce MMR was agreed upon by all, global, countries post Millennium Development Goals (MDGs). The SDG no.3 was designed to reduce global MMR to less than 70 per 10 0000 live births by 2030 (1,7). It also aims to prevent any country from having an MMR that is twice more than the global average (1). The global target for reducing the MMR by 2030 suggests that each nation should reduce MMR by two thirds from the 2010 baseline and that each nation should not exceed 140 deaths per 100 000 live births (1, 7).

1.1.2 Maternal health problems in Malawi

According to the Ministry of Health in Malawi, in the year 2015, the country's MMR was above the acceptable level as it stood at 634 per 100 000. This means Malawi missed the year 2015's required 75% MMR reduction as the figures ascended to 574 per 100 000 births in year 2010 (8, 9). MMR is more complex and higher in rural areas of Malawi because most women deliver at their homes through the use of *Azamba*[1] or traditional birth attendants. It is believed that one in every 36 pregnant women die from pregnancy-related complications in Malawi (8). However, in rural areas, the numbers are not accurate due to poor or lack of reliable statistics and data.

Malawi's constitution states that the government is mandated to provide health-care that is adequate and meet the needs of the citizens according to international standards of health care (10). In line with the Ouagadougou's 2004 Declaration on Primary Health care, the constitution encourages community participation in deciding their health care needs (11). Therefore, the government is obliged to promote universal access to health care services for its people. As a result, in 2010, the Malawi government and the private hospitals signed a memorandum of understanding to

[1] Azamba is the local name for TBAs

provide health services. This understanding calls for free health services for pregnant women and infants without checking the patient's social-economic status.

Despite these efforts, Malawi has unmet needs to treat emergency obstetric complications. To date, only 20% of the needed emergency obstetrics services are available throughout the country (12, 13). In 2004, Malawi adopted a Sector-wide Approach Program (Swap). The country later designed the Essential Health Package (EHP) and Emergency Maternal Obstetrics Complications (EmOC) policies that mandated women to deliver babies in hospitals and clinics. However after these efforts, a survey in 2010 reported that only half of the births that required EmOC received the necessary care (11, 14, 15).

According to the deaths audit in Malawi, sepsis and post-partum haemorrhage are the main causes of maternal deaths. This is due to a shortage of additional investment in promoting access to EmOC and services in family planning (8, 15). A study conducted in Thyolo district, in the southern region of Malawi, found that out of 3,085 hospital deliveries, there were 133 maternal complications and deaths, six of which were caused by haemorrhage. This represents 4.5% fatality rate; 1% greater than WHO recommendations (13, 16).

In 2004, Malawi Ministry of Health developed a Program of Work (PoW) that was in place through to 2011, to oversee how interventions would be implemented in improving the health of Malawians (15, 17). The envisaged health indicators included: (a) to achieve 80% of hospital delivery than 58% in 2011; (b) to increase the number of ANC visits from 58% to 65%, and (c) to start and increase ANC in first trimester from 9% to 20% (10, 15).

Perceptions of maternal healthcare services' quality among community members are important because they influence the choice that women make on where to deliver their babies (1, 9). However, lengthy and red taped procurement processes, inadequate funding and a shortage of human resources may undermine service users' expectations. An Emergency Maternal Obstetric Needs Care (EmONC) assessment that was conducted in 2014 in health facilities found that there is incomplete resuscitation equipment for both mothers and babies in many of the health facilities in

Malawi. Similarly, in the rural areas of Dedza, there are shortages of equipment for emergency obstetric care and hospital infrastructure (18, 19).

Owing to the shortage of doctors and clinicians, most obstetric care is done by nurse-midwives in Malawi. To address the shortage, Malawi developed midlevel providers such as; Clinical Officers, State Registered Nurses, Medical Assistants, Nurse Midwife Technicians and Enrolled Nurses to cover Obstetric Emergency Care (13). Clinical Officers mostly conduct operations including caesarean section (C/S) in district hospitals (20). Registered nurses provide ANC and other obstetric care services. The rest of the cadres are found at both district and rural level (20). In rural areas, health facilities are run by nurse-midwife technicians, enrolled nurses and medical assistants. The nurses are responsible for routine maternal healthcare services.

In some parts of the country, a pregnant woman is perceived to be vulnerable to witchcraft in the first three months of pregnancy. This belief may lead to late commencement of ANC because women would not reveal their pregnancy to people around them fearing that they may be bewitched or have the baby killed through magic (21). Some women believe that post-partum haemorrhage is caused by witches who send evil spirits to kill unborn babies out of mere jealousy. Therefore, they visit traditional healers/herbalists to get medicine that will prevent attacks from the witches and also control the haemorrhage during home deliveries (21). However, these practices often result in maternal deaths as women opt to go to the hospital too late (21). The belief in witchcraft, ancestors, cultural practices and other traditions contributes to poor utilisation of ANC services in Malawi (17).

1.2 Problem statement

Failure to meet coverage targets and low utilization of maternal health services, can lead to high MMR in Malawi(15). There are maternal health services deficiencies emanating from a shortage of EmOC staff, medical equipment and low demand. These lead to exposure of mothers to pregnancy-related complications such as haemorrhage and premature deaths of mothers and babies (23). While these are challenges faced in Malawi, maternal health is important for nations and it reflects on the overall health status of any nation (4).

A health system of a nation functions well when people have a clear knowledge of how to use maternal health services. Malawi, being one of the countries that have the highest MMR in the Sub-Saharan region, it needs to pay attention to maternal health services and how the community perceives them (16). However, not many studies have been conducted on community perceptions on the use of maternal health services in rural health facilities of Malawi (24). Many interventions on MMR have targeted the improvement of women's knowledge and practices that are related to maternal health services (6).

Malawi's majority population (84%) lives in rural areas. Therefore, there is growing concern that MMR may remain high in the country if poor maternal health services in rural communities continue (2, 18, 25). Long distances between health facilities and people's homes, and shortage of medical staff, significantly contribute to poor maternal health in Malawi (18). Almost 43% of the people living in rural areas in Malawi are poor. Due to poverty, it becomes difficult for them to access health facilities that are located many miles away from their villages (26). As a result, many mothers choose to give birth at home assisted by *Azamba* or unskilled traditional birth attendants (27).

Although some studies focus on the perceptions of women of maternal health services in Malawi (27), others have only focused on maternal health services on offer. Studies have not established communities' perceptions and how they utilize the offered services.

Furthermore, some studies have targeted individuals instead of the whole community. Such approaches have not managed to deal with various critical factors such as; how the community participates in these services; what kind of services are offered in the facilities; the beliefs the community has on maternal health issues and general social determinants of maternal health behaviour (28, 29).

Accordingly, this study aimed to explore the community's perceptions on maternal health service delivery in rural areas of Dedza district in Malawi. Obtaining such information assisted the researcher in demystifying perceptions and identifying how the community can be fully involved in maternal health services (16).

It is believed that reproductive health decision-making processes are a shared responsibility. Although some communities are involved in decision-making processes, in Malawi women of childbearing age are not fully empowered to make such decisions. This is the reason this study involved the community to contribute towards addressing that deficit (30). Relative to this, other studies have shown that if the community participates in maternal health services provision, more pregnant women will use the services in rural areas of Malawi (16, 31). This study can be used to inform communities and motivate them to participate in solving problems of low utilization and access barriers. Irecognize that community members are not solely responsible for all the weaknesses in maternal health services. However, they can play a role in holding the government and health workers accountable for their responsibility to enable communities' access and use of health services.

1.5 Justification of the study

The status of maternal health is connected to the perceptions that people have of the maternal health services. Likewise, many studies on maternal mortality in Malawi and Uganda established that involvement of community members help women to utilize maternal health services (16, 32). In rural contexts, patterns of behaviour are mostly driven by perceptions and opinion. Therefore, understanding the perceptions of communities on martenal health services in rural contexts is important in efforts to reduce MMR. Given the view that maternal health care services are effective when the community perceives them as reliable through a common understanding between the community and health care providers, then investigating these perceptions becomes critical (33, 34). This is further affirmed by the view that the success of maternal health services in Malawi depends on the inclusion and participation of everybody in that community (35).

This study can be used to mobilise the community towards participating in solving problem of low utilization and minimise barriers that reduce access to maternal health services. This involves helping the community members to recognise that participation does not only mean that they are solely responsible for the weaknesses of the maternal health services. However, this study also wishes to help community members notice that they can hold the government and health care providers accountable. Doing so

will enhance the capacity of the community to access and use of the maternal health services.

1.6 Research question

How do community perceptions influence maternal health services in rural areas in Dedza district in Malawi in order to reduce maternal mortality rate?

1.6.1 Aim

This study aimed to explore community perceptions of maternal health services in rural areas in Dedza district in Malawi.

1.6.2 Objectives

The following were the objectives of this study that targeted three (3) rural villages in Dedza district in Malawi:

1. To explore community understanding of existing health care service package offered by health care providers in rural areas in Malawi.
2. To explore community perceptions of the existing maternal health services delivery in rural areas in Malawi.
3. To understand the maternal health services delivery challenges/barriers and possible services improvement strategies in the communities under investigation.

1.7 Literature review

This literature review covers areas that relate to this study. Central to this review is factors that lead to MMR and determinants of maternal health services. These include socio-economic factors and the global agenda on the reduction of MMR.

The literature review also discussed SDGs, safe motherhood initiative programs and global perspectives on barriers to maternal health services. In addition, factors that contribute to MMR in Malawi such as; health services and community-level factors were also discussed.

1.7.1 Determinants of maternal health services.

Understanding the determinants of Maternal health services is important towards reducing MMR. The discussion below focuses on the following MMR determinants; socio-economic status, availability of resources, community level delays, community participation in seeking maternal health services and quality of care in maternal health services.

1.7.1.1 Socio -economic status

Availability and access to maternal health services is crucial for every community because it prevents unnecessary deaths. However, in every country there are socio-economic factors that compromise the use of maternal health services. They contribute to unjustifiable inequalities in every country's services (36). In the rural parts of the world, some of the underlying inequalities in maternal service are; lack of skilled health service providers, low level of female education and poverty(36). These factors are of great concern.Women in Africa face maternal death from preventable causes such as access to health care services. Therefore, it is not hard to imagine that women's perceptions of maternal health services affect reproductive health outcomes in Malawi, hence contributing to high maternal mortality rates (37).

1.7.1.2 Availability of resources and health services provider's behaviours

A study in Nigeria found that the communities' perceptions on the quality of care found in hospitals was based on the availability of prescribed drugs. In terms of the general satisfaction with the services, the communities focuesd on the health care providers' behaviours and the physical conditions of the facilities (38). Verbal abuse, negative attitude from health care providers, lack of information sharing and emotional support affected women's utilization of the health services (39). These factors are some of the reasons that many women in rural areas stay away from utilizing health services. This can increase the number of pregnancy related complications and deaths.

1.7.1.3 Community participation in maternal health services

Community participation influences maternal health services provision in rural areas. Community participation is a way of empowering local people to define their needs and allow them to explain how they can be met (40). It is also about involving

procedures, that have been tested and tried to solve the health problems of rural poor people. Community participation is well accepted by community members themselves because it involves a culture that is acceptable to them (41). It helps community members to earn a a broader meaning of health and a motivation for them to improve it.

Furthermore, community participation encourages self-confidence, self-reliance and cooperation among local people. It helps community members to own and control their lives (41). Literature shows that when women and men in the community are given a chance to identify maternal and infant health problems, they come up with solutions that improve the health services (42). The community, through its fora, can conduct meetings with health service providers. They will also be able to conduct awareness campaigns on maternal health issues, among themselves (42). According to the study that was conducted in Mwanza district in Malawi, community sensitization strategies help reduce MMR (42). This study found that the involvement of community leaders in outreach programs helps reduce MMR. The study used public meetings, incentives and male involvement. The community was mainly targeted here because a large number of women lacked access to essential health services. Also, due to the cultural beliefs and traditions, community involvement was problematic and wanting (43).

1.7.1.4 Quality of care

Some studies describe the quality of health care services as composed of effective communication between health care providers and patients; the availability of health care managers, safety, equity and effectiveness (44). These, in turn, promote patient-centred care and efficiency (44).

One of the factors that prevent women from seeking maternal health services, and increasing MMR, is the poor quality of health care offered by health facilities (45). A study in Ntcheu district in Malawi established that the increase in the quality of care improved the maternal health services (48). For example, the facility delivery registered up to 99.1% for ANC and 97.2% for clinic delivery. There was however a small percentage of those who started ANC during the first trimester (48). Another study in Malawi also found that women were not given privacy and support when they were in labour. Although women were greeted with some degree of respect, there was

lack of communication as they were not given a chance to ask questions (49). The treatment of women in the health services focused by this study affects many of them because they are unable to report all their health problems .

1.7.2 Social-cultural determinants in maternal health services

There are several factors that can influence a woman to access maternal health services in health care facilities. Some women prefer the use of TBAs, while others are hindered by cultural beliefs and use of traditional medicine. The use of TBAs and cultural beliefs will be discussed below.

1.7.2.1 The use of traditional birth attendants (TBA) or Azamba

When activities of TBAs were at the peak in Malawi, 60% of women gave birth under the supervision of TBAs. Women felt comfortable with TBAs because they stayed in the same or nearby village. Furtehrmore, TBAs were usually respectful and loving even though they were clinically unskilled (50). Studies in Malawi and Tanzania found that the reason women used TBAs was that the aftercare they received from them included traditional rituals. Research also revealed that TBAs make proper follow-ups on women after giving birth. Therefore, women appreciated the quality of aftercare services offered by TBAs after giving birth, compared to care they received from the health facilities (51).

However, it is argued that the primary reason women went to health facilities is that TBAs lacked; proper training on post-partum care and the requisite equipment to handle serious complications that may arise between the mother and the baby (2, 51, 52). Therefore, since TBAs could not manage complications arising from child bearing, there was need for proper training, mentoring and good work relationship between the health facilities and the TBAs (52). Research further confirmed that good communication enables women to get adequate and correct help because of the training and good facilities available at health care facilities (52).

1.7.2.2 Cultural beliefs

Social behaviours, ideas, myths and customs affect the way people seek, and respond to maternal health services. Research has established that beliefs about pregnancy and labour need to be addressed by making the community aware of the need to

change some of their cultural beliefs especially those that affect maternal health (52). According to Kumbani, et.al. (2013), nurses' attitudes at the health facilities affect the way women perceive the services on offer. The study also found that some nurses shout at women when they visit the clinic, after they deliver at home, because they did not follow the set by-laws that require them to deliver at certified health facilities (47). Although women are given opportunities to wait at a facility shelter, most of them do not go because they fear that they can be bewitched. They also feel that they may be wasting their time at the shelter since they can sometimes wait for a month or more without giving birth hence affecting their farming work at home (52).

1.7.2.3 Level of education and lack of knowledge

Maternal education affects the place of delivery and ANC attendance. It is found in previous research that women with high level of education had high chances to deliver at a health facility. These women were likely to attend ANC four times, as recommended by WHO (72). The husband's level of education was also found to predict the place of delivery. Educated husbands influenced women to deliver at a health facility (72).

Another study revealed that if a community, in general, was highly educated, it mobilised itself to demand better maternal health care services. They also demanded a role in health care services delivery committees (74). Research also reported that educated women easily recognized danger warning signs in pregnancy and reported to a health facility, something uneducated women were less likely to do (75). Women's chances of utilizing maternal health care services were also influenced by the others in their area of residence (76). Education helps to improve the status of women and enables them to make good health care decisions other than identifying pregnancy warning signs (77). Some studies also reported that five years of primary school education is enough to empower women to know the dangers of pregnancy and utilize family planning methods (78).

Women's lack of education and power, over men, prevent them from utilizing maternal health care services (64). Moreover, the inability of women to see the need for using health services, is influenced by that they have never experienced any complications

in their previous pregnancies. This is still a barrier to maternal health services (65). Additionally, cultural beliefs limit women from attaining education, thereby confining them to rural areas. Rural set-ups reduces women's access to information on reproductive health compared to those in urban areas. Therefore, women in rural areas' choice on reproductive health is limited (34, 66).

1.7.2.4 Poor health decision-making

Community perceptions on the services offered and lack of women empowerment in maternal health service decision contributes to poor maternal health care services (64). Women have minimum influence in decision-making due to traditions. It is important to involve women in decision making because they also do have the experience that can help them have more commitment to the sustainable maternal health services (64, 67).

Moreover, the social environment where personal behaviour is attached can play a role in maternal health services (64, 67).

Research reports that even if women can recognize the symptoms of pregnancy related to complications, it is difficult for them to make correct decisions, to seek necessary health care (68). More other people hold decision-making powers, these are; the spouses, mother-in-law or the community (68). Therefore, any poor decision by those who have control can negatively affect the health of the woman (68).

1.7.2.5 Community level delays in seeking maternal health services

Delays in seeking health care services contribute to MMR. Research reports that, in rural Malawi at a community level, there were delays in decision-making and in choosing the appropriate level of services due to socio-economic issues. There is need that community representatives should be involved in decision-making processes on maternal health services (70).

1.7.2.6 Age of a woman

The age of a pregnant woman influences maternal health care services in rural areas. Young pregnant women are less likely to visit health facilities for ANC especially when they are not married (70, 71). Young women can also develop many pregnancy related

complications such as post-partum haemorrhage (PPH) that leads to death when they deliver outside the health facility. In contrast, another study found that women who are younger utilize health care services maximally because they do not have many children to look after (70). Since women have multiple responsibilities, older women who have many children find it difficult to leave the children alone as they go for ANC (71, 72). . Research also found that low literacy level and bearing children at a young age increased the risk of maternal death (70).

1.7.3 Global and local agendas

Women's sexual and reproductive health has been the main focus in global efforts to improve their health. Due to these efforts and after the introduction of the MDGs in 2000, the number of maternal deaths has dropped by 44%; from 385 in 1990 to 216 per 100 000 live births in 2015 (53). Although, more needs to be done, this is a significant improvement. This section's discussion focuses on; sustainable development goals, safe motherhood initiative, primary health care in promoting maternal health care access and reducing MMR, Universal health coverage in Malawi, and Health Surveillance Assistants (HSAs).

1.7.3.1 Sustainable development goals (SDGs)

The SGDs have the mandate to move the world from focusing on the poorest countries only to a universal and equitable health approach (54). This will enable the world to be more concerned with the health of everyone globally and across all sectors (54).. The SDGs focus on ensuring good health and improving the well-being of all people through addressing the social determinants of health. They describe how structured determinants lead to differences in vulnerability and inequities in health. Target number three of the SDGs is on the reduction of MMR to not more than 70 deaths per 100,000 births. It extends the work of MDG Goal Number Five (54).

1.7.3.2 The Safe motherhood initiative

Malawi introduced the safe motherhood initiative in 2000 to reduce maternal mortality rate (55). The motherhood initiative intended to involve the whole community, including men (55). This is because men are decision-makers in many families of Malawi. This initiative highlighted that safe motherhood would meant allowing women to access

maternal health services. In so doing, maternity homes were built closer to health facilities which were meant to reduce the risk of MMRs by preventing home deliveries (55). In Lilongwe rural, in the central region in Malawi, the Traditional Authority (TA), established a by-law that prevents women from giving birth in their homes or at TBAs. To get buy-in, these by-laws are explained to the people in their communities through community meetings and awareness campaigns (55).

1.7.3.3 The role of primary health care in promoting maternal health care access and reducing MMR

In Africa, Primary Health Care (PHC) has the responsibility to promote the delivery of hig-quality maternal health services and ensuring that access levels to these services are high (56). It recommends identification of the needs of the community and implementing interventions such as improving living conditions through multisector collaboration and approaches (56).

In the African continent and other developing nations, there is a need to empower the community, especially in rural areas, because a large number of maternal and child deaths occur in these areas (56). Re-engineering of PHC in some parts of Africa, countries such as South Africa, means realignment and changing of PHC using the foundation principles of the Alma Alta Conference of 1978 (Health for All), that includes the district hospital as the main driver of PHC. This recommends restructuring of systems and re-organizing of referral systems (57). However, some studies show that this is not working. There isan increase in MMRs and infant mortality because of the separation of the district health services from the clinics (57).

1.7.3.4 Universal health coverage in Malawi

Universal health coverage refers to the health services that are delivered at a low fee or free of charge without burdening the nation (58). This is composed of promotive, curative, preventing, rehabilitative and palliative health care services that people need (58). It is argued that maternal health care services that are not equitable, accessible and inclusive deprive citizens of their rights to health. They pose a danger to mother and child health in rural areas. Universal health coverage ensures that people in a nation have adequate coverage and access to health care services which are of good quality through universal financial protection (59).

A study that was conducted in Malawi found that there is an uneven distribution of public and private facilities, and lack of effective public-private services level agreement (60). The study further established that health inequities and inequalities caused by geographical factors affect maternal health care services provision. The study then recommended universal health care coverage which is people-centred and could meet the demands of the population (59). It also recommended use of bottom-up approaches to context-specific needs in Malawi (60).

1.7.3.4.1 The role of Health Surveillance Assistants (HSAs)

With the help of community support system, HSAs help strengthen the relationship between the community and the district health office (111). Literature shows that their presence has reduced the burden of disease, mortality, morbidity and the pressure for health services at the health care facilities (125). They help people in the community to have access to health care services as they are the nearest and always available in their catchment areas (125).

1.7.4 Global perspectives on barriers to maternal health care services

There is a link between the local and global perspectives on maternal health care services. Therefore, understanding the perspectives at a local level helps in understanding it at a global level. In this regard, there is myriad of barriers affecting the maternal health care services. These include; access to the services, financial and infrastructure barriers, lack of knowledge, poor decision-making, and community level delays. Below, I discuss each one of them.

1.7.4.1 Maternal Mortality rate and access to maternal health services

High quality of maternal health services and access to them are key to reducing MMR worldwide. Literature shows that 26%-48% of maternal deaths can be prevented through antenatal care in rural health centres (18). It also shows that access to maternal health services is poor in the developing countries. WHO with its partners have recommended the re-engineering of strategies such as the MDGs and PHCs. Globally, in most rural areas, people use public health services because they cannot afford private services. However, in many rural areas, public services are not available.

This shows that the health status of women and children depends on their socio-economic position (36).

1.7.4.2 Financial and infrastructure barriers

Financial problems create barriers to health service use. Studies report that financial problems like the cost of medicine, consultation and admission fee were some of the perceived causes of failure to access health care services (62). The findings indicate that only those who are financially well off were able to access maternal and new-born care services in private facilities (62). Another study used incentives to involve community participation in maternal health services, especially males, by rewarding positive behaviour. The reward was giving ANC priority services to pregnant women accompanied by the spouse (63). This helped most of the people in rural areas who struggle financially. The use of incentives also helped and motivated them to access maternal health services.

Research conducted in Kenya found that the community perceived transport infrastructure as the one that prevented people from accessing health care facilities. It is also reported that poor road infrastructure and transportation prevented effective maternal health care access in rural areas of developing countries (63).

1.7.4.3 Cost and distance

Services utilization by pregnant women is affected by the cost of health care services. Costs include; fees that woman pay at private health facilities, money used for transport and time that women spend when they go to these facilities (46).

Some studies found that in many countries, there is inequity in the distribution of maternal health care services (72). The studies further demonstrate that urban areas are favoured and have easy access to maternal health care services compared to rural areas (72). The absence of infrastructure such as roads and proper bridges over rivers make it difficult for women to access health care services. This means walking long distances to the clinic. When the rivers are flooding, it prevents women from accessing the health facilities (46, 72). This forces women to seek maternal health care services from the TBAs hence endangering their lives (46). In Westen Africa, research found that women complained of cost as the reason that prevented them from seeking health

care services. The costs included; fees for utilizing the health services, drugs,and transportation (73).

