

**WEIGHING THE OPTIONS FOR DELIVERY CARE
IN RURAL MALAWI: COMMUNITY ACTORS'
PERCEPTIONS OF THE 2007 POLICY GUIDELINES
AND REDEFINED TRADITIONAL BIRTH
ATTENDANTS ROLES**

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Abstract

Despite significant recent improvements, maternal mortality remains high in Malawi. To address this, the Government prioritised strategies promoting skilled birth attendance. However, in a country where 80% of the population resides in rural areas, there are tremendous barriers to institutional deliveries. Historically rural women have been supported in childbirth by Traditional Birth Attendants (TBAs), and by skilled birth attendants (SBAs) at the health facility. In the past, TBAs were trained to help bridge the gaps in provision and accessibility of care but in the 1990's, the WHO recommended halting their training because it was perceived as ineffective for maternal mortality reduction. In 2007, the Government of Malawi issued Community Guidelines to promote skilled birth attendance and banned TBA utilization for routine deliveries. This grounded theory qualitative study used interviews and focus groups to explore community actors' perceptions of the 2007 Policy Guidelines and their implementation, and how the Policy affected the decisions and actions of rural women regarding their delivery care. Findings from this study indicate that although all actors may agree that delivering at facilities is safest when complications occur, this does not necessarily ensure their compliance. Women, men and TBAs particularly, perceived the Policy as prescriptive. Furthermore, the implementation of the policy aggravated some of the barriers women already faced. Issues of disrespectful and neglectful care at facilities also partly led women towards non-compliance. Furthermore, a view from the ground demonstrated that the Policy had led to a rupture of linkages between TBAs and SBAs, which have had a detrimental effect on the continuum of care. This study helps fill an important gap in research concerning maternal health policy implementation analysis in LICs, by focusing on the perceptions of those at the receiving end of policy change, and on their needs, and aspirations.

Key Words: maternal health, traditional birth attendant, policy implementation analysis, linkage, quality, community participation, bottom-up approach, remote rural community, skilled birth attendant

Declaration

I hereby declare that this submission is my own work and that, to the best of my knowledge, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree of the university or other institute of higher learning, except where due acknowledgement has been made in the text

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Finally, this thesis could not have happened without the contribution of all the participants who gave their time to be part of it. I am thankful also to staff at the Nkhoma CCAP Hospital and to Maimwana (Mchinji) for all their help during my stay in their area. I am grateful to my friends in Malawi who offered their homes and hospitality during my stay.

Dedication

This thesis is dedicated to the Traditional Birth Attendants of Malawi who, for decades and despite changes, have assisted women through childbirth, to the best of their ability. It is also dedicated to the rural women of Malawi, to their strength, their will, and the love they show for their children.

Acronyms and Abbreviations

AIA	Actors interface analysis
ANC	Antenatal care
AK	Authoritative knowledge
BBA	Birth before arrival
BEmOC	Basic Emergency Obstetric care
CHW	Community Health Worker
CEmOC	Comprehensive Emergency Obstetric care
CoC	Continuum of care
D& A	Disrespectful and abusive (care in childbirth)
EmOC	Emergency Obstetric care
FDG	Focus group discussion
GT	Grounded theory
GBD	Global burden of diseases
GVH	Group Village Headpersons
HIC	High income country
HSA	Health Surveillance Assistant
INGO	International Non-Governmental Organisation
LIC	Low income country
LMIC	Low and middle income country
MDG	Millennium Development Goals

MMR	Maternal mortality ratio
NGO	Non-Governmental Organisation
NMT	Nurse Midwife Technician
NOP	Birth with no one present
PHC	Primary Health Care
PPH	Post-partum hemorrhage
PISM	Presidential Initiative for Safe Motherhood
PMNCH	The Partnership for Maternal, Newborn & Child Health
PMTCT	Prevention of mother to Child transmission
PSMI	Presidential Safe Motherhood Initiative
SBA	Skilled birth attendant
SDH	Social determinants of health
SMI	Safe Motherhood Initiative
SSA	Sub-Saharan Africa
TA	Traditional Authority (or TA chief)
TBA	Traditional birth attendant
VH	Village Headperson
WH	Waiting home