1.8 Conclusion

This chapter has briefly highlighted the determinants of maternal health services and potential barriers. While considering global factors that affect maternal health services, the chapter also discussed factors, particularly in the Malawi rural context. Among others, long distances to clinics, behaviour and attitude of health providers, low socio-economic status, low education and cultural beliefs, among others, influence maternal health services in rural areas.

CHAPTER TWO

RESEARCH METHODOLOGY

2.1 Introduction

In discussing the methodology used in this study, this chapter respectively presents; an explanation of from the study design study site, study population and sampling, data collection, and data analysis.

2.2 Study design

The study employed the exploratory qualitative research design to understand how the community perceives maternal health care services in rural areas of Dedza district in Malawi. This design enabled participants to explain their perceptions on the use of maternal health care services within their communities. Qualitative studies help to investigate the social, psychological, and economic environments in which research is being conducted (79). The interview questions for this study were open-ended to access more detailed information. Because of the nature of the exploratory qualitative research, this study could access the underlying perceptions of participants which helped with identifying the social behaviour (79).

2.2.1 Study site

The study was conducted in Dedza district in Malawi. Malawi is found in Central Africa. It is divided into three regions; Northern, Southern and Central (55). Malawi has 28 districts, which are further subdivided into Traditional Authorities (TAs) and villages. Traditional Authorities are customary leaders responsible for oversight of several villages (55). Village headmen govern the villages and report to the TAs (55). TAs are “managers of customary land, custodians of customary law and guardians of traditions and culture” (55).

Malawi’s human population is estimated to be 18.6 million. The country is one of the poorest nations in the world (80). According to the global United Nations statistics, in year 2019, over 20.8% of the population in Malawi lived below US$1.90 per day (World Bank report, 2019) (81). Malawi has one of the high MMR rates in the world, at 984 deaths per 100 000 live births in 2010, and 574 deaths per 100,000 in 2015 (22).

Malawi failed to reach the Millennium Development Goal (MGD) of reducing the MMR by at least 75% by 2015 as per 2000 baseline (80, 82).

Dedza district where this study was conducted (see Figure 2.1) has a total population of 671,137 people; 31 Health Centres[2] and one referral district hospital. Dedza district is one of the districts with high MMR rates (11). The district has more than 54,362 number of women who are of childbearing age. Among those in the child bearing age, 33,000 of them get pregnant every year with an MMR rate of 704 deaths per 100,000 births mostly due to haemorrhage (18). There is still poor knowledge of reproductive health issues at the community level in Dedza district (11, 23). The infant mortality rate is estimated at 79 deaths for every 1000 live births. There is also a high mortality and morbidity rate among children under five years of age. This is estimated at 160 deaths per 100,000 live births (11, 23).

Dedza district shares boundaries with the Republic of Mozambique to the south-west; Ntcheu district to the south; Lilongwe to the north-west; and Mangochi and Salima to the east. More than half of the people in Dedza district depend on a small-scale subsistence farming and maize is their staple food (23).

This study was conducted in Mphasayaweni, Kachipeya and Kalamba villages which are under Kachere Traditional Authority. The three villages utilise one of the 31 health centres and were purposively selected for this study *(Fig 2.1).* These villages were chosen because they have the same characteristics in terms of language, culture, beliefs and socio-economic backgrounds. The similarities would help explain the MMR realities and women's access to maternal health services. Additionally, for the purposes of accessability for the researcher, the villages are adjacent to each other.

[2] A health centre in Malawi is the same as a Primary health care facility.



s

Figure 2.1: Map of the study area in Dedza District, Malawi. The inserted box in and around Lobi and Mtendere shows the general geographical area where Kalamba, Mphasayaweni and Kachipeya villages are found..

Source: http://www.norwich-dedza.org/dedza_map.html

2.2.2 Study population and sampling

The population sample included men and women residing in the three rural villages of Dedza district. Purposive and convenient sampling approaches were used to select eight men aged 18-49 years from each of the three villages for the focus group discussions (FGDs). Convenient sampling involved identifying participants who were readily available in the village; this was achieved after church meetings (83). Purposive sampling allowed me to use my own judgement in selecting participants with characteristics that relate to the study objectives.

Conviniently, male participants were those who had children and living in identified villages. Furthermore,I focused on participants who were considered to have

knowledge and experience that could assist in answering the research question. A total of 24 men (eight from each village) were selected to participate in the study. The first village consisted of eight men aged 18-24 years. The second village consisted of eight men aged 25-34 years while the third village had a group of eight men aged 35-49 years. Separating men according to these age groups provided a wider perspective of views, allowed men to open up and give insights into some cultural aspects that could not be discussed in the presence of young men.

A total of 15 women of child bearing age, 18-49 years old, were recruited to participate in this study. Five women from each of the three villages participated in the in-depth interviews (IDIs). These participants were identified and selected purposively through general community development meetings. These community meetings usually take place at the end of every month.

A total of 3 FGDs and 15 IDIs were used for data collection. Data saturation was used to determine the sample size. Data saturation is important because it is an indication of data validity and it occurs when additional data collected adds nothing new to the understanding of the research topic (84).Saturation was reached at these numbers. But if saturation would not have been reached,the sample size would have been more (84).

This study needed to understand how the community in rural Dedza district perceived maternal health services in the area. Therefore, purposive sampling helped with targeting women participants who had experienced child-bearing. For men, a similar condition applied to the selection of their spouses. This experience is considered typical to the knowledge of the research topic. The age range helped with diversifyinh the opinions by participants.

2.2.3 Inclusion and exclusion criteria

With regard to FGDs, men who had pregnant spouses or those who had children and were 18-49 years oldwere included in the study. On the other hand, men who were above 50 or below 18 years of age, and those who had never had children were

excluded. Women who were 18-49 years of age and had had children or were expecting a child were included.

The reason for excluding men and women who were over 50 years (even though some of them might have been still productive) was because the study needed the characteristics of the participants to be similar since maternal health services in this district have been consistent for a long time. Such distinction helped in striking a balance of the age characteristics between participants.

2.3 Data collection

This study only used focus group discussions (FGDs) and one-on-one individual In-depth Interviews (IDIs).

2.3.1 Focus group discussion with men

Primary data was collected through FGDs with men (Appendix G). Three FGDs were carried out, one in each village lasting about 45 minutes to one hour. The FGDs were conducted between May and June 2018, for a period of over three weeks. They took place on Sundays in the afternoon because it was when most of the participants were free from farming activities. An FGD guide was used to direct the discussions with men that sought to understand their perceptions on maternal health care services in rural communities. The discussions focused on, how services are offered, and how the communities participates in the services (Appendix G).

The interview guide helped me to find out how men in the communities, perceived maternal health care services offered in rural areas. It also assisted in understanding how the communities were involved in these services. Furthermore, how beliefs and myths affect maternal health care services. Involving men in this study was important because men are considered as heads of the family, therefore decision-makers, in Malawi. Since men are decision-makers, their perceptions of maternal health care services are important as they mostly influence women's decisions on maternal health.

FGDs consisted, only, of men who accepted to participate in the study. Using FGDs was chosen because this method could help generate ideas and insights that might have been difficult to access without focused discussions. Audio records were used to

capture the FGDs with male participants, who consented to the recording of their views (Appendix C).

To identify male participants for the FGDs, I had to explain the purpose of this study to community members who had gathered for a community meeting. I asked the people who accepted to participate, to meet with me after their meeting, for further details. I later asked for eight volunteers who had the characteristics described above in line with purposive sampling and briefed them on the nature of the interviews, their purpose and expectations.

Representation for each of the three villages, of focus for this study, was ensured. IDIs and FGDs were conducted in Chichewa, a language that participants could understand and use to fluently communicate. There was one female trained note-taker who took notes during the IDIs. She was 35 years old, married and had three children. However, the age and marital status of the research team did not matter to the participants. What mattered was that the note-taker and the researcher were health care providers.

2.3.2 In-depth interviews with women

Semi-structured, one-on-one, in-depth interviews (IDIs) were carried out with women who were once pregnant or had had children (Appendix H). To locate the participants for IDIs, community leaders referred me to homes where there were potential participants. These were people with the characteristics similar to those I was looking for, for this study. Before their participation, I explained the purpose of the study to each potential participant separately, in their homes. I then only recruited recruited those who were willing to participate.

The IDIs took place between May and June in 2018, for over three weeks. Audio records were used to capture the interviews with women participants who signed the consent forms accepting recording of the interviews (Appendix E). The IDIs were conducted in the three villages, of focus for this study, because all of them used Mtendere and Lobi health centres for maternal health care services. An interview guide which used open-ended questions in both English and Chichewa was used to facilitate the discussions (Appendix H). The IDIs lasted 25-30 minutes.

2.4 Data preparation and analysis

The sub-sections below, outlines the processes that were followed in preparing and analysing data.

2.4.1 Ethical consideration

Approval to conduct this study was obtained from the University of the Witwatersrand's Human Research Ethics Committee (**Approval number: M170867**; see Appendix J), the Malawi Ministry of Health (**Approval number: 1978**; see Appendix I) and the local government authorities in Dedza district.

Before conducting the IDIs or FGDs, all participants were given full information by reading, together with them, the information sheet outlining the purpose of the study (see Appendix A). Participants formally consented to participate to the study by signing consent forms prior to their participation. Informed consent forms also ensured confidentiality and protection ofparticipants from harm (see Appendix A).

Protection of the participants', confidentiality in this study was achieved by assigning a unique code to to replace each participant's name before starting IDIs or FGDs. FGDs were labelled as follows; FGD 1.1, FGD 2.1 and FGD 3.1 (90). This preserved anonymity of participants and maintained confidentiality by not disclosing the real names of the participants (90).

Before using the digital recorders, participants were assured that interview transcripts were not going to be shared with other people and that any information divulged was solely for the purposes of this study. Permission was also sought from participants to audio record the interviews (89) (Appendix B). Participants were given a consent form for audio recordings to sign before the interview started to ensure that they participated freely (89).

Although total confidentiality could not be guaranteed in FGDs, it was necessary to keep the data and audio recordings safe on a computer, which was password protected. The audio recorded data will be kept under lock for six years, after which they would be destroyed (87, 91). Information in the data sets was not connected to

participants' real names. Participants in FGDs were also advised not to discuss, condemn or trash what others were saying, rather to respect each other's views.

In cases where problems emerged, such as participants' complaints of abuse by nurses at the health centres, they were given the details of support services they can get from government hospitals.

2.4.2 Data preparation

In preparation for analysis, I transcribed all the interviews in verbatim. I translated the interviews from Chichewa language to English language. In ensuring credibility of transcripts, the note taker translated the English version of transcripts back to Chichewa. Data cleaning was done by reading through the transcripts and removing any typographic errors.

Thematic inductive analysis was used to explore community perceptions on how they utilized maternal health services in rural areas of Dedza district in Malawi. Data was then coded and a code book was generated. Themes were generated from codes after listening to the recordings, reading through the transcripts several times while making comparisons with each important idea and connecting the themes (83). Clear links between each objective and its summarized findings derived from raw data were developed. This helped in the transparency of the links that were derived from raw data and helped justify the research objectives (86) (see Appendix K).

The data analysis process started by reading transcripts for familiarization. Each transcript was read separately, and text segments were identified (87). Thematic analysis approach was followed in analysing data by describing and interpreting participants' ideas (88). Data were coded inductively using MAXQDA software Version 12 leading to the generation of themes and sub-themes.

In ensuring credibility of the results, coding involved repeated checking, and comparison with each transcript. Themes were generated through inductive analysis approach involving reading and interpreting of raw data. This allowed for a comparison of codes between IDIsand FDGs to ensure that the results were trustworthy, and

credible (89). Each transcript was read separately so that text segments could be identified (87).

2.4.3 Trustworthiness and credibility

Trustworthiness helps find out if the person conducting the study has managed to establish faith in the truth of the findings from the informants and the situation being studied (92). In this study, a stringent selection of issues, place and participants was used to ensure trustworthiness.

Credibility adds to trustworthiness. Credibility involves proving beyond reasonable doubt that the results of the study can be believed by the participants (93). In this study, credibility was achieved by ensuring the collection of rich data to saturation. This was also achieved through translation of the research guide and use of local language for FGDs and IDIs. Credibility was also ensured through triangulation, which involved collecting data from both male and female participants of different ages (93, 94).

Furthermore, this study described and interpreted human experiences, shared by people who had similar experiences through IDI and FGDs. FGD participants were grouped according to different age groups but all had children as a unifying factor. Women were of different ages and had different numbers of children. Despite the variations in age groups, the study did not find the views between the groups significantly different. The experiences could be easily recognized as familiar by all groups. In as much as multiple tools were used to gather data, use of descriptive exploratory qualitative method was appropriate (92).

2.4.4 Dependability

This is the extent to which findings from a study are considered dependable and reliable even when a similar study is conducted in another context (95). It confirms the accuracy of the study and that the findings were deducted from the available data. In this study, participants were able to express their feelings freely which helped increase dependability (93). Dependability can also be achieved when the findings are consistent and are able to describe the exact methods of data analysis and gathering (96, 97).

2.4.5 Transferability

Transferability concerns the level at which results of a research project can be transferred to other settings. It also checks if there is consistency of the findings in other research contexts. For this study, the rsearcher ensured transferability thorough providing a detailed description of the research context and each process that was followed. This provides the opportunity that if an external researcher conduct a similar study in the same context, following the same research process,may yield similar findings (93).

2.4.6 Confirmability

Confirmability is the process of verifying that the findings are truly from the data gathered. It was achieved by auditing the data from collection to analysis stage. It involved repeated checking of the data that was being used (93). For this study, participants gave similar information in both FDGs and IDIs. This helped to establish and minimize biases or prejudices which were likely to occur from both parties in the course of the study.

2.5 Reflexivity

As an insider, I was familiar with the culture and villages where I conducted the study. The researcher was born and bred in one of the villages in the area. Therefore, I share the same culture as that in the research site (7).

The participants seemed to relate more to the role of the TBAs than other health care providers. I assumed that participants would talk against health care services, but I discover that all women utilized these services. However, these women did not fully adhere to the requirements of ANC such as scheduled visits. My assumption was that pregnant women would have accessed free maternal health care services from public and private clinics (CHAM) due to implementation of service level agreement put in place to promote universal health care access in Malawi. The government promised to fund these health care services through general tax revenue and donor funding (60).

2.6 Risks and Benefits

Doing research in rural areas comes with various risks and expectations. In this regard, people in rural areas approached this study as something that would solve their health and socio-economic problems. Therefore, I explained to them that the study only sought to understand their perceptions of maternal health. I further told them that possible solutions may be provided by various stakeholders such as the MoH and health NGOs who may use these results for policy formulation or improvement. I also informed participants that the potential benefits from FGDs were that they could manage to learn from each other in the course of the interaction.

2.7 Conclusion

This chapter discussed the qualitative research methodology that I used for this study, to answer the research questions and objectives that I set out. Exploratory qualitative research was used. The study site and the reason for its choice were discussed. The study population included both men and women particularly those who were in the reproductive age groups; 18-49 years. Data were transcribed to verbatim in Chichewa and translated to English and from English to Chichewa.

CHAPTER THREE

RESEARCH RESULTS

3.1 Introduction

This chapter presents findings from three FGDs and 15 IDIs conducted with Dedza district rural community members. The chapter starts by presenting, participants' demographics for both FGDs and IDIs. This is followed by a presentation of the key findings of the study according to the study objectives. The findings are presented according to the themes that were formulated through data analysis. Respectively, the themes are; 1) Mother and child health services; 2) Appreciation and preference of health care providers; 3) Health service provision; 4) Patient challenges; 5) Introduction of maternal health services bylaws; and 6) Maternal health services improvement plans. The chapter ends with a conclusion.

3.2 Demographic profile of the FGD participants

Table 3.1, below, describes the demographic profiles of community members who participated in FGDs. The focus group discussions were conducted with the male members of the community.

As shown in Table 3.1, FGDs were conducted with men only (100%). Participants were 18-49 years old. They were all married. There were three (33.3% of the total FGDs sample) participants that were aged 18-20 years. Eight (33.3%) of the FGDs participants were aged 25-34 years. The last eight (33.3%) of the total FGDs participants were 35-49 years old.

The highest level of education that FGD participants had attained was Form 3, equivalent to Grade 11 (in the South African education system). Out of the total FGD participants 87.5% (21) of them did not finish primary school. Only, three (12.5%) of the participants reached high school and dropped out of school. The participants comprised of 20 small scale farmers representing 83.3% of the total male participants andfour small scale business, representing 16.7% of the total participants respectively.

Table 3.1 Demographic profile of the FGDs participants

Description	N	%
Gender		
Male	24	100
Age		
18-24	8	33.3
25-34	8	33.3
35-49	8	33.3
Marital status		
Single	0	
Married	24	100
Widow	0	
Education		
Primary	21	87.5
Secondary/High School	3	12.5
Tertiary	0	0
Occupation:		
Small scale farmers	20	83.33
Small scale business	4	16.66
Occupation of spouse		
Housewives	15	62.5
Small scale business	9	37.5
Total number of children	96	100
18-24 years	15	15.63
25-34 years	28	55.20
34-49 years	53	29.17

3.3 Demographic characteristics for IDI participant

Table 3.2, below, describes the demographic information for IDI partcipants. IDIs were conducted with women only (100%). The participants were aged 18-49 years. All of them were married. There were three (20% of the total IDI participants) participants who were aged 18-20 years. Eight (53.3%) IDI participants were aged 25-34 years. Lastly, four (26.7%) participants were aged 35-49 years.

The highest level of education that IDI participants had attained was Form 1, equivalent to Grade 9 (in the South African education system). Out of all participants, 13 (86.67%) of them did not finish primary school. Only, two (13.33%) of the participants reached high school but dropped out of school. Participants comprised of nine (60% of the total IDI participants) housewives; three small scale farmers representing 10% of total

participants and three small scale business representing 10% of the total participants respectively.

Participants had a total of 49 children from all the three communities. The communities had 30.61% (Community no.1), 32.65% (Community no.3) and 36.73% (Community no.2) of the total number of children. This is illustrated in the table below:

Table 3.2 Demographic characteristics for IDI participants

Description	N	%
Gender		
Female	15	100
Age		
18-24	3	20
25-34	8	53.3
35-49	4	26.7
Marital status		
Single	0	
Married	15	100
Widow	0	
Education		
Standard 3 (Grade 3)	3	20
Standard 4 (Grade 4)	2	26.7
Standard 5 (Grade 5)	4	13.3
Standard 6 (Grade 6)	2	13.3
Standard 7 (Grade 7)	2	13.3
Form 1 (Grade 9)	2	13.3
Occupation:		
Housewives	9	60
Small scale farmers	3	20
Small scale business	3	20
Total number of children	**49**	**100**
Community no. 1. 18-44 years	15	30.61
Community no. 2. 22-43 years	16	36.73
Community no.3. 26-34	18	32.65

3.4 Presentation of the FGDs and IDIs Findings

Five themes, and their respective sub-themes, emerged from the findings (FGDs and IDIs combined) of this study. The themes and sub-themes are outlined in Table 3.3 below.

Table 3.3 Themes and Subthemes for FGDs and IDIs

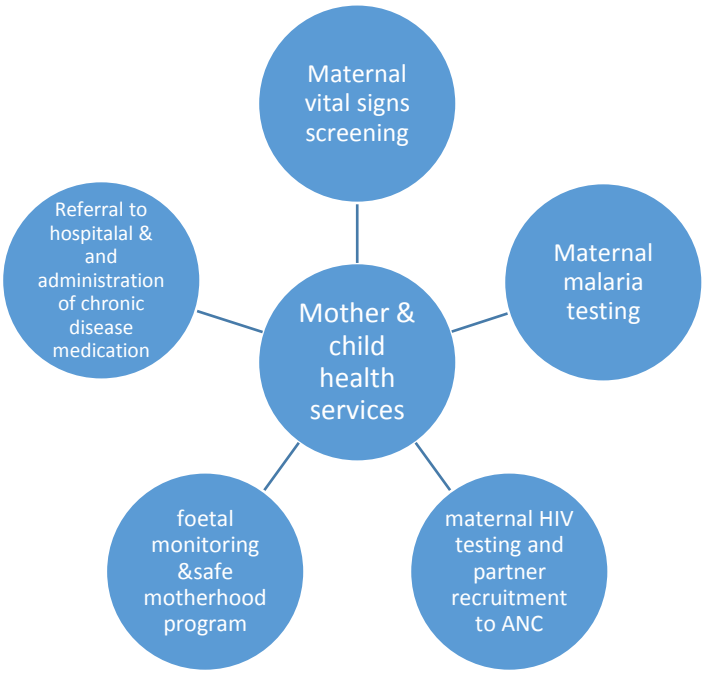
FGDs and IDI IDI Themes	FGD sub-themes	IDI sub-themes
1. **Maternal health service Package understanding**	Vital signs and general screening of diseases	Vital signs and general screening of diseases
	Maternal testing of HIV and partner recruitment to ANC	Maternal malaria testing, HIV and partner recruitment to ANC
	Foetal monitoring	Foetal monitoring
	Introduction of Safe-motherhood program	Introduction of Safe-motherhood program and incentives
	Hospital referrals	Hospital referrals
		Administration of chronic disease medication
2. Community Appreciation and preference of Health care providers	Hospitable health care providers	Hospitable health care providers
	Hospitable TBAs	Hospitable TBAs
	Health Surveillance Assistants	
3. Maternal **Health Service provision** barriers and **challenges**	Longer waiting time	Longer waiting time
	Mismanagement of resources	Lack of resources
	Negative health care provider attitude	Negative health care providers' attitude
4. Maternal health service **Patient challenges**	Health facility location preference	Health care provider and health facility location preference
	Myths, beliefs and traditional medicine	Myths, beliefs and traditional medicine
	Family interference and use of traditional medicine	Family involvement in maternal health care delivery
	Costs and distances	Costs and distances
		Poor maternal health skills by health care providers
	Confusion and feeling hopeless	Confusion and feeling hopeless
	Late antenatal care	Late ANC
	Sanctions for out of facility baby delivery	Community sanctions
	Dissatisfaction with by-laws	Dissatisfaction with by-laws
	Support for health facility delivery	Support for health facility delivery

5. Proposals on improving maternal health services improvement plans	Training and community health education	Training and community health education
	Introduction of clinic committee	Introduction of clinic committee
	Infrastructure improvement	
	TBAs service termination	
	Behaviour change of health care providers	Behaviour change of health workers
	Support for health facility delivery	Support for health facility delivery

3.4.1 Theme one: Mother and child health services

Theme one responds to the first objective of this study. The objective explored communities' understanding of existing maternal health care service package offered by health care providers in rural areas in Malawi. The findings from both FGDs and IDIs reveal participants' familiarity with mother and child health services which include; maternal vital signs screening, maternal malaria testing, maternal HIV testing and partner recruitment to ANC, foetal monitoring, and safe motherhood programs, referral to hospital and administration of chronic disease medication.

(Figure 1). Schematic diagram ot theme number 1 and its subthemes



3.4.1.1 Vital signs and general screening of diseases

The government promotes the provision of adequate maternal health services in rural areas of Malawi. Participants from both FGDs and IDIs highlighted that the maternal health services provided in their health facilities included testing of malaria and referral to hospital when they had complications:

> *"… these women, they tell us that when they go for ANC, they test their blood to see if they have malaria parasites during every visit. They also give them tablets to treat malaria if they are found to have the parasite in their bodies" (Participant # 2, FGD 3).*

> *"They give us tablets to treat malaria to take in the presence of the nurse to avoid defaulting. …They sometimes distribute free mosquito-nets to protect us from mosquito bites" (Participant # 1, IDI; Participant # 4, IDI).*

Participants indicated that the nurses assist in preventing malaria from infecting pregnant women by giving medication and some preventative equipment such as mosquito nets. There are programs both in rural and urban areas that distribute free mosquito nets as well as give them health education.

> *"They … give us vitamin tablets. They [also] give us anti-malaria tablets and mosquito nets to use at home" (Participant # 5, IDI).*

Participants also highlighted that, vital signs screening included; blood pressure check, blood tests for haemoglobin levels, sugar levels and urine test to see if they have infections.

> *"Yes, when we hear these words [maternal health services…], we think of weighing and checking of blood pressure for pregnant women…" (Participants # 3; FGD 2,).*

> *"… they test the women's blood levels. Yes, to check if they have enough blood in the body" (Participant # 6, FGD3).*

> *"We go for blood pressure check and they check sugar levels, when we visit the clinic for ANC" (Participant # 7, IDI).*

> *"They weigh us and give us injection to prevent the baby from contracting tetanus" (Participant # 6, IDI).*

Participants also reported that the health care workers test their urine and weigh them. Urine is tested for the presence of any infection. Participants were also weighed in order to check if the baby is growing well inside the mother's womb.

> *"They test urine to see if we have an infection. They give us tablets for malaria and some tablets to take every day to increase blood levels" (Participant # 8, IDI).*

> *"They check if our weight is going up (weight gain) to see if the baby is growing. Before, they used to give powdered milk if you are not gaining weight, but now they stopped" (Participant # 7, IDI).*

3.4.1.2 Maternal testing of HIV and partner recruitment to ANC

Participants associated maternal health services with HIV testing. This is because every pregnant woman is tested for HIV when she goes for ANC. Most health centres conducted HIV testing on the first ANC visit, in order to promote prevention of mother to child transmission. Below is what Participant #2, FGD 3, said:

> *"These days, they ask women to go with their husbands when they go to start ANC. They want them to go to the health centre when the pregnancy is three months old to start ANC. When they both go there, that is when they take blood to test for HIV. Yes, they test both of you" (Participant # 2, FGD 3).*

Women participants reported that when they were accompanied by their husbands to start ANC at the health facility, they both test for HIV. This strategy was put in place to allow both partners to know their status and start HIV treatment immediately if they tested positive.

> *"Yes, we go there with our husbands because they want to check if we have HIV virus that can be transmitted to the baby. If they find that we have it, they put both of us on treatment so that the unborn baby can be protected. If you go alone, they still test you for HIV"* (Participant #14, IDI).

Male participants also said:

"We go with the women to start ANC that is what the government wants. When we are early, then they promise to attend to us first although we still end up spending long hours at the clinic due to so many activities that take place" (Participant # 4 FGD).

"Men accompany their wives to the clinic. Yes, it is a new rule. The nurses test both of us for HIV. It is not like they force us, no. The counsellors explain nicely, and they give us a form to sign if one agrees to be tested" (Participant #6, IDI).

It was, however, highlighted that it is not all the men who accompanied their spouses to start ANC, although people are beginning to understand the importance of this:

"If your husband refuses to go with you to start ANC, and you start treatment alone without your husband, and you sleep together, it means the baby will contract the HIV virus" (Participant no.1, IDI).

3.4.1.3 Foetal monitoring

Participants indicated that nurses conduct foetal monitoring to assess the health of the mother and that of the child. Foetal monitoring is fundamental during ANC visits because it helps to detect any pregnancy problems that may affect the foetus.

"Yes, the services involve examining women to see how their health is. They check the position of the baby and if the baby is alive…" (Participant # 6 FGD 2,).

"They examine me to find if the baby inside me is growing and breathing well, they say, yes, it is breathing" (Participant # 7, IDI).

"If the baby is not alive inside, they tell us. They ask the woman, 'are you okay'? No, the baby is not what? Is not breathing. They tell us if our blood is running fast meaning high blood pressure" (Participant # 4, IDI).

Participants indicated that foetal monitoring was performed to determine pregnancy complications in order to facilitate further patient referrals.

"Some women are told in advance if the baby is lying across in the womb and when it is like that, the nurses send them to the district hospital for operation" (Participant #3,

IDI participants further indicated that foetal monitoring was performed to assess the foetus' wellbeing. They checked if it was; in the correct position and alive.

3.4.1.4 Introduction of Safe motherhood and incentives

Safe motherhood initiative is popular in Malawi, especially in rural areas. Partly, because it is associated with incentives. In relation to this programs, some participants had this to say:

> *"When they brought the program called safe-motherhood initiative and they introduced it among us, and it said that every woman who goes to start ANC at three months and everyone who delivers in a clinic will receive money, it was very good until they stopped it without telling us"* (Participant # 4, FGD 1).

Some participants indicated high interest in safe-motherhood incentives. This was because most of the community members did not have a sustainable source of income. Participant #2, FGD 3, reported:

> *"It was something that every one of us was looking forward to. We did not worry anymore about money to pay at the clinic. The women were discharged with the baby with ease. No more asking for clinic bills at clinic A; instead, they came back with money and a baby if she followed all the rules for the safe-motherhood program"* (Participant #2, FGD 3).

Coommunities appointed men and women to volunteer in safe motherhood programs in order to give them ownership. Participant #10, IDI indicated her role in safe-motherhood programs: .

> *"Yes, I did the training for safe motherhood. So, in the past months, we have been helping mothers with safe-motherhood education. Women come to us to ask for advice; we give them cards so that they can take when going to the clinic A" (Participant # 10, IDI).*

The safe motherhood program paid women money, in return for using the maternal health services at clinic A.

> *"Yes, the money was given to us at clinic A after delivering the baby there. The safe motherhood people made sure that pregnant women start ANC at three months, and they follow all the visits until they give birth at the clinic. I do not know about clinic B because I never went there" (Participant # 3, IDI).*

3.4.1.5 Hospital referrals

Participants indicated that health care providers can determine complications that may happen during delivery. Therefore, the women who may have experienced complications were referred to Dedza district hospital for an operation and further management. Participants #7 and #6 IDI reported below:

> *"…. that is when we go for abdominal examination to see if the baby is lying in a correct position and they send us for operation [to the hospital] if it is not in a correct position" (Participant #.7, IDI).*

> *"Those who need operation are also told to go to [name of hospital] when they are towards the end of the 8th month" (Participant # 6, IDI)."*

3.4.1.6 Administration of chronic disease medication

FGD participants reported that blood pressure (BP) medication was given to them at every ANC visit. They took it every day. This is because, most of them went to the clinic for non-pregnant related conditions:

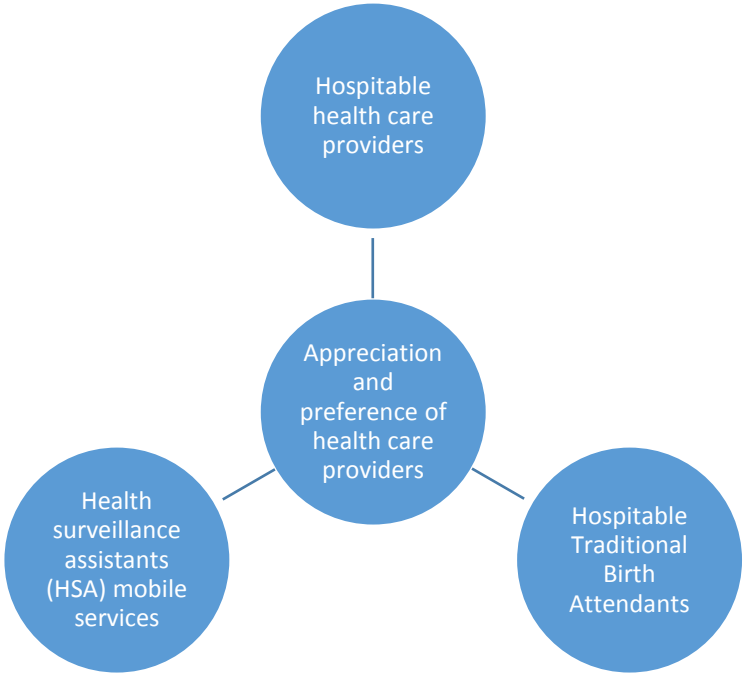
> *"If you have high BP, they give you tablets to control it and you drink every day. …" (Participant #.11, IDI).*

> *"… there are tablets that they give us to treat BP. Those who are on ARV receive treatment every month…." (Participant # 3, IDI).*

3.4.2 Theme two: Appreciation and preference of health care providers

Theme two responds to objective two of this study. The objective explored community perceptions of existing maternal health services delivery in rural areas of Malawi. The participants of this study appreciated health care providers, TBAs and Health Surveillance Assistants (HSAs) who were responsible for maternal health care services provision. This is illustrated in the Figure 2, below:

Figure 2). Schematic diagram of theme 2 with its subthemes



3.4.2.1 Hospitable healthcare providers

Some participants complained about the treatment that they received at the health facilities. However, there were also significant findings were participants appreciated the health care serice providers' good work and hospitality. This is illustrated below:

> *"So, when the women go there, they welcome them [and] explain to them what the problems are. They tell the nurses how they feel in their bodies. After that, the nurses examine you to find what the problem is. When they find the problem, they can see that the problem is that or is this. Then they decide on what type of tablets to give you according to the problem…"* **(**Participant #2, FGD 1)**.**

"The nurses are experienced; they tell them to wait at the waiting area[3] *a month before the date of delivery to avoid accidents of home delivery"* **(**Participant #7, FGD 2)**.**

"Some nurses treat you well, but others just shout at you. The nice ones stay with you until you give birth, but most of them are rude" (Participants. # 2, IDI).

[3] Waiting area is called waiting shelter in some countries. It is a place next to the health facility where women go and stay before labour starts. It is usually those women who have been identified as having problems with their pregnancies although these days, every woman is asked to go to the waiting area at 8 months to reduce MMR.

3.4.2.2 Hospitable Traditional birth attendants

Participants expressed their praise for TBAs, even though they were banned from practicing in Malawi. There is high respect for TBA with The following exemplifies these sentiments regarding TBAs:

> *"…Yes, they deliver nicely at the TBA although sometimes others end up with problems to take out the placenta. Yes, they deliver at the TBA without problems though some who are unlucky die. There, the TBA is with them throughout, and they can make porridge for them, massage them and treat them with respect" (Participant #11, IDI).*

TBAs were preferred partly, because of the respect they had for pregnant women, when they were assisting them. Some participants had witnessed the death of women at the hands of TBAs but they considered that as an accident that could also happen at a health care facility. This is what the participants said:

> *"Yes, the reason some women still go to the TBA for delivery is because they are treated better, they are respected more than when they go to hospitals. Not even private hospitals can match the treatment that they get from TBAs. Some nurses are ignorant about humanity that is why they are so rude"* (Participant #1, FGD1).

> *"It is because they are treated better, they are respected than when they go to the clinic. Not even private hospitals can match the treatment that they get from the TBAs" (Participant # 3 FGD 1).*

> *"There was nothing that could be done for her, it was not the TBAs fault, and she did not know that things would turn out that way. She had been helping people without any problems. It is the same at the hospital, sometimes people die. Delivering at the TBA was not a problem. If you are unlucky then bad things happen, anything can happen anywhere, whether at the TBA or at the clinic. Everything has its own time after all" (Participant # 2, IDI).*

3.4.2.3 Health Surveillance Assistants (HSAs) mobile services

FGD participants appreciated the HSAs[4], for the health education they provided. These are community health care workers who link communities with the health sector.

[4] HSAs are called community health workers in other countries

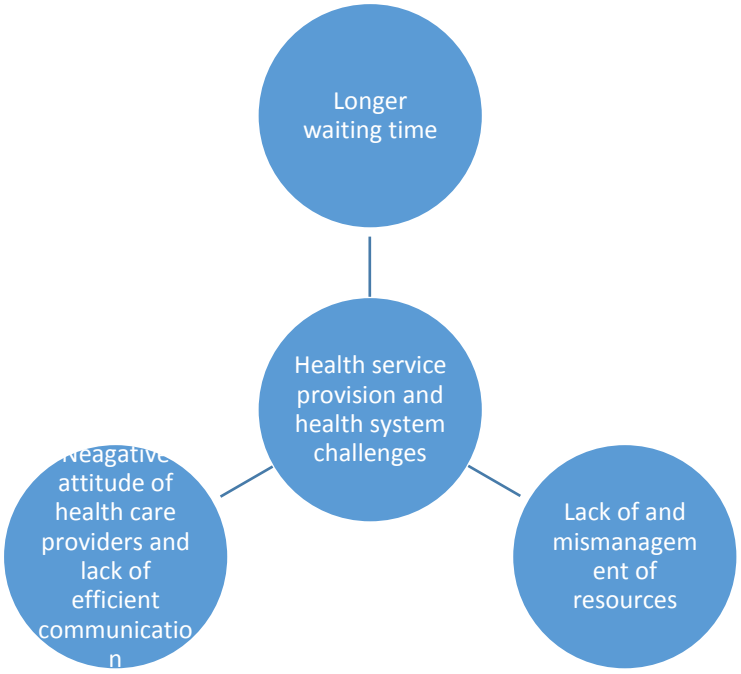
> *"Just to add to that, the HSAs, as you asked before, they go into different villages according to their allocation to give health education and identify people who need medical care. Like this area, there are HSAs that are allocated to us. Another area as well, each area has its own social and health needs and they are under different HSAs" (Participant # 2, FGD 3).*

> *"Sometimes when you are lucky, the HSAs can have tablets like aspirin or other small tablets, but no, they do not keep tablets. They just give health education or refer sick people and pregnant women to the clinic" (Participant # 6, FGD 3).*

3.4.3 Theme three: Health service provision and health system challenges

Theme three also addresses the study objective two which explored community perceptions of the existing maternal health services delivery in rural areas of Malawi. The challenges experienced included waiting time, mismanagement of resources, lack of efficient communication and negative healthcare worker attitude, poor maternal health skills by health care workers, costs and distance. These are illustrated in the figure below:

(Figure 3*). Schematic diagram of *theme 3* and *its* subthemes.



3.4.3.4 Longer waiting time

Participants complained about the time it takes to be attended to in both health facilities A and B. Long waiting time affect the maternal health services not only in rural areas but in a lot of health facilities globally.

> *"Just to add to that, sometimes it just happens that the nurses are full of themselves and rude. It can happen that a person waits for a long time even though there are few patients. The nurses are not busy, but they just ignore us"* (Participant # 4**,** FGD 3).

> *"Women complain that sometimes they can arrive at the clinic in good time, but for them to be attended to, even if there are not a lot of patients, the nurses just do not care, and true they just do not care. These are the problems that we face when we go to the clinic"* (Participant # 5**,** FGD 3).

> *"We wait for a long time when we go for ANC because there is usually one nurse who examines us" (Participant #4, In-depth Interview).*

Occasionally, there would be few patients at the health facility, however, nurses wasted time by charting with each other because they did not care about patients:

> *"Uuuh, sometimes the nurses are not busy, they just ignore us, they chat with each other especially when you are not going for ANC we wait for too long before we are helped" (Participant# 11, In-depth Interview).*

3.4.3.5 Lack of and mismanagement of resources

Participants highlighted challenges relating to poor staffing as a human resource problem. Rural health facilities usually face shortages of stuff because most health care providers prefer to work in urban areas. This was reflected bellow :

> *"You stay long at the clinic when they go with other non-pregnant related complaints because of the shortage of health workers like nurses in government clinics. Medicine, most of the times, is also hard to find. Because you can go there only to be told that no, there are no tablets. We end up going to buy the tablets from small shops"* (Participant #2**,** FGD 1).

> *"The nurses at the government clinic are understaffed, and they pay little attention to patients; we try to find money and send our women to the private clinic. We don't want to send them to places that we know they will suffer"* (Participant #5, FGD 3).

Participant #7, FGD 2, criticized the lack of resources and medication at the facilities.

> *"…Uh., mai[5], when it comes to clinic B, the tablets are sold to street vendors, if you are lucky that the medicine has just arrived, and you happen to be there, they give you very few tablets, the rest of the tablets are sold to vendors. When we go to clinic A, which is private, there they give us all your treatment. It is because we pay"* (Participant #7, FGD 2).

The health facilities also lacked equipment and human resources to effectively run health services for pregnant women.

> *"Other problems that we meet at the clinic are that of a shortage of equipment. These clinics in rural areas, it happens that a person walks a long way to the clinic, and to get to the clinic, it is very far. It is not easy to get there" (Participant # 6, IDI).*

Occasionally, patients were asked to buy; utensils, equipment and plastic paper to use as a linen saver when they went for delivery:

> *"We are supposed to be ready when we are going for delivery. We must have a razor blade, a plastic paper and some clothes and baby wrappers. We must pack them ready in a bag because the clinic does not provide this" (Participant # 7, IDI).*

> *"What is needed mostly for a pregnant woman is that she needs to prepare. She must be ready anytime she will receive a gift of a baby. So, when this gift comes, you must be ready by buying clothes, plastic paper to use at the clinic, basin, and a razor blade to cut the cord with" (Participant # 9, IDI).*

FDG participants reported that theshortages of drugs and unavailability of staff was as a result of mismanagement of resources. This is illustrated by Participant #4, FGD 2, below:

[5] It is the same as Madam

"They like to sell the tablets to vendors there at clinic B. So that when people go there, even the children, the medicine that they receive are broken into halves sometimes two tablets broken into halves and they tell us to buy the rest of the treatment. So, people just decide to go to the private clinic even if it is difficult to find money" (Participant # 4, FGD 2).

3.4.3.6 Negative attitude of health care providers and lack of efficient communication

All participants from IDIs reported on the negative attitudes of health care providers. It was observed that they were not comfortable with the attitude that health care providers had for pregnant women and other patients, at the health facilities. Both health facilities A and B had reported complaints from participants:

"The nurses are sometimes so rude. It is not all of them and sometimes women make them behave like that. For example, at the ANC, they tell us to bring a basin, plastic paper, prepare our bag with wrappers and baby clothes and nappies. When we go there without taking these things, the nurses do not like it. They shout at us all the time" (Participant # 11, IDI).

Participants highlighted that there was a lack of communication regarding the safe motherhood incentives. FGD participants felt let down when the incentives were stopped:

"We, men make sure that everything is done according to the rules of safe motherhood. We knew that when she is discharged, she will come home with some money. Yes, this helped to implement safe-motherhood initiatives as well… these days that it has been stopped, the women are no longer getting any money and that men must take money to go and pay for the discharge of the mother and baby, this is a setback, and they did not come to inform us that they are going to stop giving money, it is worrisome" (Participant #3**,** FGD 1).

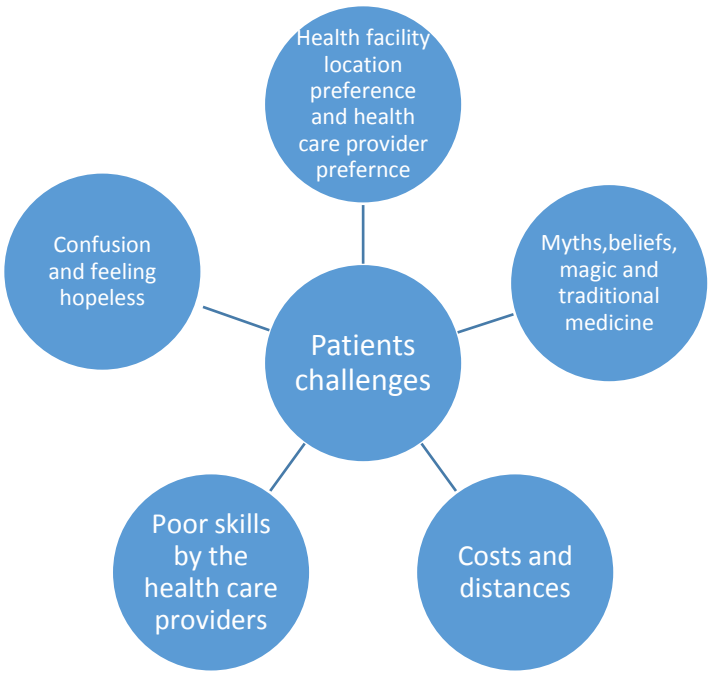
"Nobody told us that they are no longer giving out money to women after giving birth. We just heard that women are being asked to pay for the services as they used to do for free. It is worrying indeed" (Participant # 7, FGD 3).

3.4.4 Theme four: Maternal health services patients challenges

Theme four responds to objective three of this study. Objective three wanted to understand the maternal health services delivery challenges/barriers and possible service improvement strategies in communities under investigation. In rural areas, there are various challenges that prevent community members from utilizing maternal health services.

Challenges faced by patients, for this study, included: family interference in maternal health care delivery; health care facility location preferences; health provider preferences; myths, beliefs, traditional medicine and magic; confusion and helplessness; delays in visiting health care facilities; lack of teamwork; late ANC visit and utilization, and community lack of knowledge. Fig 4, below illustrates theme and its subthemes:

(Figure 4). Schematic diagram of theme 4 and its subthemes.



3.4.4.1 Health facility location preference and health care provider preference

Participants indicated that choice between the two health facilities was made on the basis of treatment they received. They preferred private health facilities because they

were treated better here compared to the government health facilities. It was observed that it was hard for most participants to accummulate money to pay for the services at the private health facilities. However, they accumulated the money to attend to private health facilities to avoid negative experience that they would get from government health facilities. Participants felt that nurses at clinic A were better than those at clinic B. Other participants criticized nurses from both facilities. Although it is normal for one to chose a health facility due to its services, in rural areas where health services are far, it is important for everyone to have access to free services.

> *"I go to clinic A because I know that even if it needs a lot of money to pay for the services, but I will be assisted well. While at clinic B, you travel a long distance and you come back without any assistance" (Participant # 4, IDI).*

> "*Although some are rude, the nurses at clinic A treat people better than those at clinic B" (Participant #3, IDI).*

> *"There are so many services at clinic A, even at clinic B. I like to go to clinic A because they do not send us back without any tablets. They prescribe a treatment for us based on what is in stock. At clinic B, they keep the tablets for their own business, so what is the use of walking all this distance when you know you will come with nothing?" (Participant #.1, IDI).*

IDI participants preferred to be treated by male nurses, especially when they were in labour because they treat them with respect. Participants from IDIs recommended the good work that most male nurses did. This was in contrast to some cultures where male health care providers are not allowed to assist pregnant women with delivery. This is illustrated below:

> *"They treat you badly, but sometimes, you meet with nice ones. What can you say, if you are lucky you meet with a male nurse? Male nurses are better than female nurses" (Participant # 3, In-depth Interview).*

> *"We can say, male nurses are better than female nurses, laughs…. Female nurses are different from each other; others are rude and pride I guess that is the way they were born" (Participant # 4, IDI).*

Participant #9, IDI, reported that female nurses talk too much compared to male nurses. This is so because female nurses shout at pregnant women when they go for ANC or delivery unlike male nurses:

> *"Yes, with women, they talk too much. With men, they just help you deliver your baby nicely" (Participant # 9, IDI).*

3.4.4.2 Myths, beliefs, magic and traditional medicines

The findings further revealed that most of the participants hide the correct gestational age to protect themselves from enemies who may bewitch them and their unborn baby. These beliefs are common among communities in Malawi, especially in rural areas. Pregnant women take traditional medicine to prevent miscarriage, magic, sorcery and witchcraft. Participants for this study confirmed this:

> *"When I am pregnant, I do not tell anyone no. You only tell family members. You do not know who the next enemy is. When the pregnancy is visible, that is when people will know that I am pregnant. They will not know the correct gestational age at all. It is because enemies can bewitch you. They can kill the unborn baby and you. Yes, it happens… people are dangerous" (Participant #6, IDI).*

> *"Others follow traditional rules like going to traditional healers to protect their pregnancies so that other people cannot bewitch and kill the unborn baby. Others go there when they are between four and five months" (Participant # 14, IDI).*

There are various rituals that are conducted when a baby is born. Participants said that protection of those unborn babies' fontanel is required.They said if this is not done,it can cause problems to the baby. Hence they prevented this by the following:

> *"So, it means when we are seven months pregnant, we must stop sleeping with our husbands. It also means that when I have given birth, I must stay for three months before sleeping together with my husband. This is to protect the baby's fontanel" (Participant #.7, IDI).*

Findings demonstrated that participants preferred traditional over western medicine. Some participants also indicated that they mix traditional and western medicines because they believe in them both. This is highlighted by some participants who said:

"Sometimes people end up just digging up thovisi[6], yes, what can they do? … Some people dig the traditional medicine and boil or soak them in water and drink them when they are sick… but the problem is that you do not know what you are treating, and this can lead to complications that can lead to death" (Participant # 4, FGD 1).