Glossary of terms and phrases

<i>Ali ndi 'pakati'</i>	the phrase meaning to be pregnant, literally “in between life and death’
<i>chipatala</i>	Chichewa word meaning: health facility, health centre, hospital
<i>Guardian</i>	Person who accompanies the woman at health facility for delivery; there are usually one, sometimes more (they will stay with her at the facility until she returns home)
<i>mayi a chinsinsi</i>	Secret woman
<i>Mzimba /Azamba</i>	TBA (traditional birth attendant; sg)/ TBAs (pl.)
<i>“the legs are tired”</i>	women are in labour and too tired to work further
<i>“the passage is too narrow”</i>	birth canal is not wide enough to permit delivery, labour is obstructed
<i>To be sick/ the sickness</i>	to be pregnant; the labour
<i>“vuto/ mavuto”[s; pl],</i>	problem (sg)/ problems (pl); (also “zovuta”, “zikavuta”); terms used to describe complications which may occur in pregnancy.

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1 Chapter 1: Introduction

1.1 Introduction

This chapter introduces the thesis, which investigates community actors' perceptions of the implementation of a Policy aimed at maternal mortality reduction, in three rural areas of Central and Southern Malawi. It provides some background to the study and presents the research problem. Moreover, it states the research aims and presents the research questions, and finally provides an overview of the thesis structure.

1.2 Background to the study

1.2.1 The country context

Malawi is a landlocked country, neighbouring Tanzania to the north/north-east, Zambia to the West and Mozambique to the east and southwest. It covers an area of about 118,500 square kilometres, and has a population of just over 15.8 million people (National Statistical Office-Government of Malawi 2015), over 80% of whom live in rural areas. As shown in Figure 1 below, Malawi is divided into three regions (Northern, Central, and Southern) and 28 Districts, themselves subdivided into traditional authorities (TA), which are ruled by chiefs and at the more local level by group village headpersons¹ (GVH) and village headpersons (VH). In Malawi, all chiefs have considerable status and power in their villages and areas. Malawi relies heavily on an agricultural economy, which yields one third of its gross domestic product, and 90% of its export revenues (World Bank 2015).

¹ Although the terms 'village head' and 'village headman' are commonly used, the term village headperson has been selected here to stress that those can be either men or women in Malawi.



Figure 1. Administrative map of Malawi

Malawi has two main seasons: a hot wet season from December to April, when most heavy rains fall, and a hot dry season between May and November. During the rainy season, Malawi experiences flash floods which make travelling to and from rural areas difficult. Conversely, droughts have also hit the country in recent years, provoking food shortages (Republic of Malawi. 2012). In 2015 and 2016 there were calls for a review of government policy regarding food shortages (<http://www.dw.com/en/malawi-declares-national-disaster-over-food-crisis/a-19183292>, [accessed 20/12/16]). Often the period before the new crop is harvested is what Malawians in rural areas call ‘the hungry season’. Food gets increasingly scarce and in large families decisions about sharing become increasingly difficult. In 2014, 50.7% of the Malawian population was living below the poverty line, 94.8% of whom in rural areas (National Statistical Office-Government of Malawi 2015). The Human Development Index (HDI), a

composite index “measuring long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living”, places Malawi in the low-development category, ranking 173 out of a total of 188 countries (United Nations Development Programme. 2015).

In rural areas, most of the population survives on subsistence farming, and a greater proportion of women do unpaid work on their families’ farms (United Nations Development Programme. 2015). With regards to the Gender Inequality Index -which reports on gender-based inequalities in reproductive health, empowerment, and economic activity-Malawi ranks 140 out of 155 countries (United Nations Development Programme. 2015). Malawi is historically a tribal society, however VH, and GVH can be men or women. The country has a patrilineal system (in the Northern Region and some of the Southern Region) and a matrilineal system (Central Region and some of the Southern Region). In some areas, women, particularly younger women, have limited control of resources and decision-making (OECD 2014). Barber, who conducted an ethnographic study of perceptions and decision- making regarding birthing in a rural area of Southern Malawi found:

A strongly matrilineal and matrilocal lifestyle...with substantial power residing with older women. Men are heads of households when resident and responsible for the welfare of their own matrikin...childbearing women’s older female matrikin make most decisions, at least for younger women, and men generally support them (Barber 2004. p.2).