"…Uh, the rules… uh sometimes if you see that you have been going to the clinic with a problem of heart palpitations for a long time when they just give you iron tablets, you decide to also take traditional medicine that will help you out of the problem. The most important thing is to go to the clinic. If it does not help, then you can use both clinical and traditional medicines" (Participant #.7, IDI).

"…a person can take both western and traditional medicines; it depends on one's belief" (Participant #4, FGD 1).

Some participants preferred traditional than western medicine because of costs. Therefore, it is not clear if this was preference or it was lack of money to pay at the health facilities.

3.4.4.3 Costs and distance

Costs and distance were two factors that were considered in deciding where a pregnant woman could deliver her baby. These factors also affected the maternal health services. Participants reported below:

"There are no bicycles here to be used as ambulances in the village. There is a problem with transport and sometimes it is not the woman's choice that she does not go to the clinic. It is due to the distance; the clinics are very far. It is dangerous to walk at night" Participant # 7, FGD 3).

"There is no unity in the village, sometimes there is no one who is willing to go with you when you go with your wife to the clinic so people just use traditional medicine because it is near them" (Participant # 6, FGD 2).

"Even though there are two clinics in this area, the distance is longer enough to clinic B than to clinic A. They are both far and we need money to pay for transport and the

[6] It is traditional medicine in the form of roots that people in the rural areas in Dedza in Malawi soak in water and drink to treat some ailments

> *services at the clinic, so what else do we do other than use the TBAs and magic men" (Participant # 3, FGD 1).*

Findings also highlighted that people in the villages under study, used over the counter medications as a way of avoiding long distances to the health care facilities, unlike going to the nearest public clinics. The quotations below illustrate some of these views:

> *"It is easier to buy tablets from the grocery shops at Thete Trading centre. And it is cheaper just to buy medicine from the shop than go to the clinic…" (Participant #, FGD 2).*

Additionally, findings revealed that, although at a cost, private clinics were closer and offered better services compared to the two government clinics.The participants said:

> *"These days health services are very expensive. We pay not less than K6000, it depends on how complicated the labour was. Like if they increase the birth passage and put some stitches, you pay K7000 for a girl and if it is a boy you pay K8000[7]" (Participant #8, IDI).*

3.4.4.4 Poor skills by the health care providers

Participants reported that there was a lack of skills and knowledge among health care providers, particularly, nurses in the labour ward. For this reason, participants avoided using the health care facilities. Participants reported that in some cases, when they were in labour, they were left to deliver the baby alone:

> *"What I experienced, the last time I went to the clinic is that most of them were young nurses…Yes.., they did not know well what they were doing. They left me alone during delivery and I delivered alone. I called, nurse! Nurse! No, the nurse came to attend to me" (Participant # 15, IDI)*

> *"They are cruel mostly when you go to deliver your baby; they sometimes leave you alone in labour ward" (Participant # 7, IDI).*

[7] In this case, 8000 Malawi Kwacha is equivalent to 120 South African Rand.

"They just hear the baby crying while you are alone. They come running, in the end, to help you" (Participant #13, IDI).

"No, they were in their houses; they leave patients alone in the labour ward and go to their houses, it happens at clinic A" (Participant # 3, IDI).

3.4.4.5 Confusion and feeling hopeless

Findings also illustrated that participants were conflicted on whether to use TBAs or health facilities because of community by-lawst.Participants said:

"No, the TBAs are cheap and polite, but if we go to deliver there, then we just know that we will be summoned by the village headman, even the TA. So, we just look for money to go to a health facility" (Participant # 2, IDI).

"You think of the care at a TBA, then you compare it with the care that you get from the nurses at the clinic. It is better to go to the TBA, but we get scared of being summoned by a village headman, so we just go to deliver at the clinic to avoid paying the fine" (Participant # 9, IDI).

Participants expressed that their needs were not responded to by the facilities management. This shows that facilities management discouraged communities to raise their complaints.

"Basi[8]. The girl and her mother just took the dead body home and buried it. They buried the baby. What can they do? Nothing else. They have nowhere to complain to" (Participant # 8, IDI).

*"No, we have never complained to anyone about the bad treatment, which is given to us by the nurses at the facilities. We just stay quiet. We do not know who to tell our problems. We feel that nobody can listen to our complaints" (Participant # 1, IDI**).***

"No, we just stay back, we just complain within ourselves. We will be saying, "The way

[8] This means she was helpless, there is nothing she could do, and she has no say because no one can listen to her.

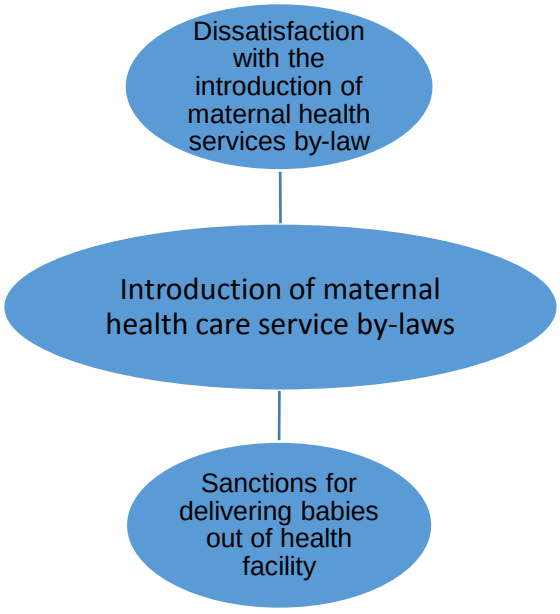
> *"she treated me, but the way that nurse treated me". Other people are born rude, so, if you point out this to them, then you will never be treated well next time you go back to the clinic" (Participant # 3, IDI).*

3.4.4.6 Dissatisfaction with the status quo

Respondents expressed dissatisfaction with the way things are done in the provision of maternal health services. This included the introduction of by-laws. The issue of by-laws responds to the study objective three which wanted to understand the maternal health services delivery challenges/barriers and possible services improvement strategies in the communities under investigation.

Maternal health services by-law are widely used in Malawi, in order to reduce MMR. However, these by-laws create fear among communites and violate human rights. These by-laws are more reinforced in rural and disadvantaged areas, thereby widening the gap between the rich and the poor. The maternal health care services by-laws include; sanctions for delivering babies out of a health facility and support for health facility delivery. Participants expressed dissatisfaction with maternal by-laws as illustrated in the Figure 5, below:

Figure 5: Schematic diagram of maternal health care services by-law themes and subthemes



3.4.4.6.1 Dissatisfaction with the introduction of maternal health services by-laws

Participants expressed dissatisfaction at the introduction of fines for out of facility delivery. The by-laws are enforced by community leaders, and these leaders are the ones who collect the fines from people who break them. The following excerpts indicate their dissatisfaction:

> *"If a woman does not deliver at the clinic, she pays a fine to the village headman. Because of culture, if someone does not want to go to the clinic, she pays a fine. We are already having problems to buy even aspirin, on top of that, the government says pay this money as a punishment for not following these rules, it is not easy for us" (Participant # 4, FGD 3).*

> *"They charge you a goat or equivalent to that. I think it is something around R2000? You pay to the village headman. Sometimes they ask you to pay to the TA as well. It depends on what the village headman says. Then we say if one could not get money to pay for transport to go to the clinic, how can she find money to pay for the fine?" (Participant # 5, IDI).*

> *"The problem is money; women do not go to deliver at clinic A, which is better of the two because of money. To go to clinic B is usually trouble. The nurses are rude, and we still need money to pay for transport. So, on top of this problem, the government decided to charge us a fine if we do not deliver at the clinic, I think they are just adding more financial problems to us the poor" (Participant # 13, IDI).*

3.4.4.6.2 Sanctions for delivering babies out of a health facility

Participants also shared some of the sanctions experienced at the community level about the poor health care services. This happened when they delivered babies outside the health care facilities, either at home or at a TBA. This is what some participants had to say:

> *"They charge you K2000[9]. They say this fee should encourage pregnant women to use healthcare services. It is hard to find money, so women are forced to go to the clinic than paying that amount of money" (Participant # 4, FGD 3).*

[9] This is equivalent to 40 South African Rand.

Participants continued to say:

> *"In the past, before these by-laws were set in the villages, a lot of women were losing lives because they used to deliver at the TBAs or in their homes without being assisted by a western trained person. Now with this law of paying fines when you break it, there are significant reductions in death of new-born babies and mothers. We do not hear of these accidents frequently. Yes, just to add to that"* (Participant #1 FGD 3).

> *"…They introduced the rule that every pregnant woman should go to the clinic for delivery, and nobody should go to the traditional birth attendants" (Participant #.15, IDI).*

Participants supported sanctions for out of facility deliveries by saying:

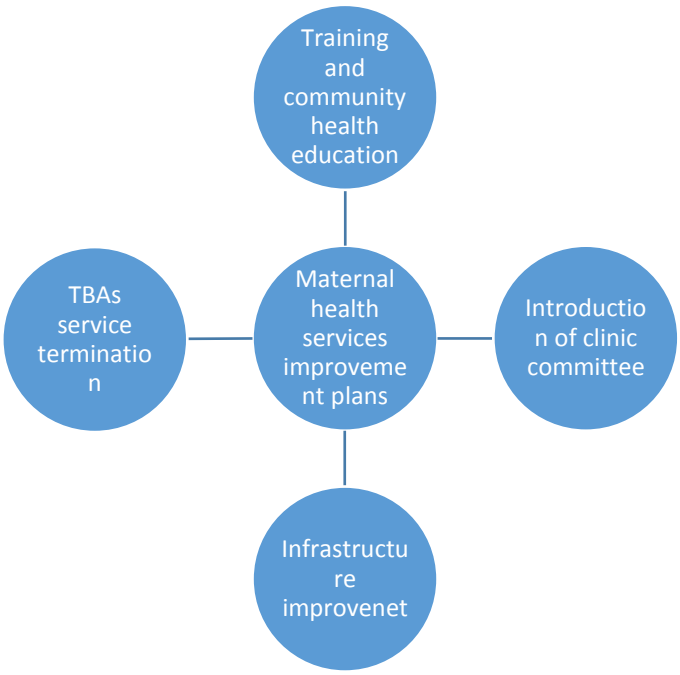
> *"Now with this law of paying fines, there are significant reductions in death of new-born babies and mothers. We do not hear of these accidents frequently. Yes, just to add to that..." (Participant # 1, IDI).*

> "*A woman died a few years ago because when she delivered her baby, some things were left behind. The traditional healer failed to help her because she bled a lot. When they decided to take her to the clinic, it was too late, and she died on the way to the clinic. It is good that we are not allowed to deliver at a TBA anymore" (Participant # 9 In-depth Interview).*

3.4.5 Proposals on improving maternal health services

Theme five therefore responds to study objective three that sort to understand the maternal health services delivery challenges/barriers and possible services improvement strategies in the communities under investigation. Improvement strategies included; behaviour change of health workers; training and community health education; improvement of infrastructure; the introduction of small committees; reduction in utilizing services from TBAs and introduction of small groups. The themes and subthemes are illustrated in Figure 6, below:

Figure 6: Schematic diagram of maternal health services improvement plans theme and subthemes.



3.4.5.1 Training and community health education

Participants endorsed the need for training TBAs. Although, the Malawi Government has been training TBAs and supplying equipment although Maternal deaths still occur on their hands. Participants preferred TBAs to other health service providers but recommended some training in order for them to be able to deal with pregnancy related complications.

> *"Most women are not aware of the disadvantages of not using the health facility in case the woman starts to lose blood whilst in labour. ... The TBA does not have the skills and capacity to stop the bleeding and to replace the blood. They do not have the right equipment to use to replace water in the body or blood. They cannot measure how low a patient's blood levels are, and these things put the women in danger so there is need for them to be trained as well"* (Participant #8, FGD 2,).

> *"So, it can come from training. Through these trainings, we can stand up for ourselves when we meet with these rude nurses" (Participant # 3, IDI).*

> *"We all learn through education. Even yourself, you can teach us on safe motherhood issues, even how to stand for ourselves when we meet with these rude nurses at the clinics. If we are left like this, we cannot know anything. We*

cannot know what to do. There is no togetherness in this village. We can be very grateful if there can be any committees on this matter" (Participant #9 IDI).

3.4.5.2 Introduction of clinic committee

Health facility management include local residents as members of the board. However, the study findings showed that there is lack of such inclusion. Participants expressed a wish to have small committees that can help raise money and also resolve issues that arose when pregnant women visit the health facilities. This is what they had to say:

"This is because if we can sit down and find a way to have a committee that will take care of any donation that can come to help in terms of transport to the clinic. This should not only be for pregnant women but anyone who needs to go to the clinic in this village…" **(**Participant #1, FGD 3).

"….** there is a need for small committees so that we can sit down and find a way to raise money so that it can be used when there is an emergency. If we can identify a donor to give money to fund the transport issues that will be welcome. …"* (Participant #3, FGD 2).***

Community participation means decision-making that involve people of that community. Participants stated that communities failed to resolve maternal health problems because they lacked committees which can help resolve this. This is reported below:

"There are no proper committees set in the village concerning this issue although we help as individuals when there is a need" (Participant #1, FGD 1).

"There is a need to sit down and discuss safe motherhood initiatives. If we can come together and form a group and discuss the importance of safe motherhood. We can discuss if there is a problem and find solutions" (Participant # 9, IDI).

3.4.5.4 Infrastructure improvement

Furthemore, participants proposed several infrastructure improvements such as the building of a small clinic for minor cases, an efficient transport system and a community bicycle. They indicated that these proposals will prevent unnecessary community delays to reach health facilities. Most maternal deaths happened because of delays of pregnant women to health facilities. This can be easily avoided as illustrated below:

> *"Just to add to that, there is need to check how many patients are there at a time in our village so that we can have a vehicle that can be taking them to the clinic on specific days" (FGD 2. Participant # 4).*

> *"Another thing is that we want to help each other as a village as well as an area. We have a vision, what we think is, if we can have a clinic nearby to reduce the distance to the clinics and if this clinic can be under the government to encourage everyone to use it. Having this clinic can help with safe-motherhood initiative programs. It can reduce a lot of problems concerning pregnancy…"(Participant #7, FGD 3).*

3.4.5.5 TBAs service termination

Although most participants commended the positive attitude and treatment of TBAs, some recommended that pregnant women must use health services. This is to reduce maternal mortality rate. Participants reported:

> *"Sometimes she can come back from the TBAs while damaged. Because some people had difficulties giving birth at the TBAs, some came with some damages like damaged uterus, but they used to be taken to the hospital that is why they banned them; they are not supposed to help any pregnant woman"* (Participant #8**,** FGD 2).

Participants acknowledged the dangers of using TBA services, they did not hold them accountable, as stated below:

> *"We cannot say that they are wrong but because the TBAs do not have the equipment to treat complications; then we can say these women must follow*

*the rules that say deliver at the clinic to reduce accidents of mother and baby dying…" (*Participant # FGD 2, 7)*.*

"The reason some TBAs have been stopped to practice is that they keep pregnant women who have problems for too long before they admit that they have failed. Yes, they take long to send pregnant women with complications to the clinic" (participant #8*,* FGD 3).

3.5 Conclusion

This chapter presented the findings from both IDIs and FGDs. The chapter discussed demographic information in terms of marital status, age, education and occupation. Themes and sub-themes were generated from both IDIs and FGDs. In presenting these, the chapter has sought to maintain the voice of the respondents by keeping outstanding responses in the original direct speech.

CHAPTER FOUR

DISCUSSION OF RESEARCH FINDINGS

4.1 Introduction

The previous chapter thematically presents the findings of this study. The identified key themes focussed on findings that have implications on rural women's rights to health. The findings will help with identifying ways that the Malawi Government can improve current health services in order to accommodate the needs of women who stay in the country's rural areas. The five main themes that emerged from this study's findings are discussed on this chapter. This discussion includes: mother and child health services; appreciation and preference of health care providers and health system challenges, patient's challenges, maternal health services by-laws and maternal health care services improvement plans. The findings are discussed according to this study's objectives. The chapter starts by a discussion of theparticipants' demographic characteristics.

4.2 Demographic characteristics and the utilization of maternal health care services in rural areas

4.2.1 Age

The age of women participants in this study ranged from 19 to 44 years. All of the women reported to had attended an ANC. However not all of them started within the first trimester of the pregnancy due to myths and beliefs around early attendance of ANC. Smilary, a study conducted by Chakraborty, et.al. (2003) in rural Bangladesh, found that young women during their first pregnancy are more likely to use maternal healthcare services compared to women who have more than one child (96). It has been established that young women are not aware of the problems that occur during their first pregnancy hence they are afraid to deliver outside a health facility. However, having more children may also influence women to use health services less often due to the lack of childminders while they are at the health facility (98).

Relative to this, literature has also shown that there is usually an increase in maternal health services utilization among women with more than five children. The reason is

that, after women living in the rural area had no complications on their previous pregnancies, they did not find the importance of later delivering at the health care facility (72, 98). Therefore, the age of a pregnant woman influences maternal health service utilization in rural areas. Contrary, younger pregnant, unmarried, women are less likely to visit health facilities for ANC, forpersonal security and face-saving (71). Nevertheless, findings of this study show that age does not strongly determine the utilization of maternal health care services.

4.2.2 Marital status

All participants in this study were married.

4.2.3 Education

The highest level of education attained, among all the participants and their spouses, was Form 3 (Grade 10 in South Africa) while the lowest level was primary school (Grade 3 in South Africa). The findings show that the level of education of an individual does not determine their utilization of maternal health care services. Those who had secondary school education had similar financial problems just like those who had primary school education. This could be because not completing secondary school education in Malawi draws one to the basic modus operandi, which is farming.

Once: Although my job in this thesis is primarily to edit the language and ensure a smooth flow of your grammar. I have continuously made some analytical arguments or input. I add another one here, again, you do not have to treat these as a must do. But you may also consider them.

In the above paragraph, more than language editing, I think the argument you are attempting to make and that many readers may agree with you, or is more scientifically supported by your finding is that:

“In the context that this study was conducted, there was evidence that the level of education did not determine the socio-economic status of an individual. Those who had secondary school education had similar financial problems just like those who had primary school education. However, this is because the highest level of education

attained by the participants of this study was universally low. It did not help them become more employable or further their studies".

NB: What difference does it make to be a Grade 8 school leaver compared to a Grade 2 school leaver in terms of employment? Nothing, I would say. Therefore, your argument needs to be very contextual on this note, and clearer that the level of education discussed here is already low at a more universal level.

Studies similar to the current study, found that MMR increased in places where men lacked secondary and college education education (99). In the current study, women were required to use maternal health services, even though Dedza is one of the districts with high levels of MMR. Moreover, men take the responsibility to find money and ensure that their wives are sent to the private clinics for ANC. However, these findings are not conclusive on the correlation between the level of education and MMR outcome.

Furthermore, a study conducted in Nigeria, by Dahiru and Oche (2015) found that women with an increased level of education are more likely to; have a health facility delivery and attend ANC more than four times, as recommended by the WHO (72). The husband's level of education is also a predictor for the place of delivery. This is because, educated spouses influence their women to deliver at a health facility (72).

Compared to less educated, most educated women are; socio-economically empowered and have access to health information. This helps them to have decision-making powers concerning their health and wellbeing (100). However, if they were not unemployed, the main sources of income for the women who participated in the current study were; small-scale farming and small-scale businesses. This meant that there was poverty in these areas as reported by some participants, and this affects their socio-economic status.

4.2.4 Occupation

Due to rurality, the main form of employment in Dedza district, is precarious domestic work in homes or gardens. People migrate to urban areas to seek stable employment. Small-scale farming, in the rural areas, does not give people sufficient food to last for

a full year. Most women in this area are housewives, even though a small number of them are involved in small-scale businesses such as selling tomatoes, vegetables and Irish potatoes while the men sell dried fish and cassava.

4.3. Theme one: Maternal health services package understanding

Theme one is in line with the study objective one that explored community understanding of existing maternal health care service package offered by health care providers in rural areas of Malawi. This study established that participants perceived the mother and child health services to include maternal vital signs and general screening. They also include maternal testing of HIV and partner recruitment to ANC; foetal monitoring; safe motherhood incentives; hospital referrals and administration of chronic disease medication. Participants for this suty did not remember all the procedures they went through when they visited the health facilities. The participants only mentioned HIV tests, malaria tests, weight checks Women participants, did not know why some procedures were undertaken on them. They attempted to list them, but they could not clearly identify or explain all the recommended maternal health care assessment procedures. Similarly, other studies found that some women utilize maternal health services with the aim of just obtaining an ANC card. This help women to avoid reprimands by health care staff if they do not prove that they attended ANC (101). Although the maternal health care services are the same in both facilities, the difference is on the costs and, availability of resources and supplies.

4.3.1 Vital signs and general screening of disease

Maternal vital signs form an important part in the provision of maternal health care services. The current study found that maternal health care services provided in health facilities, of focus for this study, include vital signs screening such as; Blood Pressure checks, blood screening for haemoglobin levels, sugar levels and urine tests. This is in line with the WHO recommendation that every pregnant woman must have access to basic medical examination such as; vital signs, height, and weight check; HIV and STI tests. However, although the clinics conduct the check-up procedures as per recommended by WHO, they do not make it clear to the beneficiaries (102, 103). This is evident from the findings, because, women did not know why the nurses conducted

the check-ups. It should be noted that the WHO recommends the use of vital signs check-ups to detect early warning signs of pregnancy complications for prevention of maternal death (102, 104).

4.3.2 Maternal HIV testing and partner recruitment to ANC

Malawi introduced mandatory HIV testing as part of the routine antenatal services (105). The current study found that pregnant women are tested for HIV whenever they go for the first ANC visit. They are also requested to bring along with them their spouses for HIV testing. According to Angotti, et.al. (2010), Malawi is among countries, in the world, that have the highest HIV prevalence rates. Out of the total population of adults in Malawi, 12% of them are HIV positive (105, 106).

The current study's findings show that the health system in Malawi concur with the joint UNAIDS and WHO programs that promote routine-provider initiatives for HIV testing (105). The routine testing helps Malawi to work on the public health goal of promoting widespread HIV testing (107). Additionally, couple counselling is encouraged because many women are afraid to disclose to their spouses when they are HIV positive. They fear the possible negative reaction from their husbands (108). From what has been established in this study, it is clear that the majority of Malawians perceive HIV testing at ANC as compulsory and in exchange for antenatal health care services (105). This strategy seems to work. Pregnant women who undergo the tests for HIV and AIDS have increased in numbers since 2005 (105).

However, mandatory HIV test compromise the human rights and freedoms of choice. This means, from a human rights perspective, HIV testing should be conducted after the client's consent, not through coercion. This implies that there is a violation of this human right when pregnant women and their spouses in Malawi, are compelled to undergo HIV testing even when it is against their will (105).

There is also unbalanced power-relations between health care providers and patients. Patients are subjected to the power and knowledge of the nurse. Patients accept any

help that comes from the nurses without questioning. They did not know their rights in the relationship with their health.

Although there are above controversies, compulsory HIV testing in Malawi have saved many infants by preventing mother to child transmission of HIV (108) . This means the dilemma of human rights inherent in mandatory HIV testing and the value that the mother earns from this mandatory testing ought to be balanced. To achieve the balance, both parties (patients and health care providers) need to make their positions and choice known to each other and have them justified before HIV testing can be conducted.

The current study also revealed that when pregnant women go to the clinic with their spouse to start ANC, they in return, do not pay for the health care services at the private clinics and that they are given priority (109). Furthermore,, if women are given letters inviting their spouses for HIV testing, men will come in large numbers unlike when HIV is not mentioned in that letter. This may imply that male spouses take HIV and AIDS seriously, and are willing to champion the prevention of mother to child transmission (108-110).

Since waiting time is usually long at the clinics, it is usually difficult to recruit partners to attend the clinic for ANC. A study in Malawi found that many clinics attend to women who bring their spouses first because they do not want them to wait for too long (111). This is a good strategy because it has managed to attract more men into PMCT hence recording a reduction in MMR. However, the assumption that women should be treated only if they have come with their spouse implies that women are idle and secondary citizens, who can stay at the clinic long hours and nothing is expected to suffer their absence at home. This assumption is faulty, because findings of the current study demonstrate that many women work hard in their gardens, in businesses and they are expected to engage in domestic work. Perhaps, this treatment of men when they goto the clinics can better be explained. If men's involvement in maternal care has not been part of African traditions in many countries, in the continent, then the speedy treatment is a deliberate ploy to promote their participation in maternal health issues (112).

4.3.3 Foetal monitoring and referral to hospital

Foetal monitoring for pregnant women is crucial . Every pregnant woman needs to have her foetus monitored at the health facility during ANC services. Findings for this study show that nurses at the clinics conduct foetal monitoring as part of maternal health care service provision. Participants explained and stressed the importance of foetal monitoring. Through this process, nurses can determine complications that may happen during delivery.

Other studies elsewhere, found that foetal monitoring is the most critical component care for a woman who is in labour. The use of simple and traditional methods of foetal monitoring is effective although there are other advanced ways, for example, electronic foetal monitors. However, telectronic monitors are not available in poor rural areas (113, 114). The current study has shown that, although, rural areas have maternal health care resource shortages, they are still provided with the required basic maternal health care services as recommended by the WHO (115).

4.3.4 Introduction of the safe-motherhood program and its incentives

The Universal Declaration of Human Rights (UDHR) (1948) indicates that every woman has the right to adequate health care (116). This is realised through the safe motherhood initiative programs that aim to invest in shared societal interests (116). The results of this study showed that there is a safe-motherhood program in the study area although some participants did not know if it was still functional. In the study area, there are safe motherhood ambassadors who assist pregnant women by giving health education and referring them to the clinic for ANC. Under the Presidential initiative in Malawi, in 2012, Maternal Safe motherhood program was initiated (117). It was aimed at reducing MMR. The program targeted traditional and religious leaders who have more influence in their communities (117). The introduction of special safe-motherhood initiative program proposed the implementation of by-laws. The by-laws are implemented by chiefs and they involve initiating punishment of women who do not bring their spouse to the clinic for ANC. Another by-law involves the punishment of women who delay to start ANC as well as those who do not deliver at a health facility (117).

This study found that there were mixed feelings about the introduction of safe-motherhood programmes. There were some participants who found this program helpful because it involved some community members as volunteers.

The findings of this study showed that safe-motherhood programs and incentives encouraged women to start ANC at three months. If a woman did not miss an appointment, will be given a sum of money when she goes for delivery. In addition, ANC visits, were made free at private clinics. Free access was a relief to men because they no longer needed to pay for their wives' health services.

The Safemotherhood programme rewarded couples that utilized the maternal health services. However, when it was remed, there was a confusion among the beneficiaries. They later were asked to begin paying for the ANC services. Similarly, a study conducted in Malawi, by Chimseu (2014) found that the safe motherhood incentives enabled women to deliver at a health facility. Women also attended the facility at least once during their pregnancy (118). Likewise, in India, the introduction of a voucher scheme, aimed at increasing delivery by skilled health workers among poor people. This was aimed at improving emergency obstetric care for the poor, and the results showed that it succeeded in providing substantial benefits to the poor people (119). The only way that Malawi can achieve the prevention of MMR is through the improvement of its health system. This means the incentives were not a solution on their own since they were not always available hence fuming the frustrations of the communities.

4.4 Theme two: Community appreciation and preference of Health care providers

Theme two responded to objective two of this study which explored community perceptions on the existing maternal health services delivery in rural areas of Malawi. This study had no objective focusing on TBAs, however, the findings showed that TBAs were strongly preferred by the communities, unlike the clinics. Therefore, including TBAs, this section will discuss the findings in support of maternal health care provision. Findings of this study showed that the appreciation and preference over

service providers were due to; hospitable health care providers, hospitable TBAs and HSAs for offering mobile services.

4.4.1 Hospitable TBAs

Findings of this study revealed that TBAs were considered more hospitable because they treat people with better respect relative to nurses in the health facilities. Despite that Malawi law banned TBAs from practising, women visit them without the knowledge of their community members and leaders. The ban on TBAs was introduced to help reduce MMR which was disproportionately high on women who opted for TBAs during labour. Another study found that maternal deaths were due to unskilled TBAs who were unable to identify maternal complications (52).

Literature from elsewhere has demonstrated that the reason women still visit TBAs is that a lot of them stay long at the health centres waiting for labour to start (50). The common practice is that, as soon as labour begins, women rush to the TBA and deliver and come back the same day to their houses (52). Additionally, women use TBAs because of culture, distance and socio-economic reasons. Kumbani, et al. (2013) demonstrated that “due to the lack of money to pay for health care services at the clinics”, women prefer TBAs that health facilities (52).

Another study found that the place of living also affects the place a woman wants to deliver her baby. For this current study, the reason people in Dedza rural villages go for TBAs is that they live in rural and remote areas which are usually very far from the next clinics. This has both physical, health and economic implications. Furthermore, few people who stay in urban areas may opt for TBAs, although, that cannot be matched with those numbers from rural areas whose poor economic conditions and the distances to the next available clinics leaves them with no other choice. This is particularly true when we consider that urban areas in Malawi have vast public and private health facilities in comparison to rural areas. Therefore, urban dwellers are not affected by; long distances to the clinic and, unavailability of medical equipment and supplies. Additionally, owing to better employment in the urban areas, lack of money to access health care services is not a common issues for urban dwellers, relative to rural area dwellers (120).

The current study has also established that some women visit the TBAs and traditional healers to conceive, if they have conception problems or sterility. For them, this is reason enough to patronise the TBAs even though they are Illegalised. The participants also favoured using TBAs because they respect their patients. Furthermore, TBAs help repel any magic that can lead to maternal and mortality deaths. During such occasions, TBAs and herbalists perform rituals for pregnant mother until she gives birth (121).

There have been changes in the utilization of TBAs since they were officially banned in Malawi, in 2017. Despite the ban, literature shows that TBAs contribute hugely towards maternal health. This is well recorded in rural areas of the country because TBAs help diagnose early signs of labour and conduct maternal health campaigns (122).

While the ban might have seemed to work; rural poor women were not given necessary and sufficient alternatives to use. This study has demonstrated that many women walk long distances to get to the next clinic, and most of them die or deliver while in transit.

Therefore, the ban has only increased women utilization of maternal health facilities but it has not improved the quality of the health care services for the rural poor. There are still inequalities and inequities in accessing these services. This is contradictory to the WHO member states agreement of 2005 that “everyone should have access to health care services needed without being discriminated by financial or poverty problems” (123).

Moreover, based on the findings of the current study, the introduction of universal health coverage in Malawi in 2012, which advocated for free access to health care services, is contravened (123).

4.4.2 HSAs mobile health services

They are known as Community Health Workers (CHWs) in some countries. Their duties are; offering preventative health services and providing curative health services. Therefore, HSAs are assisted by the village health committees (VHCs) (111). They go into different villages according to their allocation. Since HSAs live in rural areas

that have limited resources, they are responsible for extending primary health care services to underserved and poor communities at a low cost (124).

This study's findings revealed that the communities trust HSAs than clinical nurses because they reside in the same community and they share culture and beliefs with the communities.

With the help of community support system, HSAs help to strengthen the relationship between the community and the district health office (111). Literature shows that their presence has reduced the burden of disease, mortality, morbidity and the pressure for health services at the health centres (125). They help people in the community to have access to health care services as they are the nearest and always available in their catchment areas (125).

The ban of TBAs in Malawi, might be important but the government needed to have improved its maternal health services first to address the issues of; distance to the clinics and costs. While HSAs could be considered a solution to this dilemma, those who implement the programme are not 100% effective because they are not well-trained nurses or clinicians and cannot substitute these professions. Therefore, the government need to improve the way HSAs are trained since they deal with matters of health which lie at the confluence of life and death. Although the rural community commended them, it could be because of their visibility, availability and accessability.

4.5 Theme three: Maternal health service provision barriers and challenges

Theme three responded to objective three that aimed at understanding maternal health services delivery challenges/barriers and possible services improvement strategies in the community under investigation. This study found various challenges that were experienced in the provision of maternal health services including socio-physical challenges such as; waiting time, lack of resources and mismanagement of resources, negative health provider attitude. Additional challenges were; lack of efficient communication, poor maternal health skills by health care providers, costs and distance.

4.5.1 Longer waiting time

Findings showed that patients take a long time before they are attended to at the clinics. This is primarily due to the shortage of healthcare providers to attend to the patient numbers and negative attitude of health care providers towards patients. Findings also showed that, occasionally, the nurses sit and chat with each other without serving the patients. MMoreover, patients are sometimes returned home if they try to access the health care facilities in the afternoon or after working hours yet pregnancy must be treated as an emergency case. Some studies found that most of health care users find long queues and long waiting times problematic. This is a challenge that health care providers have been confronted with (126).

In South Africa, the bill of rights, the Principles of Batho Pele, and the Principles of Quality Care helps to address patient satisfaction (126). The application of the Bill of Rights protects vulnerable patients who cannot express themselves. The Batho Pele is also used to improve service delivery. The Bill of Rights advances that patients have the right to complain if they are not satisfied with the health services (126).

In Malawi, the constitution says that every patient has the right to complain. However, this study showed that most of the participants do not know that they have such rights. This study has also revealed that pregnant women in Malawi consider waiting for too long at a health facility as a norm and acceptable. They do not realise that it affects the quality of care they receive and the outcome of such health care (126).

Literature has shown that if a facility is far from a community, it takes a long time for a woman to get there. Furthermore, most women deliver outside the facility without skilled health care providers even when they had desired to deliver at the health facility. In agreement with this view, the study established that there is a need to go for ANC at the clinics although not all of the women delivered at the clinics (127).

4.5.2 Mismanagement of resources and lack of resources

Lack of resources usually affects maternal health services provision in many rural areas of Malawi. The findings of this study demonstrated that there is a shortage of medicine and healthcare providers. In some cases this shortage of resources is

deliberate as the study revealed that health care providers sell drugs to local people and send patients back home without any treatment. The study also showed that patients are not given enough medicine to finish a course, and are directed to local sellers most of which are retailers for health care providers. Therefore, patients opt for over the counter medicine or private clinics, to avoid wasting their time at the clinics.

WHO, in its global strategy for women health, outlined the need for policymakers to develop prioritised national health plans and allocation of more funds towards maternal health care services even though the desired use of resources does not take place (128). This means, to achieve sustainable improvement with the available limited resources, requires a change of attitude towards maternal health care services by acting morally and prudently (129).

Malawi introduced the universal health coverage policy in 2004. The objective of this policy is to ensure that all citizens enjoy enough coverage and access to good health care services through universal financial protection (60). Conversely, in the Sub Saharan Africa, literature shows that universal health coverage has followed a top down approach that does not pay any attention to people at the bottom especially those from rural areas. This fails to bridge the gap that can help rural people to access the Essential Health Package (EHP) to achieve universal health care coverage (60). These loopholes force rural people to go to private clinics for better health care services.

The current study also found that pregnant women buy their own linen and razor blades to use on the delivery bed and cut the umbilical cord. Shortage of equipment, drugs and other supplies, and long distance to the clinics further hamper rural health care access (60).

One report established that health care systems in the low-income countries do not function well due to lack of skilled health care service providers. This is similar to what this study established as it was reported that sometimes nurses lacked professional ethics, work experience and were disrespectful to the patients (20).

The absence of common agendas in the health care system is contributing to a lack of resources in remote areas. This calls for good policies by all governments (102, 119).

Furthermore, WHO mandate highlights that at all levels (local to global), government policymakers must ensure that resources are distributed and used effectively. They must strengthen the health care workforce that includes effective monitoring and evaluation systems including the principles of human rights and political commitment (130).

Literature has also shown that there is connection between poverty, equity, human rights and health. Both equity and human rights advocate for equal opportunity for access to health by groups of people who had historically suffered discrimination or social marginalisation (131). The health sector needs to strengthen its capacity on raising awareness on equity and human rights policies by being effective and building public support from commitments, for equity and human rights endeavours (131).

4.5.3 Negative health care provider attitude

The study found that negative health care provider attitude is a critical problem among all health care users in rural areas. Thus, nurses' negative attitude towards pregnant women and other patients was cited as a serious concern. Regarding this, studies have shown that many pregnant women are more concerned with the treatment they receive from the health care facilities. These observations are in line with what the current study found. Participants cited this problem as a serious matter of concern (2).

Findings of this study further showed that sometimes, pregnant women meet negligent health care providers who leave them alone when they are in labour. In some cases, guardians are the ones who help them deliver, and when no one is there, the new-born babies fall out of the bed to the floor, and some of them die (5). Likewise, another study in Thyolo in Malawi found that there is an overbearing negative attitude of health care providers towards pregnant women that prevent them from utilizing health services (132).

Although institutional birth rates have risen in rural Malawi , maternal mortality rates have not slowed down. This is because of poor quality health care (133). Furthermore, findings showed that owing to gruesome experience, some women feel unsafe to deliver in public health facilities. They also feel that their lives are threatened because

there have been deaths pregnant women, at the health facilities. This contradicts the quality of health care, which is defined as having clinical effectiveness that is safe and is perceived by the patient as good. If users feel unsafe with the services, there is no quality healthcare. If the healthcare is not satisfactory to the user, then the utilization will be low, and this may lead to out of facility delivery that leads to an increase in MMR (134, 135).

Participants also reported that, the difference between the two clinics is the way the nurses treat pregnant women. They argued that patients are treated poorly at the public clinics which makes them loaf the experience. This is in line with another study conducted in Malawi, which found that women wanted health care providers to communicate to them appropriately and not belittling and shouting at them (2).

In particular, women in Malawi are sometimes threatened to be sent back even if they are in labour if they do not explain why they want to deliver in a district hospital without being referred there by a health centre (2).

The above findings concur with another study that established that women are mistreated in labour and that there is nothing much that is done globally to address this problem (136). It also found that some women are threatened with withholding treatment and or poor outcome of their baby if they do not cooperate (136). This review shows how, globally, women experience childbirth which lacks supportive care, but they denied autonomy by health care providers. This is not something to do with only health facilities but involves various failures, starting from the health care system that usually has poor policies and culture that result in the disempowerment of women (136).

In addition to it being a concern of poor quality care, mistreatment of pregnant women is also a human rights issue. Bohren, et al. (2015) define human rights as “the right that every person is entitled to in the form of living with dignity as well as the right to dignified and respectful healthcare during their pregnancy and childbirth” (136).

The findings of this study showed that women are denied their human rights by being abused, disrespected and punished. According to the adopted human rights standards, women have the right “to be equal in dignity, to be free to seek, receive and

impart information, to be free from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health" (136) page 24. This is in agreement with the WHO global agreement for maternal, new-born and child health that advocates for quality skilled-care for women and, new-borns during and after pregnancy (128). Punishing a poor pregnant woman who struggles to find resources is violating her human rights.

4.6 Theme four: Maternal health service patient challenges

Theme four is responded in line with objective three that aimed at understanding maternal health services delivery challenges/barriers and possible services improvement strategies in the community under investigation. This section discusses findings related to: health facility location, and preference of health provider, myths, beliefs, costs and distance, confusion and feeling hopeless as some of the conditions that trigger community involvement.

4.6.1 Health facility location preference

This study found that most participants prefer to be assisted by male nurses because they do not experience any negative attitudes from them. They think that male nurses are more caring than female nurses. This contradicts literature that shows that many women fail to use maternal health services because they sometimes are treated by male health care providers which is against their culture and privacy. These are usually conditioned by a religious obligation that does not allow women to expose their body to strangers other than their husbands (137).

The study findings showed that the choice between the two health facilities was made on the basis that they were not treated well whenever they went to the public facility compared to the private facility. Some said that at both clinics some nurses did not treat them well.

The results also showed that people perceive going to the private clinic as a guarantee to good medical care and availability of resources. Furthermore, people chose the private clinic because of the availability of medical resources and nurses. They get the

prescribed medicine on the same day unlike at the public clinic where they are sent back because of lack of medicine.

This is in agreement with another study that showed that the previous use of a health care facility for delivery influences subsequent uses. It showed that women who had complicated deliveries are the ones who utilize maternal health services mostly (138). The findings also showed that a woman who experienced bleeding during pregnancy or birth would be given traditional medicine and get better without going to the clinic.

On the other hand, some women were reluctant to deliver at health care facilities because of health facilities negligent practices. They feel the facilities are unfriendly and cold, unlike the TBAs. They also thought that the TBAs have the technical skills although they do not have enough resources to always provide safe delivery (139).

Although, there are long distances problem and financial cost for women to decide where to deliver, studies have proven that the demand by the public clinic to bring some equipment with them makes women prefer a private clinic. Nevertheless, this result showed that the demand to bring the equipments is available at both private and public clinics. This complements many studies that demonstrated that in poor resourced areas, women have to bring their own equipment to the clinic for delivery (139). This is challenging for women in poor rural areas.

Community perceptions on the quality of maternal health care are usually examined along with the patient's satisfaction, the number of staff and their attitude as well as the availability of other resources. The study results showed that apart from the public clinic being free of charge, the negative attitude of health care providers and frequent out of stock medication prevent patients from utilizing it (140). Based on these findings, it can be assumed that there is lack of quality care at the public clinic. Yet, increased quality care helps improve maternal health services. (46, 47).

In as much many people perceive private health facilities to be better, it depends on the type of health system. The results showed that even at the private clinics, the women still bring the equipment such as; plastic paper to use as a linen saver in labour ward, razor blades to use to cut the cord, similar to public clinics. It is not all the time that private facilities are better than government facilities as these results have

revealed that sometimes both of these clinics have similar challenges including negligence.

Although Literature shows that women are more satisfied with maternity care in private clinics and hospitals because of better equipment and communication, this study has not proven that those women who attend private clinics get better information or better communication from health care providers. It also showed that women were not informed when the incentive program was stopped although this was facilitated by private clinics.

Literature shows that women who use private health facilities have higher rates of intervention than those in public facilities. Nevertheless, women are entitled to equal access to quality maternal health care services, regardless of the place they choose to deliver or attend their ANC (141).

4.6.2 Myths, beliefs and traditional medicine

Owing to their perceptions of the health services offered by nurses in the rural areas, some community members prefer traditional medicine than western medicine. This was due to their beliefs and lack of money. People know some traditional medicine that can help cure diseases such as malaria and increasing blood levels. The findings showed that there are some illnesses like nausea, general body pains, bleeding and child delivery problems that they treat with traditional medicine.

The findings also showed that there are some cultural beliefs that people follow when women are pregnant. For example, they drink medicine such as soaked pawpaw leaves to treat anaemia in pregnancy. They believe that their medicine treats pregnancy complications better than western medicine. However, most of the participants said that, this did not mean that they should not go to the clinic when there is no improvement. One participant said that she takes traditional medicine because of a lack of satisfaction with western medicine.

Similar to other studies elsewhere, findings showed that women do not tell the correct gestational age to avoid being bewitched and losing the baby. Most of the participants

in this study reported that they do not tell anyone the correct dates for delivery to prevent miscarriages that may be caused by enemies from bewitching them (112).

While some participants reported that they take traditional medicine to prevent miscarriage, especially when they bleed, they take traditional medicine from a TBA or a traditional healer to stop the bleeding. This medicine is taken for at least four to five months.

The results also showed that protection of the unborn baby's fontanel is required to prevent it from not closing after birth. This is done by not sleeping with the spouse when the pregnancy gets to seven months and three month after delivery. This compliments some studies that found that w5omen are allowed to stay in their mother's house for up to three months after giving birth and return to their husband after that (142).

Literature shows that in Zimbabwe, the belief about pregnant women being vulnerable to witchcraft in the first trimester prevents them from attending ANC. They, therefore, use TBAs and traditional healers (143). It also reveals that some pregnant women combine both western medicine and traditional medicine and that traditional medicine strengthens the baby (143).

Other women do not use maternal health services because of fear of sorcery that might prevent the baby from being born, hence leading to caesarean section (C/S) (143). In addition, it was revealed that some women deliver at the TBA because the labour is fast as they are given some herbs to enhance it. The same happens when they deliver in the clinic. Some family members can give them traditional medicine to rub on the abdomen in cases of obstructed labour (142). Some literature shows that even the placenta has its ritual called 'placenta burial' in which after birth it is taken and buried at a road junction. In some traditions such as Nepal and Mexico, women are not allowed to stand alone at the junction as the foetus can be taken away by evil powers (142).

Other participants acknowledged using both local and western medicine, and that they do visit both the TBA and health facilities. Traditional healers are considered to have

long-time experience and that has made them acceptable within the maternity care sector in their areas.

The study found that traditional healers practised with caution especially for pregnant women because they were aware of the side effects. Contrary to the Mali findings where medicine is given without hiding, in this study such medicine was given in secrecy to avoid being seen by the nurses. Although traditional medicine is administered openly in Mali, there is a lack of systemic studies on the safety of commonly used medicine among pregnant women (144).

Nordeng et al. (2013) found that the use of traditional medicine depends on the severity of the illness. This findings agree with what this study found wherein participants said that they just dig *thovisi* (roots and leaves) and soak it in water and drink to treat so many illnesses.

Literature shows that the environment and socio-cultural factors affect how rural women seek health care. The presence of a maternal health facility nearby does not stop the women from using traditional medicine (145). They use it for the safety of the mother and the baby (145, 146)

Globally, literature also shows that there is increased usage of traditional and herbal medicine among pregnant women. Women use different traditional medicine during different pregnancy trimesters. Most of them use traditional medicine to treat nausea, and others for other different reasons. Yet others use traditional medicine in the third trimester to induce and facilitate labour as well as to increase breast milk when the baby is born (145, 147).

The study showed that besides pregnant women and the community having the knowledge on the importance of maternal health services, people are still mixing local traditional beliefs and modern methods for the management of pregnancies. Maternal health services need to be offered within a friendly environment that understands the culture of the community.