In Malawi, early marriages are still common, and 65% of women will have become mothers by the time they are 20 years of age (Malawi National Statistical Office (NSO), ICF Macro. 2011). In 2014, the total fertility rate (children per woman) was of 5.6. In rural areas only 59.8 % of women aged 15 years and above were literate (National Statistical Office-Government of Malawi 2015). The context described briefly above points to the fact that Malawi is a country where gender-based inequalities persist and where some of the most vulnerable pregnant women may be those living in poor, remote, rural areas. This is one of the reasons why their perspectives were sought in this study.

1.2.2 The Maternal health context relevant to this study

1.2.2.1 The organisation of maternal health services in Malawi

In Malawi most maternal health services are delivered by the state. At primary health care level they are provided at local health centres, at secondary level at district hospitals, and at tertiary level at national central hospitals (Banda 2013). However, a number of other providers also exist:

Major providers of health services include the Ministry of Health owning 392 (63%) of the total health facilities, the Christian Hospitals Association (CHAM) with 161 (26%) and Ministry of Local Government (MoLG) owning 5%. Others which account for 31 (6%) of the total facilities are NGOs including Banja La Mtsogolo (BLM): a non-for profit nongovernmental organization which specializes in the delivery of sexual and reproductive health services (AHWO 2009, p.16)

Besides the Government, the second biggest not-for-profit provider of health services is the Christian Health Association of Malawi (CHAM). In Malawi, maternal and childcare are currently free at the point of use and the Government has entered into a service level agreement in 2010 with CHAM, so that patients should not be charged for services when attending at those private facilities, as well as at NGO's facilities (Banda 2013). A large number of CHAM facilities are based in rural areas in all three regions, and some were included in the site selections in this study.

There are a total of 540 delivery facilities in Malawi (Leslie, Fink et al. 2016). Most pregnant women who need it are referred to district hospitals to receive emergency obstetric and new-born care (EmONC), however these facilities are in limited number. Therefore there are still major difficulties in being able to provide those services to every woman who needs them (Kongnyuy, Hofman et al. 2009), as the Government report below acknowledges:

In 2005, there were... 42 facilities offering EmONC comprehensively and 8 health facilities nationally offering EmONC at a basic level. Furthermore, the targets set in the 2007 roadmap of having 50% of health centres providing Basic EmONC and 80% of hospitals providing comprehensive EmONC by 2010 are far from being met (Republic of Malawi Ministry of Health 2011, p.47).

Moreover where those services are provided, their quality cannot always be guaranteed. A very recent cross-sectional study which assessed the quality of all delivery facilities in the country found that “that delivery facilities in Malawi are both accessible and highly utilized, but that facility quality falls substantially short of global standards of evidence-based care” (Leslie, Fink et al. 2016, p.12). Moreover, despite every effort from the Government to ensure that delivery services are affordable and available to all women at facilities, transport remains a major obstacle to women's attendance, particularly in rural areas (Kongnyuy, Hofman et al. 2009, Sarelin 2014, Aarnio, Chipeta et al. 2013, Marks, Dietsch et al. 2016). In Malawi, 85% of the population lives within 8 kms of their nearest health centre (Phoya 2014) , but 15% are located at least 8 kms or more from those, “and only 20% of the overall population lives within 25 km of a hospital” (Republic of Malawi Ministry of Health 2011, p.25). However, being near a facility does not guarantee access to the highest quality or most comprehensive delivery services (Leslie, Fink et al. 2016). Human resources for maternal health and

delivery care are also unevenly distributed between rural and urban areas, as the following Government report remarked:

There is a particularly significant mal-distribution of health personnel, which favours urban areas, and the secondary and tertiary levels of care. A Ministry of Health report published in 2003 showed that half of Malawi's doctors worked in its four central hospitals together with 25% of the nurses. While the majority of Malawians live in the rural areas, 97% of clinical officers and 82% of nurses in the public sector are in urban areas (Republic of Malawi Ministry of Health 2011, p.25).