4.6.3 Costs and distance

The term ‘costs’ generically refers to what it takes to access health services it could be price or distance. Some literature shows that if the distance is longer than 55 kilometres to get to the health facility, there is likelihood of having high MMR (149). This study discovered that due to long-distance, women deliver on the way to the clinic The findings showed that there are health system challenges such as finances and distance that prevent women from utilizing maternal health services. The distance between the village and the clinic is a systemic challenge in the provision of healthcare. This study found that the participants’ perception is that the private facility offers better services but at a cost due to service fee and transport. Participants also stated that some women fail to deliver at a health facility due to lack of funds services and transport. This experience contradicts the purposes of universal health coverage by the Malawi government, discussed above. Many health services struggle to be equitable, accessible and inclusive on these parameters.

Literature shows that the rights of the people to health care is neglected especially among the vulnerable people (148). Relative to this, this study has shown that participants face challenges in getting required maternal health services as well as general health service throughout their lives. Therefore, there is social exclusion in low income areas where the resources are scarce, and poor people’s right to health is undermined.

Studies recommend equity in access to resources in order to maintain the dignity of poor people. There is a need for social inclusion to underpin policy formation that will promote service delivery (149-151). Transport is also one of the most important factors contributing to difficulties for accessing maternal health care services in rural areas. The results of the current study are not different. They showed that people of Dedza are affected by issues of transport, costs and distance. Transport is further aggravated by the unavailability of ambulance, poor roads and lack of regular means of transport.

.

4.6.4 Confusion and feeling hopeless

This research has shown that participants were in a dilemma on whether to use TBAs or go to clinics. This is because of the community by-laws, clinical care at the health facilities and the TBAs good gesture. This was expressed by both the FGI and IDI participants. They expressed hopelessness on their experiences when they are pregnant or when they go for other non-pregnant related conditions. Nurses are negligent for women who are in labour pains. Even though women know that the treatment they get at the clinics is incorrect and poor, they cannot just abandon the clinics for fears of being fined by the chiefs.

The findings of this study showed that women did not know anything about their right to complain when they are not satisfied with the services at the clinic. They believed that such treatment was normal. Findings showed that another reason for not complaining is that they do not want to antagonize the nurses, as they need them repeatedly.

Some studies show that women get less care from nurses as they spend more time checking for vital signs of the mother and baby but not the immediate conditions of the expectant mothers (152).. This was confirmed in this study when women complained that they have many problems with the clinics but they do not know where to take them and doubted if the nurses could listen to their concerns.

Literature shows that most people in rural areas are the ones who deliver outside the health facility and have less ANC visits. This is due to poverty, low education and long distance to the health facilities. The problem worsens when women are fined for shunning clinics not because of their fault but because of distance and poverty. Yet, WHO advocates that women and new-born babies should not be punished for their low socio-economic status (152, 153).

Therefore, there is need for MoH to set clear rules that do not take trample on women's right to dignity and appropriate health care in order to prevent MMR. The fines are not helping the poor people in the villages but subject them to further tortures. In view of

this, this study suggests that there can be a better way of preventing MMR without bringing in any confusion and hopelessness among the powerless and the poor.

4.6.5 Maternal health service by-laws

Some participant expressed dissatisfaction with the way by-laws were introduced and work. In Malawi, traditional leaders play a major role in decision making at the community level. They are involved in mobilizing the community through campaigns, and they encourage women to deliver at clinics.

Studies show that women and the community are responding positively to these by-laws, and very few women flout such laws (153). The traditional culture in Malawi gives respect to village headmen so that whatever they command gets to pass without being questioned. This study confirmed that women do not question the village headman whenever he fines those who shun the ANC.

Literature suggests that punishment is not always the only choice that is appropriate and possible to counter ANC noncompliance. There is a need to convene meetings with the community and health care providers to find better and collective solutions to this problem (154).

In the current study, some participants mentioned that, because of the sanctions, people are using both TBAs and the clinics during pregnancy. When it is time for the baby to be born, they go to the clinic. They argued that traditional medicine helps with quick labour and ease of labour pains. This can be done both at the TBAs home or in the health centre.

Furthermore, literature shows that some health care providers refuse to help women who come to the ANC without their partners (154). Policies such as these are counterproductive because they deny women access to health care services against the requirements of the WHO and human rights. These programs need to be planned and executed in a manner that respects women's rights and autonomy.

4.6.5.1 Dissatisfaction with by-laws

Findings showed that participants were concerned with the fee that they pay for the services at the private clinic. This is because it is not easy to find money to pay for the

services as well as fines imposed on them whenever they fail to use maternal health services. These fines are usually in the form of goats, chickens and money. The traditional leaders use punishment to ensure that women utilize maternal health care services (153). There are positive results in the reduction of MMR, however, the enactment of these laws is both oppressive and culturally repressive. The traditional leaders are being directed by government to impose the by-laws on people who do not have the voice to question them (153). It is disturbing to note that the same government, which is supposed to protect rural women's rights, is in the forefront championing the invasion of women rights.

4.7 Theme five: Proposals on improving maternal health service programs

Theme five highlighted improvement plans that were suggested by participants from both the FGDs and IDIs. This is in line with objective three that seek to understand the maternal health services delivery challenges/barriers and possible services improvement strategies in the communities under investigation. These include: improving the transport system for the pregnant women and very sick patients, specialized community clinics, and non-punitive measures for women who deliver at the TBAs. In addition, participants suggested behaviour change for health care providers, training and community health education. They suggested that if they can have enough education on their rights, infrastructure improvement, and institute small committees in the communities to oversee this process.

4.7.1 Training and community health education

Participants recommended having training and health education on their human rights so that they are aware of and know-how to reclaim them.

They believe that through community training, they will be able to voice out their challenges when they are ill-treated by health care workers. The study showed that all patients have knowledge of when, how and where to take their complaints whenever they are abused by the nurses. Another problem that they expressed was that the community does not work collaboratively, hence could not fight on one front when things go wrong.

Participants believed that if they can have a coherent community; they can address some maternal health issues within their communities. This is in line with what a study in Pakistan found that if trained community health workers can give health care messages to a community that is empowered, they can help to significantly reduce MMR (168). The involvement of community health workers helps because they easily build a rapport with the community and understand its needs. This study has shown that by involving community members, it follows that TBAs are involved, and can help identify solutions to maternal problems. They are also able to choose representatives who can take their grievances to the clinic together with the community health worker (156).

Furthermore, both FGD and IDI participants proposed the need for the community to have an ongoing community awareness and training program on the importance of utilizing maternal healthcare services. Both women and men can learn about safe-motherhood and be able to stand for their rights whenever abused by the nurses.

The community also suggested the establishment of committees to investigate issues concerning health care services for pregnant women. It was observed that people who live in urban areas, although they can afford to buy medical supplies and maternal kit, they are not required to bring them to the hospital. Yet,poor villagers are asked to buy and bring these to the clinic on top of the many challenges rural womengo through. This is evidence of inequity and inequalities that exist when it comes to accessing maternal healthcare services in Malawi (155).

4.7.2 Introduction of clinic committees

Participants recommended the establishment of small groups where they can discuss issues of safe-motherhood. Another study established that this kind of procedure works well where community health workers engage the communities through health education on the dangers of pregnancy and the need for meaningful decisions (157). This helps to promote community participation, which is defined as a way of empowering the local people to articulate their needs and give suggestions on how to meet these needs through procedures that have been tested to solve health problems.

Literature shows that community participation gives the motivation to improve their health, and provides a broad meaning of health issues. Furthermore, community participation encourages self-confidence, self -reliance and cooperation among local people. It helps community members to own and control their lives (41). Some literature also shows that when women and men in the community are given a chance to identify maternal and infant health problems, they come up with solutions that improve the health services (42).

Another study in Bangladesh recommended the development of strategies in the form of community education in order to change health-seeking behaviour especially to educate communities to change and make timely decisions regarding healthcare seeking. It recommended the provision of skilled birth attendants in communities and upgrading of facilities close to the communities (157)

Likewise, another study in Malawi that aimed to understand the kinds of delays women face before they are taken to the clinic concluded that delays in decision-making processes and socio-economic reasons at the community level play a big part (43). These studies showed that by communicating the perceptions of women in the community and community groups, it helps to formulate strategies to that address challenges such as transport to health care facilities and other issues that require government and donors' attention. The study further found that where the male partner was involved, the woman would deliver at the clinic (69).

Literature has also shown that women's group can prevent both maternal and neonatal deaths (70). Similarly, a study conducted in Ethiopia sought to improve health care services through community involvement, and it found that the number of neonatal and maternal deaths reduced. It also established that there were increased numbers of women who used contraceptives among those people who participated in the activities of the community groups (158).

From the discussion, it is clear that when the communities are given a chance to develop strategies to address their maternal health needs, MMR is reduced effectively and they become innovative within their cultures (82, 158). Through community

groups, women are asserted and capacitated together with other partners to take social and political actions that help reduce MMR (159).

4.8 Conclusion

This chapter has discussed the study findings on; mother and child health status assessment; health provider appreciation and preference; health services provision and health system challenges; patient's challenges; maternal health care services by-laws and maternal health care services improvement plans. It has also confirmed that both health facilities follow minimum procedures for maternal health care services. Although there is a shortage of equipment, there is basic equipment that is available to conduct maternal health care. There are also several challenges on maternal health care services provision. For example long waiting time and lack of resources, costs and distance, among others. These challenges are caused by both the health system and patients. Maternal health by-laws were also discussed in terms of how pregnant women get sanctions for delivering out of health facility and how the participants echoed their dissatisfaction with the by-laws. Lastly, the discussion provided suggestions for improving healthcare services and infrastructure.

CHAPTER FIVE

STUDY CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The main aim of this study was to explore the community perceptions of maternal health services in rural areas of Dedza district in Malawi in order to reduce maternal mortality rate. This chapter will provide the conclusion, recommendations and study limitations.

5.2 Conclusions

The participants were asked to describe the current maternal health services offered in their community. The findings showed that the community is able to access basic maternal health care services from the two clinics although they face problems of long-distance and lack of resources. The study also found that only basic maternal health care needs of pregnant women are available in these maternal health care centres. This is because Malawi is poor and has limited health care resources. This condition affects how the country's population accesses health care.

The study also explored rural community perceptions on the existing maternal health care services available to them. The study chose this remote area to understand the challenges rural communities face in accessing health care services. Furthermore, the study explored what the community perceived as the consequences of not using maternal health care services. The study found that Malawi government implemented various strategies to reduce MMR. However, the challenge was that the strategies that are in place end up being perceived as punitive. These strategies put exert pressure on the expectant mothers and those around them. By demanding that women should give birth only at a public health centre, it subjects them to financial, moral and ethical challenges. These may have been avoided by giving birth at the TBAs who are not only convenient but also affordable and humble. . Therefore, the government rules infringe women's right to freedom of choice and association. This is particularly true when we consider that the health centres are; located far from their homes, often lack

essential medical supplies andmanaged by nurses who are, disrespectful, and unwelcoming.

Although participants were aware that TBAs were banned by law, in the study sites, they appreciated and valued them more than the nurses. This was because of; the way TBAs treat their patients and, their speedy and responsive reaction to emergencies. Therefore, expectant mothers still attend TBAs, together with ANCs.

Regarding the factors that discourage the community's involvement in maternal health services, the study established that, it is the responsibility of the state to ensure that universal maternal health care services are achieved, by removing all the barriers that limit women from accessing and participating in maternal health care services. The barriers include; a lack of financial resources and socio-cultural obstacles. The participants in this study perceived and considered private health facilities as being better relative to public health service, given the main reasons provided in the findings section. Perhaps, this gives government through the MoH and its health care service workers an opportunity to reflect on their policies and practices, to understand why and how rural communities consider their services as worse than those of the private providers.

5.3 Recommendations

Within its limited scope, this study recommends that some changes should be made to improve maternal health care services access in rural areas. The recommendations are discussed below.

5.3.1 Government should review recruitment strategies for ANC

- The government and community leaders need to find alternative ways to encourage women to use maternal health care services other than the current strategies. The use of ban and punishment is wanting, because it violates women's freedoms, as discussed in the above section, and their various human rights including right to access health care of their choice. Moreover, the punishments have worsened the discouragement on the utilization of maternal health services. This promotesmaternal deaths, because women now die along

the way to the distant located hospitals, which are also lacking medical supplies and human resource management.

- The Malawi government needs to consider introducing a National Health Insurance system that will ensure adequate universal health coverage such as the ones in South Africa. NHI will ensure that every person has access to free health care services.

- There is also a need for a strong relationship between the government health department, communities and TBAs. Inclusion of TBAs is fundamental because they play a significant role in maternal health, yet they are also members of the communities. In addition, the incentives that government gives to pregnant women or men who attend ANC should be extended to those TBAs who refer and encourage pregnant women to attend formal clinics.

- Some women are still visiting TBAs who no longer receive delivery kits from the government. Therefore, the government should reconsider its position and begin recognizing TBAs. and the government need to ensurethat TBAs are supplied with necessary and right medical equipment to avoid further infections and deaths.

- The safe-motherhood initiative needs to create networks and strengthen its relationship with the community. Furthermore, the safe-motherhood initiative needs to explain directly to people, the need for utilizing public health care services. For example, the termination of the incentives, which were given to expectant women when they go to the ANC, should have been easily understood if it were communicated using local structures. This would also have provided an option for explaining that, what was critical was not the money but their lives, hence they needed not to stop visiting the ANC. One general recommendation that emerged from this study is that the government of Malawi needs to seriously increase the number of maternal health care services access to pregnant women in rural areas. This includes a consideration on the available forms of transport when labour moments start especially during the night.

5.3.2 Policymakers and program managers' focus on maternal health care content programs

- There is a need to challenge policymakers and program managers to refocus the content of maternal health care programs. There is need for organizational strategies that are viable in promoting care and accountability. The analysis in this study have highlighted the shortcomings of health care services that were meant to help poor women, who do not afford paying for the services.

- There is a need to ensure that rural women's right to health is safeguarded and realised. Every government should ensure that its citizens, including expectant women and children, are protected from conditions that may prevent them from the right to health. There is also a need to consider the patients' opinions regarding the relevance and usefulness of the health care services delivered to them. The government should, carefully, consider its strategic plans concerning health needs of its citizens to ensure that such plans are meaningful and address the needs and challenges of people in rural contexts.

5.3.3 Infrastructure improvement

- This study established that there is a lack of infrastructure such as; basic equipment, transport and communication. There is also a lack of trained health professionals. There is a need for government to strengthen these areas. Likewise, health facilities, community-level services and EHP needs to be enhanced by providing free maternal health care services.

- There is a need for planning, budgeting and managing of all health care services. One of the strategies that were designed, but not implemented, to strengthen these areas was decentralising the health sector. There is need to decentralise the health sector.

- In rural areas, the government should consider bringing maternal health care services closer to the people. It must likewise revise its policies regarding maternal health care services. For example, it must involve the community on issues affecting their health. because This creates a platform for both sides to

exchange ideas regarding the pressing health matters. Involving stakeholders help in finding ways of dealing with issues bordering on social determinants of health. Since rural areas are poverty-stricken due to lack of jobs, there is need for multidisciplinary action to take people out of the poverty trap. This is because, poverty has a direct bearing on MMR.

5.4 Recommendations for future research

- There is a need for studies that will involve health professionals from both clinics A and B to find out their opinions regarding MMR since this study involved only one health centre.
- Further research needs to involve more communities in this district to attain wider perceptions and generate richer data.
- Furthermore, studies should explore the socio-economic implications of the by-laws on the rural poor communities.
- There is need to research on the outcomes of government policies and programs including the mobile health services that are designed to provide and promote maternal health care services.

5.5 Study limitations

This study had a limited scope because it was intended to fulfil the conditions of an academic programme at a Masters' degree level. A wider and longitudinal study is desirable to infer the findings on a broader country-level context.

Similarly, due to the limited scope, the focus on the primary data was on community members, not health care providers. The participants were selected purposively leading to dangers of potential researcher bias. Moreover, the district has 31 clinics but only one of them was chosen. Therefore the results could be non-representative of all the communities in this district, or Malawi as a country.

Given the limited scope, qualitative research was appropriate. The absence of serious variability in the views presented by the participants confirms this. Furthermore, the

study population, potentially represented the entire community since it consisted of men 18-49 years old, whose spouses were once pregnant or had children, and women of the same age range who were once pregnant. In other words, the results are justifiable within their limited scope.

There are village by-laws that demand that every pregnant woman uses maternal health care services, failing which, she must be fined. This law made women discuss more about what they are expected to do by the community than, what they think they should in normal life. Therefore, women regarded me as a spy who would report them to the village headmen if they disclosed the truth about socio-cultural practices and pregnant women health care service issues. Given that community leaders punish women who forego maternal health services, it is possible that this held them back from opening up to me. This was evident in many instances where they could not freely criticise the by-laws for fears of community reprisal.

However, I assured participants that they were safe and their views were accepted. I followed this by further questions and explanations to ensure that contradictions were verified.Throughout the data collection process, participants were reminded and assured that these discussions bordered on confidentiality and anonymity, therefore, no one should fear anything.

In any FGD, some members will naturally be quieter than others. However, in this study, the researcher ensured that all the participants were actively involved and contributed to the discussions. This was important as it helped people maintain their confidence and contribute honestly, hence providing me with rich and reliable data, in the process, making these findings valid and reliable.

REFERENCES

1. Alkema L, Chou D, Hogan D, Zhang S, Moller A-B, Gemmill A, et al. Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. The Lancet. 2016;387(10017):462-74.

2. Kumbani LC, Chirwa E, Odland JØ, Bjune G. Do Malawian women critically assess the quality of care? A qualitative study on women's perceptions of perinatal care at a district hospital in Malawi. Reproductive health. 2012;9(1):30.

3. Organization WH. World health statistics 2016: monitoring health for the SDGs sustainable development goals: World Health Organization; 2016.

4. WHO, UNICEF, UNFPA, Bank W, Division UNP. Trends in Maternal mortality rate. 2016.

5. Mgawadere F, Unkels R, Kazembe A, van den Broek N. Factors associated with maternal mortality in Malawi: application of the three delays model. BMC pregnancy and childbirth. 2017;17(1):219.

6. Roth DM, Mbizvo MT. Promoting safe motherhood in the community: the case for strategies that include men. African journal of reproductive health. 2001;5(2):10-21.

7. Bongaarts J. United Nations Statistics Division The World's Women 2015: Trends and Statistics New York: United Nations, 2015. 260 p. Population and Development Review. 2016;42(1):154-.

8. Malawi H. Moving towards equity and quality. Malawi Health Sector Strategic Plan. 2011;2016.

9. Organization WH, UNICEF. Trends in maternal mortality: 1990-2015: estimates from WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. 2015.

10. Cammack D. Local governance and public goods in Malawi. IDS bulletin. 2011;42(2):43-52.

11. Government M. Malawi Health Sector strategy plan .Moving towards equity and quality. In: Health Mo, editor. Lilongwe: Malawi Government; 2011.

12. Makaula P, Bloch P, Banda HT, Mbera GB, Mangani C, Sousa Ad, et al. Primary Health Care in Rural Malawi.A qualitative Assessment exploring the relevance of the Community directed interventions approach. BMC Health Service Research. 2012;12(328):1472-6963.

13. Beltman JJ, Akker Tvd, Bwirire D, Korovaal A, Chidakwane R, Lonkhuijzen LV, et al. Local health workers perceptions of substandard care in the management of obstetric hemorrhage in rural Malawi. BMC Pregnancy and Childbirth. 2013;13(39).

14. Lewycka S, Mwansambo C, Rosato M, Kazembe P, Phiri T, Mganga A. Effect of women's groups and volunteer peer counselling on rates of mortality, morbidity, and health behaviours in mothers and children in rural Malawi (MaiMwana): A factorial, cluster-randomised controlled trial. Lancet. 2013;381.

15. MalawGovernment. Malawi Health Sector Strategic Plan 2011-2016. Moving Towards equity and quality. In: Health Mo, editor. Lilongwe: Ministry of Health; 2011. p. 1-148.

16. Makaula P, Bloch P, Banda HT, Mbera GB, Mangani C, Sousa Ad, et al. Primary Health Care inrural Malawi. BMC Health service research. 2012;12(328):1-13.

17. van den Akker T, van Rhenen J, Mwagomba B, Lommerse K, Vinkhumbo S, van Roosmalen J. Reduction of severe acute maternal morbidity and maternal mortality in Thyolo District, Malawi: the impact of obstetric audit. PLoS One. 2011;6(6):e20776.

18. Chimtembo LK, Maluwa A, Chimwaza A, Chirwa E, Pindani M. Assessment of quality of postnatal care services offered to mothers in Dedza District,Malawi. Open Journal of Nursing. 2013;3(4):8.

19. Chimtembo LK, Maluwa A, Chimwaza A, Chirwa E, Pindani M. Assessment of quality of postnatal care services offered to mothers in Dedza district, Malawi. Open Journal of Nursing. 2013;2013.

20. Bradley S, McAuliffe E. Mid-level providers in emergency obstetric and newborn health care: factors affecting their performance and retention within the Malawian health system. Human resources for health. 2009;7(1):14.

21. Zamawe CO. Factors that Affect Maternal Care Seeking Behaviour and the Choice of Practitioner (s) during Complications: the Case of Mang'anja Tribe in Malawi. Research on Humanities and Social Sciences. 2013;3(18):18-26.

22. Muula A, Siziya S, Rudatsikira E. Parity and maternal education are associated with low birth weight in Malawi. African health sciences. 2011;11(1).

23. Lunguzi J. Dedza District.Social economic profile.2013-2018. In: Government D, editor. Lilingwe,Malawi: Malawi Government; 2013. p. 1-158.

24. Ronsmans C, Scott S, Qomariyah SN, Achadi E, Braunholtz D, Marshall T, et al. Professional assistance during birth and maternal mortality in two Indonesian districts. Bulletin of the World Health Organization. 2009;87.

25. office Mns. 2018 Malawi Population and Housing Census Zomba: Malawi Government National Statistics Office; 2018 [

26. Government M. Malawi Health Sector Strategic Plan. In: Health Mo, editor. Lilongwe,Malawi: Ministry of Health; 2011. p. 1-148.

27. Phiri PW, Rattanapan C, Mongkilchatis A. Health and social care in the community. ASEAN Institute for Helth Development,Mahidal University SaluyaThailand. 2015;23(5):493-501.

28. Kok MC, Namakhwa I, Nyirenda L, Chikaphupha K, Broerser JEN, Dileman M. Health Surveillance Assistant as intermediates between the community and health sector in Malawi: Explaining how relationships influence perfomance. BMC Health service research. 2016;16(164).

29. Kabagenyi A, Jennings L, Reid A, Nalwadda G, Ntozi J, Atuyambe L. Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda. Reproductive Health. 2014;11(1):21.

30. Visagie S, Schneider M. Implementation of principles of Primary Health Care in a rural area of South Africa. African journal of Primary Health CareFamily Medicine. 2016;6:562 -72.

31. Lewycka S, Mwansambo C, Rosato M, Kazembe P, Phiri T, Mganga A, et al. Effect of women's groups and volunteer peer counselling on rates of mortality, morbidity, and health behaviours in mothers and children in rural Malawi (MaiMwana): a factorial, cluster-randomised controlled trial. The Lancet. 2013;381(9879):1721-35.

32. Kabagenyi A, Jennings L, Reid A, Nalwadda G, Ntozi J, Atuyambe L. Barrirs to Male involvement in contraceptive uptake and reproductive health services.A qualitative study of men and women's perceptions in two rural districs in Uganda. Reproductive health 2012;1(21):2-9.

33. Kambala C, Lohman J, Mazalale J, Brenner S, Allegri MD, Muula AS, et al. How do Malawian men rate the quality of martenl and newborn care; Experiences and Perceptions of women in the South. 2015.

34. Titaley CR, Hunter CL, Heywood P, Dibley MJ. Why don't some women attend antenatal and postnatal care services?: a qualitative study of community members' perspectives in Garut, Sukabumi and Ciamis districts of West Java Province, Indonesia. BMC Pregnancy and Childbirth. 2010;10(1):61.

35. Sajedinejad S, Majdzaden R, Vedadhir A, Tabatubaei MG, Mohammed K. Maternal mortality,a Cross sectional study in global health. 2015;4(11).

36. Thiede M, Koltermann KC. Determinants of the non -uptake of health services: A quantitative analysis of household survey data from Ghana, Rwanda, Bngladesh and Vietnam. New York: UNICEF; 2013.

37. Bonggart J. Trends in Maternal Mortality from 1990 to2015. Geneva,Switzerland: World Health Organiztion; 2016.

38. Uzochukwu BS, Akpala CO, Onwujekwe OE. How do health workers and community members perceive and practice community participation in the Bamako Initiative programme in Nigeria? A case study of Oji River local government area. Social Science & Medicine. 2004;59(1):157-62.

39. Idris SH, Sambo MN, Ibrahim MS. Barriers to utilisation of maternal health services in a semi-urban community in northern Nigeria: The clients' perspective. Nigerian medical journal: journal of the Nigeria Medical Association. 2013;54(1):27.

40. Rifkin SB, Kangere M. What is participation. Community-based rehabilitation (CBR) as a participatory strategy in Africa. 2002:37-49.

41. WorldHealthOrganization. Health promotion: Ottawa charter. Geneva: World Health Organization. 1986.

42. Marston C, Renedo A, McGowan C, Portela A. Effects of community participation on improving uptake of skilled care for maternal and newborn health: a systematic review. PloS one. 2013;8(2):e55012.

43. Firoz T, Vidler M, Makanga PT, Boene H, Chiaú R, Sevene E, et al. Community perspectives on the determinants of maternal health in rural southern Mozambique: a qualitative study. Reproductive health. 2016;13(2):112.

44. Raven JH, Tolhurst RJ, Tang S, Van Den Broek N. What is quality in maternal and neonatal health care? Midwifery. 2012;28(5):e676-e83.

45. Simkhada B, Porter MA, Van Teijlingen ER. The role of mothers-in-law in antenatal care decision-making in Nepal: a qualitative study. BMC pregnancy and childbirth. 2010;10(1):34.

46. Simkhada B, Teijlingen ERv, Porter M, Simkhada P. Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature. Journal of advanced nursing. 2008;61(3):244-60.

47. Simkhada B, Van Teijlingen E, Porter M, Simkhada P. Major problems and key issues in Maternal Health in Nepal. Kathmandu University medical journal. 2006;4(2 (Iss):258-63.

48. Creanga AA, Gullo S, Kuhlmann AKS, Msiska TW, Galavotti C. Is quality of care a key predictor of perinatal health care utilization and patient satisfaction in Malawi? BMC pregnancy and childbirth. 2017;17(1):150.

49. Sethi R, Gupta S, Oseni L, Mtimuni A, Rashidi T, Kachale F. The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labor and delivery. Reproductive health. 2017;14(1):111.

50. Smit J. Traditional birth attendants in Malawi. Curationis. 1994;17(2):25-8.

51. Mahiti GR, Kiwara AD, Mbekenga CK, Hurtig A-K, Goicolea I. "We have been working overnight without sleeping": traditional birth attendants' practices and perceptions of post-partum care services in rural Tanzania. BMC pregnancy and childbirth. 2015;15(1):8.

52. Kumbani L, Bjune G, Chirwa E, Odland JØ. Why some women fail to give birth at health facilities: a qualitative study of women's perceptions of perinatal care from rural Southern Malawi. Reproductive health. 2013;10(1):9.

53. Peters SA, Woodward M, Jha V, Kennedy S, Norton R. Women's health: a new global agenda. BMJ global health. 2016;1(3):e000080.

54. Buse K, Hawkes S. Health in the sustainable development goals: ready for a paradigm shift? Globalization and health. 2015;11(1):13.

55. Mkandawire E, Hendriks SL. A qualitative analysis of men's involvement in maternal and child health as a policy intervention in rural Central Malawi. BMC pregnancy and childbirth. 2018;18(1):37.

56. Maeseneer JD. Primary Health Care in Africa: Now more than ever. African journal of primary health care and family medicine. 2009;1(1):1-4.

57. Roux KWDPL, Couper I. Rural District Hospitals-Essential cogs in the district health system-and Primary Health Care re- engineering. South African Journal of Medicine. 2015.

58. Glassman A, Giedion U, Smith PC. What's in, what's out: designing benefits for universal health coverage: Brookings Institution Press; 2017.

59. Abiiro GA, De Allegri M. Universal health coverage from multiple perspectives: a synthesis of conceptual literature and global debates. BMC international health and human rights. 2015;15(1):17.

60. Abiiro GA, Mbera GB, De Allegri M. Gaps in universal health coverage in Malawi: a qualitative study in rural communities. BMC health services research. 2014;14(1):234.

61. Jowett M. Safe motherhood interventions in low-income countries: an economic justification and evidence of cost effectiveness. International Programme, Centre for Health Economics, University of York, York YO10 5DD, UK. 200;53(3):201-28.

62. Essendi H, Johnson FA, Madise N, Matthews Z, Falkingham J, Bahaj AS, et al. Infrastructural challenges to better health in maternity facilities in rural Kenya: community and healthworker perceptions. Reproductive health. 2015;12(1):103.

63. Manda-Taylor L, Mwale D, Phiri T, Walsh A, Matthews A, Brugha R, et al. Changing times? Gender roles and relationships in maternal, newborn and child health in Malawi. BMC pregnancy and childbirth. 2017;17(1):321.

64. Ahmed S, Creanga AA, Gillespie DG, Tsui AO. Economic status, education and empowerment: implications for maternal health service utilization in developing countries. PloS one. 2010;5(6):e11190.

65. Idris SH, Sambo MN, Ibrahim MS. Barriears to utilization of maternal health srevices in a semi urban community in Northern Nigeria: The client percepective. Nigerian Medical Journal. 2013;54(1).

66. Mazalale J, Kambala C, Brenner S, Chinkhumba J, Lohmann J, Mathanga DP, et al. Factors associated with delivery outside a health facility: cross-sectional study in rural Malawi. Tropical Medicine & International Health. 2015;20(5):617-26.

67. Kinney MV, Kerber KJ, Black RE, Cohen B, Nkrumah F, Coovadia H, et al. Sub-Saharan Africa's mothers, newborns, and children: where and why do they die? PLoS medicine. 2010;7(6):e1000294.

68. Agarwal P, Singh M, Garg S. Maternal health-care utilization among women in an urban slum in Delhi. Indian Journal of Community Medicine. 2007;32(3):203.

69. Kalembo FW, Zgambo M, Mulaga AN, Yukai D, Ahmed NI. Association between male partner involvement and the uptake of prevention of mother-to-child transmission of HIV (PMTCT) interventions in Mwanza district, Malawi: a retrospective cohort study. PloS one. 2013;8(6):e66517.

70. Lowe M, Chen D-R, Huang S-L. Social and Cultural Factors Affecting Maternal Health in Rural Gambia: An Exploratory Qualitative Study. PloS one. 2016;11(9):e0163653.

71. Abosse Z, Woldie M, Ololo S. Factors influencing antenatal care service utilization in hadiya zone. Ethiopian Journal of Health Sciences. 2010;20(2).

72. Dahiru T, Oche OM. Determinants of antenatal care, institutional delivery and postnatal care services utilization in Nigeria. Pan African Medical Journal. 2015;21(1).

73. Panel AP. Maternal health: investing in the lifeline of healthy societies and economies. African Progress Panel Policy Brief, September 2010.

74. Behrman JR, Wolfe BL. How does mother's schooling affect family health, nutrition, medical care usage, and household sanitation? Journal of econometrics. 1987;36(1-2):185-204.

75. Cooper LG, Leland NL, Alexander G. Effect of maternal age on birth outcomes among young adolescents. Social biology. 1995;42(1-2):22-35.

76. Gage AJ. Barriers to the utilization of maternal health care in rural Mali. Social science & medicine. 2007;65(8):1666-82.

77. Tsegay Y, Gebrehiwot T, Goicolea I, Edin K, Lemma H, San Sebastian M. Determinants of antenatal and delivery care utilization in Tigray region, Ethiopia: a cross-sectional study. International journal for equity in health. 2013;12(1):30.

78. Colbourn T, Lewycka S, Nambiar B, Anwar I, Phoya A, Mhango C. Maternal mortality in Malawi, 1977–2012. BMJ open. 2013;3(12):e004150.

79. Ulin PR, Robinson ET, Tolley EE. Qualitative methods in public health: A field guide for applied research: John Wiley & Sons; 2012.

80. Bazile J, Rigodon J, Berman L, Boulanger VM, Maistrellis E, Kausiwa P, et al. Intergenerational impacts of maternal mortality: Qualitative findings from rural Malawi. Reproductive health. 2015;12(1):S1.

81. Kongnyuy EJ, Hofman J, Mlava G, Mhango C, Van Den Broek N. Availability, utilisation and quality of basic and comprehensive emergency obstetric care services in Malawi. Maternal and child health journal. 2009;13(5):687-94.

82. Rosato M, Laverack G, Grabman LH, Tripathy P, Nair N, Mwansambo C, et al. Community participation: lessons for maternal, newborn, and child health. The Lancet. 2008;372(9642):962-71.

83. Joubert G, Ehrlich R. Epidemiology. 2nd ed. Cape Town: Oxford University Press.Southern Africa; 2007. 354 p.

84. Dworkin SL. Sample size policy for qualitative studies using in-depth interviews. Springer; 2012.

85. Connelly LM. Pilot studies. Medsurg Nursing. 2008;17(6):411.

86. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. American journal of evaluation. 2006;27(2):237-46.

87. Visagie S, Schneider M. Implementation of the principles of primary health care in a rural area of South Africa. African journal of primary health care & family medicine. 2014;6(1):1-10.

88. Braun V, Clarke V. What can "thematic analysis" offer health and wellbeing researchers? International journal of qualitative studies on health and well-being. 2014;9.

89. Jackson RL, Drummond DK, Camara S. What is qualitative research? Qualitative research reports in communication. 2007;8(1):21-8.

90. Kaiser K. Protecting confidentiality. The Sage handbook of interview research. 2012:457-64.

91. Kim Y. The Pilot Study in Qualitative Inquiry. Sage Journals. 2011;Volume: 10 issue: 2, page(s): 190-206

92. Krefting L. Rigor in qualitative research: The assessment of trustworthiness. American journal of occupational therapy. 1991;45(3):214-22.

93. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse education today. 2004;24(2):105-12.

94. Trochim WM. Qualitative validity. Research methods knowledge base. 2006:1-3.

95. Kuper A, Reeves S, Levinson W. An introduction to reading and appraising qualitative research. Bmj. 2008;337(7666):404-7.

96. Krefting L. Rigor in qualitative research: The assessmentof trustworthiness. American journal of occupational therapy. 1991;45:214-22.

97. Ulin PR, Robinson ET, Tolley EE. Qualitative methods in public health. Med Sci Sports Exerc. 2005;37(7):1249.

98. Chakraborty N, Islam MA, Chowdhury RI, Bari W, Akhter HH. Determinants of the use of maternal health services in rural Bangladesh. Health promotion international. 2003;18(4):327-37.

99. McAlister C, Baskett TF. Female education and maternal mortality: a worldwide survey. Journal of obstetrics and gynaecology Canada. 2006;28(11):983-90.

100. Emelumadu OF, Onyeonoro UU, Ukegbu AU, Ezeama NN, Ifeadike CO, Okezie OK. Perception of quality of maternal healthcare services among women utilising antenatal services in selected primary health facilities in Anambra State, Southeast Nigeria. Nigerian medical journal: journal of the Nigeria Medical Association. 2014;55(2):148.

101. Pell C, Straus L, Andrew EV, Meñaca A, Pool R. Social and cultural factors affecting uptake of interventions for malaria in pregnancy in Africa: a systematic review of the qualitative research. PloS one. 2011;6(7):e22452.

102. Organization WH. Interagency list of medical devices for essential interventions for reproductive, maternal, newborn and child health. 2016.

103. Singh A, Guleria K, Vaid NB, Jain S. Evaluation of maternal early obstetric warning system (MEOWS chart) as a predictor of obstetric morbidity: a prospective observational study. European Journal of Obstetrics & Gynecology and Reproductive Biology. 2016;207:11-7.

104. Shields LE, Wiesner S, Klein C, Pelletreau B, Hedriana HL. Use of maternal early warning trigger tool reduces maternal morbidity. American journal of obstetrics and gynecology. 2016;214(4):527. e1-. e6.

105. Angotti N, Dionne KY, Gaydosh L. An offer you can't refuse? Provider-initiated HIV testing in antenatal clinics in rural Malawi. Health Policy and Planning. 2010;26(4):307-15.

106. Greenwood J, Kircher P, Santos C, Tertilt M. An equilibrium model of the African HIV/AIDS epidemic. Econometrica. 2019;87(4):1081-113.

107. Rennie S, Behets F. Desperately seeking targets: the ethics of routine HIV testing in low-income countries. Bulletin of the World Health Organization. 2006;84:52-7.

108. Kululanga LI, Sundby J, Chirwa E. Striving to promote male involvement in maternal health care in rural and urban settings in Malawi-a qualitative study. Reproductive health. 2011;8(1):36.

109. Jefferys LF, Nchimbi P, Mbezi P, Sewangi J, Theuring S. Official invitation letters to promote male partner attendance and couple voluntary HIV counselling and testing in antenatal care: an implementation study in Mbeya Region, Tanzania. Reproductive health. 2015;12(1):95.

110. Theuring S, Mbezi P, Luvanda H, Jordan-Harder B, Kunz A, Harms G. Male involvement in PMTCT services in Mbeya Region, Tanzania. AIDS and Behavior. 2009;13(1):92-102.

111. Kok MC, Namakhoma I, Nyirenda L, Chikaphupha K, Broerse JE, Dieleman M, et al. Health surveillance assistants as intermediates between the community and health sector in Malawi: exploring how relationships influence performance. BMC health services research. 2016;16(1):164.

112. Mamba KC, Muula AS, Stones W. Facility-imposed barriers to early utilization of focused antenatal care services in Mangochi district, Malawi–a mixed methods assessment. BMC pregnancy and childbirth. 2017;17(1):444.

113. Rattray J, Flowers K, Miles S, Clarke J. Foetal monitoring: a woman-centred decision-making pathway. Women and Birth. 2011;24(2):65-71.

114. Gibb D, Arulkumaran S. Fetal monitoring in practice: Elsevier Health Sciences; 2017.

115. Organization WH. WHO recommended interventions for improving maternal and newborn health: integrated management of pregnancy and childbirth. Geneva: World Health Organization; 2007.

116. Milliez J. Rights to safe motherhood and newborn health: ethical issues. International Journal of Gynecology & Obstetrics. 2009;106(2):110-1.

117. Lodenstein E, Pedersen K, Botha K, Broerse JE, Dieleman M. Gendered norms of responsibility: reflections on accountability politics in maternal health care in Malawi. International journal for equity in health. 2018;17(1):131.

118. Anastasi E, Borchert M, Campbell OM, Sondorp E, Kaducu F, Hill O, et al. Losing women along the path to safe motherhood: why is there such a gap between women's use of antenatal care and skilled birth attendance? A mixed methods study in northern Uganda. BMC pregnancy and childbirth. 2015;15(1):287.

119. Elmusharaf K, Byrne E, O'Donovan D. Strategies to increase demand for maternal health services in resource-limited settings: challenges to be addressed. BMC public health. 2015;15(1):870.

120. Palamuleni M. Determinants of non-institutional deliveries in Malawi. Malawi Medical Journal. 2011;23(4):104-8.

121. Wilson A, Gallos ID, Plana N, Lissauer D, Khan KS, Zamora J, et al. Effectiveness of strategies incorporating training and support of traditional birth attendants on perinatal and maternal mortality: meta-analysis. Bmj. 2011;343:d7102.

122. Shukla J. Social Determinants of Urban Indian Women's Health Status. 2011.

123. Dye C, Reeder JC, Terry RF. Research for universal health coverage. American Association for the Advancement of Science; 2013.

124. Kok M, Muula S. Motivation and job satisfaction of health surveillance assistants in Mwanza, Malawi: an explorative study. Malawi Medical Journal. 2013;25(1):5-11.

125. Chikaphupha KR, Kok MC, Nyirenda L, Namakhoma I, Theobald S. Motivation of health surveillance assistants in Malawi: a qualitative study. Malawi medical journal. 2016;28(2):37-42.

126. Tana VV. Experiences of chronic patients about long waiting time at a community health care centre in the Western Cape: Stellenbosch: Stellenbosch University; 2013.

127. Srivastava A, Avan BI, Rajbangshi P, Bhattacharyya S. Determinants of women's satisfaction with maternal health care: a review of literature from developing countries. BMC pregnancy and childbirth. 2015;15(1):97.

128. Ki-Moon B. Global strategy for women's and children's health. New York: United Nations. 2010.

129. Mayosi BM, Benatar SR. Health and health care in South Africa—20 years after Mandela. New England Journal of Medicine. 2014;371(14):1344-53.

130. Nyamtema AS, Urassa DP, van Roosmalen J. Maternal health interventions in resource limited countries: a systematic review of packages, impacts and factors for change. BMC pregnancy and childbirth. 2011;11(1):30.

131. Braveman P, Gruskin S. Poverty, equity, human rights and health. Bulletin of the World Health organization. 2003;81:539-45.

132. Beltman JJ, Van den Akker T, Bwirire D, Korevaar A, Chidakwani R, Van Lonkhuijzen L, et al. Local health workers' perceptions of substandard care in the management of obstetric hemorrhage in rural Malawi. BMC pregnancy and childbirth. 2013;13(1):39.

133. Spector JM, Agrawal P, Kodkany B, Lipsitz S, Lashoher A, Dziekan G, et al. Improving quality of care for maternal and newborn health: prospective pilot study of the WHO safe childbirth checklist program. PloS one. 2012;7(5):e35151.

134. Mannava P, Durrant K, Fisher J, Chersich M, Luchters S. Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. Globalization and health. 2015;11(1):36.

135. Kambala C, Morse T, Masangwi S, Mitunda P. Barriers to maternal health service use in Chikhwawa, Southern Malawi. Malawi medical journal. 2011;23(1).

136. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLoS medicine. 2015;12(6):e1001847.

137. Ganle JK. Why Muslim women in Northern Ghana do not use skilled maternal healthcare services at health facilities: a qualitative study. BMC international health and human rights. 2015;15(1):10.

138. Byrne A, Caulfield T, Onyo P, Nyagero J, Morgan A, Nduba J, et al. Community and provider perceptions of traditional and skilled birth attendants providing maternal health care for pastoralist communities in Kenya: a qualitative study. BMC pregnancy and childbirth. 2016;16(1):43.

139. Seljeskog L, Sundby J, Chimango J. Factors influencing women's choice of place of delivery in rural Malawi-an explorative study. African journal of reproductive health. 2006;10(3):66-75.

140. Kalda R, Põlluste K, Lember M. Patient satisfaction with care is associated with personal choice of physician. Health policy. 2003;64(1):55-62.

141. Roberts CL, Tracy S, Peat B. Rates for obstetric intervention among private and public patients in Australia: population based descriptive study. Bmj. 2000;321(7254):137-41.

142. Sharma S, Van Teijlingen E, Hundley V, Angell C, Simkhada P. Dirty and 40 days in the wilderness: eliciting childbirth and postnatal cultural practices and beliefs in Nepal. BMC pregnancy and childbirth. 2016;16(1):147.

143. Dako-Gyeke P, Aikins M, Aryeetey R, Mccough L, Adongo PB. The influence of socio-cultural interpretations of pregnancy threats on health-seeking behavior among pregnant women in urban Accra, Ghana. BMC pregnancy and childbirth. 2013;13(1):211.

144. Nordeng H, Al-Zayadi W, Diallo D, Ballo N, Paulsen BS. Traditional medicine practitioners' knowledge and views on treatment of pregnant women in three regions of Mali. Journal of ethnobiology and ethnomedicine. 2013;9(1):67.

145. Mothupi MC. Use of herbal medicine during pregnancy among women with access to public healthcare in Nairobi, Kenya: a cross-sectional survey. BMC complementary and alternative medicine. 2014;14(1):432.

146. De Wet H, Ngubane S. Traditional herbal remedies used by women in a rural community in northern Maputaland (South Africa) for the treatment of gynaecology and obstetric complaints. South African Journal of Botany. 2014;94:129-39.

147. Bayisa B, Tatiparthi R, Mulisa E. Use of herbal medicine among pregnant women on antenatal care at Nekemte Hospital, Western Ethiopia. Jundishapur journal of natural pharmaceutical products. 2014;9(4).

148. Mannan H, McVeigh J, Amin M, MacLachlan M, Swartz L, Munthali A, et al. Core concepts of human rights and inclusion of vulnerable groups in the disability and rehabilitation policies of Malawi, Namibia, Sudan, and South Africa. Journal of Disability Policy Studies. 2012;23(2):67-81.

149. Atuoye KN, Dixon J, Rishworth A, Galaa SZ, Boamah SA, Luginaah I. Can she make it? Transportation barriers to accessing maternal and child health care services in rural Ghana. BMC health services research. 2015;15(1):333.

150. MacLachlan M, Amin M, Mannan H, El Tayeb S, Bedri N, Swartz L, et al. Inclusion and human rights in health policies: Comparative and benchmarking analysis of 51 policies from Malawi, Sudan, South Africa and Namibia. PLoS One. 2012;7(5):e35864.

151. Amiri M, Lavasani Z, Norouzirad R, Najibpour R, Mohamadpour M, Nikpoor AR, et al. Prevalence of urinary tract infection among pregnant women and its complications in their newborns during the birth in the hospitals of Dezful city, Iran, 2012-2013. Iranian Red Crescent Medical Journal. 2015;17(8).

152. Organization WH. The Partnership for Maternal, Newborn and Child Health 2016 annual report: coming of age in a time of transition. World Health Organization; 2017.

153. Walsh A, Matthews A, Manda-Taylor L, Brugha R, Mwale D, Phiri T, et al. The role of the traditional leader in implementing maternal, newborn and child health policy in Malawi. Health policy and planning. 2018;33(8):879-87.

154. Peneza AK, Maluka SO. 'Unless you come with your partner you will be sent back home': strategies used to promote male involvement in antenatal care in Southern Tanzania. Global health action. 2018;11(1):1449724.

155. Jonas K, Crutzen R, van den Borne B, Reddy P. Healthcare workers' behaviors and personal determinants associated with providing adequate sexual and reproductive healthcare services in sub-Saharan Africa: a systematic review. BMC pregnancy and childbirth. 2017;17(1):86.

156. Bhutta ZA, Soofi S, Cousens S, Mohammad S, Memon ZA, Ali I, et al. Improvement of perinatal and newborn care in rural Pakistan through community-based strategies: a cluster-randomised effectiveness trial. The Lancet. 2011;377(9763):403-12.

157. Killewo J, Anwar I, Bashir I, Yunus M, Chakraborty J. Perceived delay in healthcare-seeking for episodes of serious illness and its implications for safe motherhood interventions in rural Bangladesh. Journal of health, population, and nutrition. 2006;24(4):403.

158. Banteyerga H. Ethiopia's health extension program: improving health through community involvement. MEDICC review. 2011;13(3):46-9.

159. Rosato M, Mwansambo C, Lewycka S, Kazembe P, Phiri T, Malamba F, et al. MaiMwana women's groups: a community mobilisation intervention to improve mother and child health and reduce mortality in rural Malawi. Malawi Medical Journal. 2010;22(4).

APPENDICES

APPENDIX One: Plagiarism declaration

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I Priscilla Divala (Student number: 1131428) am a student

Registered for the degree of Master in Public Health in the academic year.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature:  Date: 18.6.2020

APPENDIX A: Information letter for participants -FGD Discussion

Title of the study: Community perceptions of maternal health services in rural areas in Dedza, District in Malawi.

Dear Community Member,

Thank you for your time to read this information letter. This letter, will give you detailed information about the research project: the reason why I am doing it; what you can expect; your rights as a participant; what will happen with the results from this research; any risks and benefits; and who else apart from you, has given me permission to do this work.

Who am I?

My name is Pricilla Divala, I am a University of the Witwatersrand Master of Public Health Student. As a requirement, I need to conduct a research and give a report on the findings as partial fulfilment of the degree. I would like to invite you to participate in a research project that seeks to explore community perceptions of maternal health services in rural areas in Malawi.

Why did I choose this?

Maternal health services utilization for pregnant women is of concern in Dedza and especially in these three villages of Kalamba, Mphasayaweni and Kachipewa. Even though they have health facilities in these areas with experienced nurse/ midwives, death rate of pregnant mothers and new born babies is still high.

What is expected of the participants?

You are invited to take part in a **FGD discussion** to explore the community perceptions of health services for pregnant women in rural areas in Dedza district in Malawi. This will be offered by FGD discussion which will be among 8 participants where a male research assistant will facilitate the discussion.

If you do not want to take part in the FGDs, you can leave the discussion at any time should you feel uncomfortable. You do not answer any question if you do not feel like.

The FGD discussions should last between **1 hour to 1 hour 30 minutes**. A trained research assistant will sit in the FGD discussion to assist with the interview guides, and to take notes. We would like to ask that the discussion take place in Chichewa. The FGD discussions will be **audio-recorded** so that the researchers can write down what is said. You are free to tell the researcher to stop audio recording you anytime that you do not want your voice recorded

What about anonymity and confidentiality?

Anonymity means that no information can be linked to your name or person. This includes anything you say. **Confidentiality** means that anything you say will not be told to other people. As is the nature of FGD discussions, the researchers cannot guarantee that other members participating in the FGD will not talk about what people said after the discussion. We ask that you **please respect other people's opinions** and do not talk about what other people said after the FGD discussion. The researcher will ensure that anything you say cannot be linked to you, by removing your name and affiliation from the transcription of the FGD discussion. You are allowed to withdraw from the discussion at any time and you do not have to respond

to any question that makes you feel uncomfortable. You are allowed to leave the room at any time during the FGD without giving any reason for leaving.

What will happen to what I say in the FGD discussion?

Your voice, along with those of the other participants, will be **audio-recorded** during the FGD discussion. This discussion will be written up on paper. Your views will be analysed, with other views, to better understand what people are saying. Your name will be removed during the write up of the research. No participant's name will be linked to the published data from this study, not even selected quotations. The findings of this project will be submitted for partial fulfilment of my degree in Public health.

Can I leave the study?

Your participation is entirely **voluntary**; this means that you are free to decide whether or not you wish to join the interview. There will be no consequences to you whether you participate or not. You may withdraw at any time. You are free not to answer any particular question we will respect and honour your decision.

Risks and Benefits

There should be no risks to you taking part in this study. However, you might benefit from the discussion as it will relate to your family. Ground rules will be set up at the beginning of the FGD discussion to support free participation and improve confidence in your contribution. It is important to remember that participation in this research is entirely **voluntary** and as a result **no financial reward** or incentive will be given.

What permission has been given?

Official permission to do this research has been granted by the relevant local health authorities; the Malawi Ministry of Health and the University of Witwatersrand Research Committee. Ethical permission to do this research has been granted by the Human Research Ethics Committee of the University of the Witwatersrand. Should you require any information regarding your rights as a research participant, or have any complaints regarding this study, you may contact: **The Ministry of Health, Dedza District Hospital or T**he secretary to the University of Witwatersrand Human Research Ethics Committee (HREC) on +27 (0)11 717 1234.

If you are willing to participate, we will ask you to **sign a Formal Consent Form** for both your participation and the recording of the FGD discussion. Copies of consent forms will be provided to you should you request them. ***Who should I contact if I have any questions?***

You can speak to the Research assistant or the researcher if you have any questions. The number is 0795470524.

APPENDIX B: Consent form for FGD discussion

Title of study: Community perceptions of maternal health services in rural areas in Dedza, District in Malawi.

Dear Community Member,

I understand that I have been invited to take part in FGD Discussion.

I have heard the aims and objectives of the Research Project that are proposed. I was given the opportunity to ask questions and was also given enough time to think about this Research Project. I have not been forced or pushed in any way to take part. I am clear about the aims of the Research Project.

I understand that taking part in this Research Project is completely voluntary. It is my own choice. I know that I may withdraw from it at any time without need to give any reasons.

I do understand that the FGD discussion will be audiotaped, and that this recording will be used only for the purposes of analysing as data in this Research Project. I have been told that only the researcher above will be able to access the tape recording. I have also been told that when this analysis is complete these recordings will be destroyed. I agree to participate in the FGD discussion with my voice being audio-taped.

I understand that the researcher above cannot guarantee that other members participating in the FGD will maintain confidentiality of the discussion.

I know that the results of this Research Project will be used for educational purposes, and that may include being published. I agree to this, provided any identifying data of affiliation and name are removed.

I hereby agree to participate in this FGD discussion for this Research Project.

……..... ....

Name of participant Signature of participant Witness

……..... …….....

Place Date

Statement by the interviewer:

I have given written and oral information regarding this Research Project to the participant. I agree to answer any future questions concerning the Project as best as I am able. I will adhere to the protocol as it has been approved.

…..... ..... ……..... …….....

Name of the interviewer Signature Date Place

APPENDIX C: Consent form for audiotaping in a FGD discussion

Title of study: Community perceptions of maternal health services in rural areas in Dedza District in Malawi.

Dear Community Member,

I understand that I have been invited to participate in a FGD discussion.

I have heard the aims and objectives of the Research Project that are proposed. I was given opportunity to ask questions and was also given enough time to think about this Research Project. I have not been forced or pushed in any way to take part. I am clear about the aims of the Research Project.

I understand that taking part in this Research Project is completely voluntary i.e. of my own choice. I know that I may withdraw from it at any time without giving any reasons.

I do understand that the FGD will be audiotaped, and that this recording will be used only for the purposes of analysing data in this Research Project. I have been told that only the researcher above will be able to access the tape recording. I have also been told that when this analysis is complete these recordings will be destroyed. I agree to participate in the FGD with me being audio-taped.

I understand that the researchers above cannot guarantee that other members participating in the FGD will maintain confidentiality of the discussion.

I know that the results of this Research Project will be used for scientific and educational purposes, and that may include being published. I agree to this, provided any identifying data of region and name are removed.

I hereby agree to being audiotaped in FGD interviews in this Research Project.

……..... .....

Name of participant Signature of participant Witness Place Date

---

Statement by the interviewer:

I have given written and oral information regarding this Research Project to the participant.

I agree to answer any future questions concerning the Project as best as I am able.

I will adhere to the protocol as it has been approved.

…….....

Name of interviewer Signature Date Place

APPENDIX D: Information letter for participants – in-depth interview

Title of the study: Community perceptions of maternal health services in rural areas in Dedza, District in Malawi.

Dear Community Member,

Thank you for taking the time to read this information letter, which will give you more details about our research project: who I am I; why I am doing this research; what you can expect; your rights as a participant; what will happen with the results from this research; any risks and benefits; and who, besides you, have given us permission to do this work.

Who I am I?

I am a Master of Public health student at the **University of the Witwatersrand** (see details below). I would like to invite you to participate in a research project that seeks to explore the community perception of maternal health services for pregnant women in rural areas in Dedza district in Malawi.

Why I am I doing this?

The deaths of pregnant women is high in Dedza District, I would like to explore how the community perceive the utilization of maternal health services in rural areas in Malawi.

What is expected of the participants?

You are invited to a take part in an In depth interview to explore community perception of maternal health services in rural areas in Dedza District in Malawi. The In-depth Interviews will have each participants to answer a few questions that will be asked by a trained researcher.

You do not have to take part in the in depth interviews and you do not need to answer any of these questions. You can leave the interview at any time should you feel uncomfortable.

In-depth interview should last between **45-60 minutes**. A trained research assistant will sit in the interview to assist with language challenges, and to take notes. We ask that the discussion take place in Chichewa. The in-depth interviews will be **audio-recorded** so that the researchers can write down what is said. If you do not want your voice recorded, you must let the researchers know.

What about anonymity and confidentiality?

Anonymity means that no information can be linked to your name or person; this includes anything you say. **Confidentiality** means that anything you say will not be told to other people. To ensure that anything you say cannot be linked to you, your name and affiliation will be removed from the transcription of the interview. You may withdraw from the interview at any time and you do not have to respond to any question that makes you feel uncomfortable. You may choose to leave the room at any time during interview without the need to give any reason for leaving.

What will happen to what I say during the in depth interview?

Your voice, will be **audio-recorded** during the in depth interview. This discussion will be written up on paper. Your views will be analysed, with other views, to better understand what people

are saying. During the write up of the research, we will remove your name and any identifying details. Any identifiable information will be kept secure by myself. Any published data from the project, including selected quotations, will not be linked to your name or specific facility.

Can I leave the study?

Your participation is entirely **voluntary.**

APPENDIX E: Consent form for audio taping in an in-depth interview

Title of study: Community perceptions on utilization of maternal health services in rural areas in Dedza, District in Malawi. I understand that I have been invited to participate in an in-depth Interview.

I have heard the aims and objectives of the Research Project that are proposed. I was given opportunity to ask questions and was also given enough time to think about this Research Project. I have not been forced or pushed in any way to take part. I am clear about the aims of the Research Project.

I understand that taking part in this Research Project is completely voluntary i.e. of my own choice. I know that I may withdraw from it at any time without giving any reasons.

I do understand that interviews will be audiotaped, and that this recording will be used only for the purposes of analysing as data in this Research Project. I have been told that only the researchers above will be able to access the tape recording. I have also been told that when this analysis is complete these recordings will be destroyed. I agree to participate in the interview with me being audio-taped.

I know that the results of this Research Project will be used for scientific and educational purposes, and that may include being published. I agree to this, provided any identifying data of region and name are removed.

I hereby agree to being audiotaped in in depth interviews in this Research Project.

……..... .....

Name of participant Signature of participant Witness

APPENDIX F: Consent form for in-depth interview

Title of the study: Community perceptions on maternal health services in rural areas in Dedza, District in Malawi. I understand that I have been invited to take part in an in-depth Interview**.**

I have heard the aims and objectives of the Research Project that are proposed. I was given the opportunity to ask questions and was also given enough time to think about this Research Project. I have not been forced or pushed in any way to take part. I am clear about the aims of the Research Project.

I understand that **taking part in this Research Project is completely voluntary**. It is my own choice. I know that I may withdraw from it at any time without need to give any reasons.

I do understand that **the In-depth interview will be audiotaped**, and that this recording will be used only for the purposes of analysing data in this Research Project. I have been told that only the researcher above will be able to access the tape recording. I have also been told that when this analysis is complete these recordings will be destroyed. **I agree to participate in** in-depth interviews.

I know that the results of this Research Project will be used for scientific and educational purposes, and that may include being published. I agree to this, provided any identifying data of affiliation and name are removed.

I hereby agree to participate in these in -depth interviews.

…….....

Name of participant Signature of participant Witness

……..... …….....

Place Date

Statement by the interviewer:

I have given written and oral information regarding this Research Project to the participant. I agree to answer any future questions concerning the Project as best as I am able. I will adhere to the protocol as it has been approved.

….....….....…….....

Name of the interviewer Signature Date Place

APPENDIX G: FGD interview guide

Biographical Information

a) Age
b) Marital status
c) Education
d) Name of village
e) Number of children

1. Tell me about any health services around this community? Prompt - how do you utilize them? How often?

2. What comes to your mind when you hear the word health services for pregnant women?
   Prompts: Things like weighing and vaccination?
   : Giving services to pregnant women like checking the health of a pregnant mother?

3. In your view, describe how nurses from the health centre relate with the community? Prompt – communication, collaboration, participation in community activities, how should they relate to each other?

4. What is your opinion on the involvement of the community in health services for pregnant women utilisation?
   Prompt: Who should be active and why? What do you think of male participation health services for pregnant women? What do you think is the best way for the community to get involved in the utilisation of health services for pregnant women?

5. What are your views regarding pregnant women who do not use health services during their pregnancy?
   Prompt: Is it good behaviour, why?
   Is it not good, why?

6. Is there anything else we have missed you think we should discuss?

APPENDIX H: In-depth interview guide

Biographical information

Age:
Marital status:
Number of children:
Education:

1. What do you do when you are pregnant?
   Prompt: Check-ups? At what gestational age? Do you not utilize health services, why?

   Prompt: Are there any cultural rules you choose to follow?

   Prompt: What happens when you don't follow these rules?

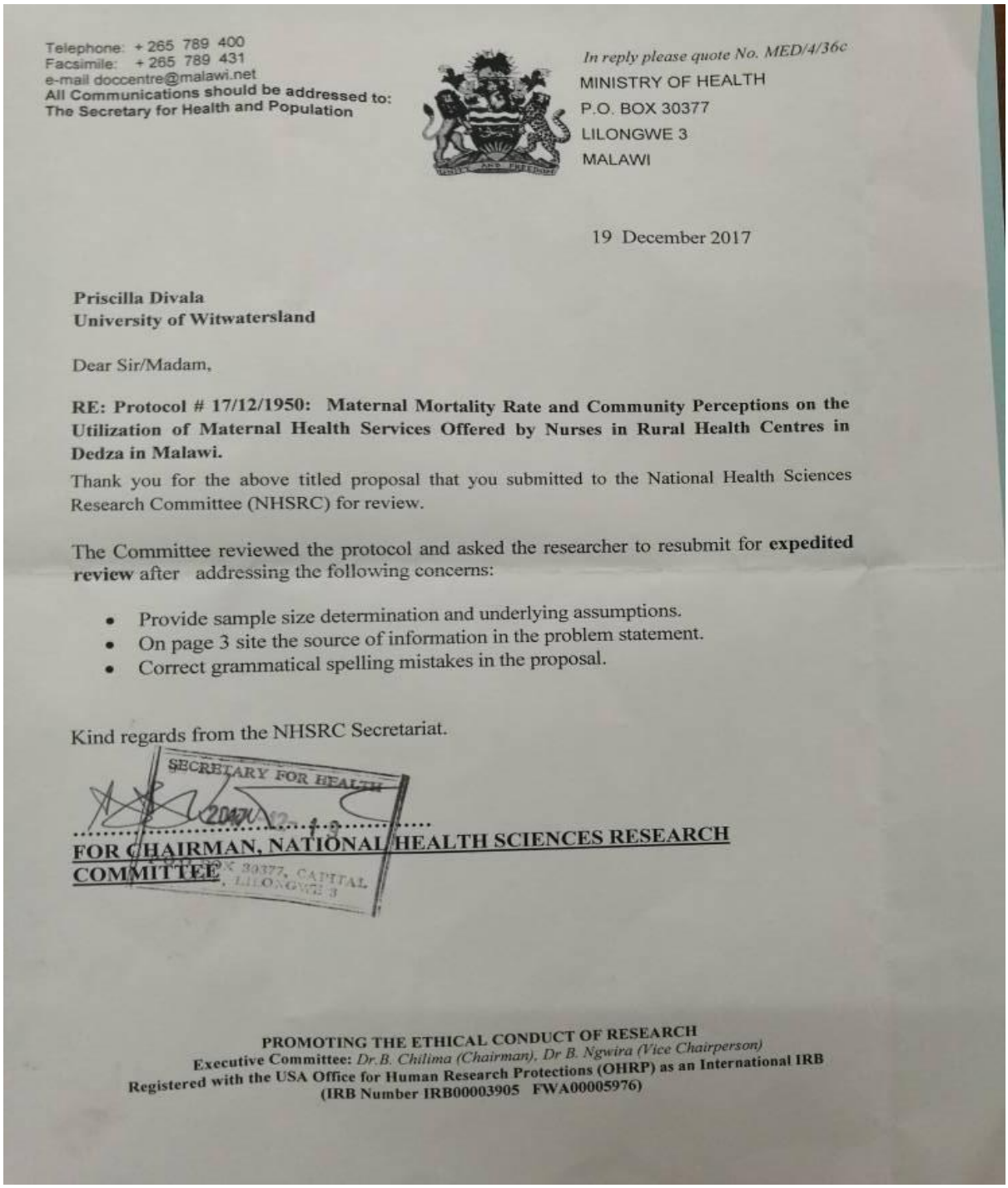
   Prompt: What do you think are the most important needs of a pregnant woman?
2. Who do you talk to about being pregnant?
   Prompt: Do you speak to family members?

   Prompt: Who assists you the most?
3. Can you tell me about services that are available for pregnant women at the clinic?
   Prompt: Will you please describe the steps that you go through when you visit the clinic for health services for pregnant women.
4. Tell me your relationship with the nurses at the clinic. *Prompt*: what should the relationship be like?
5. Do you think the community is involved with the health services for pregnant women?
   Prompt: How are they involved?

   Prompt: How is your family involved?
6. What do you do when things go wrong with your pregnancy?
   Prompt: Do you seek help from the health facility in such a case during pregnancy?
   Prompt: Do you seek help from the health facility in such a case after giving birth?
7. How do you think the community feel about the health services for pregnant women which are offered by nurses at the health facility? *Prompt*: Do you also feel the same?

   Is there anything you want to add?

APPENDIX I: Malawi Protocol 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

19 December 2017

Priscilla Divala
University of Witwatersland

Dear Sir/Madam,

RE: Protocol # 17/12/1950: Maternal Mortality Rate and Community Perceptions on the Utilization of Maternal Health Services Offered by Nurses in Rural Health Centres in Dedza in Malawi.

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review.

The Committee reviewed the protocol and asked the researcher to resubmit for **expedited review** after addressing the following concerns:

- Provide sample size determination and underlying assumptions.
- On page 3 site the source of information in the problem statement.
- Correct grammatical spelling mistakes in the proposal.

Kind regards from the NHSRC Secretariat.

SECRETARY FOR HEALTH
2017 12 19

FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

P.O. BOX 30377, CAPITAL
LILONGWE 3

PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: *Dr.B. Chilima (Chairman), Dr B. Ngwira (Vice Chairperson)*
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00003905 FWA00005976)

Appendix J. Human Research Ethical Committee Clearance Certificate

R14/49 Priscilla Divala

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M170867

NAME: (Principal Investigator)	Priscilla Divala
DEPARTMENT:	School of Public Health Kalamba, Mphasayaweni and Kachipeya Villages, Dedza District - Malawi
PROJECT TITLE:	Maternal Mortality Rate and Community Perceptions on the Utilization of Maternal Health Services Offered by Nurses in Rural Health Centers in Dedza in Malawi
DATE CONSIDERED:	25/08/2017
DECISION:	Approved unconditionally
CONDITIONS:	South African Human Research Ethics Committees (HRECs) have no standing outside South Africa. Ethics approval is also required from local HRECs in Malawi
SUPERVISOR:	Dr M. Mlambo and Mr S. Pentz
APPROVED BY:	Professor P. Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	27/10/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the 3rd floor, Philip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially review August and will therefore be due in the month of August each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix K. Coding Framework

Study Title: Community perceptions of maternal health services in rural areas in Dedza, District in Malawi.

Aim: This study explored community perceptions of maternal health services in rural areas in Dedza district in Malawi

Objective no. 1: To explore community understanding of existing health care services package offered by health care providers in rural areas in Malawi.

BROAD CODE	DEFINITION	FINE CODES	DEFINITIONS	EXAMPLE OF PARTICIPANTS' EXCERPTS
Familiarity with mother and child health services	This refers to the knowledge of the type of maternal health services offered in the health facility	Maternal vital signs and general screening of diseases	This refers to specific maternal health services provided in the health facilities	*"… these women, they tell us that when they go for ANC, they test their blood to see if they have malaria parasites during every visit. They also give them tablets to treat malaria if they are found to have the parasite in their bodies" (Participant # 2, FGD 3).*
		Maternal testing of HIV and partner recruitment to ANC	This refers to how participants associated maternal health services with HIV testing	*"These days, they ask women to go with their husbands when they go to start ANC. They want them to go to the health centre when the pregnancy is three months old to start ANC. When they both go there, that is when they take*
				blood to test for HIV. Yes, they test both of you" (Participant # 2, FGD 3).

Objective no. 2. To explore community perceptions of the existing maternal health services delivery in rural areas in Malawi.

BROAD CODES	DEFINITION	FINE CODES	DEFINITIONS	EXCERPTS/ QUOTATIONS
Health service provision and health system challenges	This refers to health system challenges that affects health service provision	Long waiting time	This refers to the length of time spent at the health facility before participants receive health services	*"Just to add to that, sometimes it just happens that the nurses are full of themselves and rude. It can happen that a person waits for a long time even though there are few patients. The nurses are not busy, but they just ignore us" (Participant # 4, FGD 3).*
		Negative attitude of healthcare workers and lack of efficient communication	This refers to the negative way the nurses treat the pregnant women at the clinic	*"The nurses are sometimes so rude. It is not all of them and sometimes women make them behave like that. For example, at the ANC, they tell*
				us to bring a basin, plastic paper, prepare our bag with wrappers and baby clothes and nappies. When we go there without taking these things, the nurses do not like it. They shout at us all the time" (Participant # 11, IDI).

Objective no 3: To understand the maternal health services delivery challenges/ barriers and possible services improvement strategies in the communities under investigation

BROAD CODE	DEFINITION	FINE CODES	DEFINITIONS	INSERT/QUOTATION
Maternal healthcare services by-laws introduction	This refers to the community rules that are put in place to improve maternal health services utilisation	Dissatisfaction with maternal by-laws introduction	This refers to dissatisfaction at the introduction of fines for out of facility delivery.	*"They charge you a goat or equivalent to that. I think it is Something around R2000? You pay to the village headman. Sometimes they ask you to pay to the TA as well. It depends on what the village headman says. Then we say if one could not get money to pay for transport to go to the clinic, how can she find money to pay for the fine?" (Participant # 5, IDI).*
		Out of facility baby delivery sanctions	This refers to some of the sanctions that are experienced at the community level with regards to nonutilization of healthcare services.	*"…They introduced the rule that every pregnant woman should go to the clinic for delivery, and nobody should go to the traditional birth attendants" (Participant #.15, IDI).*

Objective no 3: To understand the maternal health services delivery challenges/ barriers and possible services improvement strategies in the communities under investigation

Broad Codes	Definition	Fine Codes	Definition	Excerpt/Quotation
Maternal health services improvement plans	This refers to the plans that the community need to follow for improving maternal health services	Training and community health education	This refers to the suggestions by the community that if TBAs can be well trained, maternal deaths can be reduced	*"Most women are not aware of the disadvantages of not using the health facility in case the woman starts to lose blood whilst in labour. ... The TBA does not have the skills and capacity to stop the bleeding and to replace the blood. They do not have the right equipment to use to replace water in the body or blood. They cannot measure how low a patient's blood levels are, and these things put the women in danger so there is need for them to be trained as well" (Participant #8, FGD 2,).*
		Clinic committee introduction	This refers to the community wish to	*"This is because if we can sit down and find a way to have a committee that will*
			establish committees to investigate issues concerning health services for pregnant women	*take care of any donation that can come to help in terms of transport to the clinic. This should not only be for pregnant women but anyone who needs to go to the clinic in this village…" (Participant #1, FGD 3).*