As a result, the biggest share of maternal mortality takes place in rural areas (Colbourn, Lewycka et al. 2013, Republic of Malawi Ministry of Health 2011).

1.2.2.2 The decrease of the maternal mortality ratio (MMR) in Malawi

Colbourn et al. (2013), who undertook a review of the particular trends in maternal mortality in Malawi from 1977 to 2012, assessed the combination of determinants which led to its decrease in mortality in that period. They identified a scale up in the number of SBAs, a rise in the number of facility deliveries, as well as enhanced investments in the health system, a reduced number of HIV-related deaths, and a higher awareness amongst women of the dangers of pregnancy as contributing factors (Colbourn, Lewycka et al. 2013). Although the 2015 figure was not available at the time of writing, the White Ribbon Alliance Atlas of Births and WHO Malawi Country Profile put the 2014 gave an estimate of 634 for the MMR - calculated as the number of maternal deaths per 100,000 live births (WHO., UNICEF. et al. 2014). By contrast, the Malawi Government gave an estimate of 574 (National Statistical Office of Malawi 2015). This variability in numbers is linked mainly to difficulties in acquiring accurate measurement and information in certain contexts (Graham, Campbell 1992, Cross, Bell et al. 2010), particularly when a large number of births take place at home; It is also difficult in certain contexts to attribute deaths to pregnancy-related causes, rather than to other causes or underlying conditions (Kongnyuy, van den Broek 2008a, Thorsen, Sundby et al. 2012, Colbourn, Lewycka et al. 2013). Nonetheless, these numbers and targets have become key in tracking progress towards maternal mortality reduction, in Malawi and in the worldwide context of the Millennium Development Goals (MDGs) (2001) set the world the task to reduce maternal mortality worldwide by two thirds by the year

2015 (MDG5)². Malawi subscribed to the MDGs, and over the period has made strong headway, as Figure 2 below demonstrates, which was compiled by the researcher from a compendium of sources:

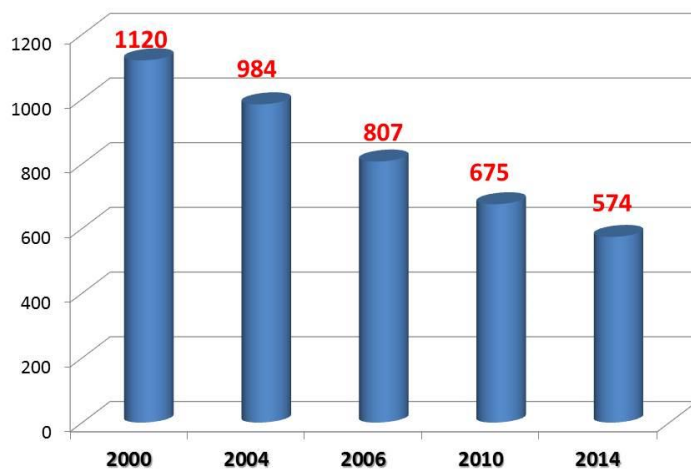


Figure 2. Maternal mortality ratio Trends in Malawi 2000 -2015, using various sources (Phoya, 2014 and National Statistical Office of Malawi 2015)

However the MDG5 target for Malawi-an MMR of 155- was sadly not met (Phoya 2014).

On the other hand, the main indicator for assessing progress towards MDG5 has been the rate of skilled birth attendance, which is the percentage number of births attended by skilled health personnel in a health facility. In that area, Malawi has also made laudable progress, as Figure 3 below (also compiled from a compendium of sources), shows:

² The Millennium Development Goals set agreed , quantifiable targets to be met by all countries by 2015, addressing poverty, health, gender equality, education, and environmental sustainability. Information on the MDGs can be found on: <http://www.un.org/millenniumgoals/> (accessed 14/02/2017)

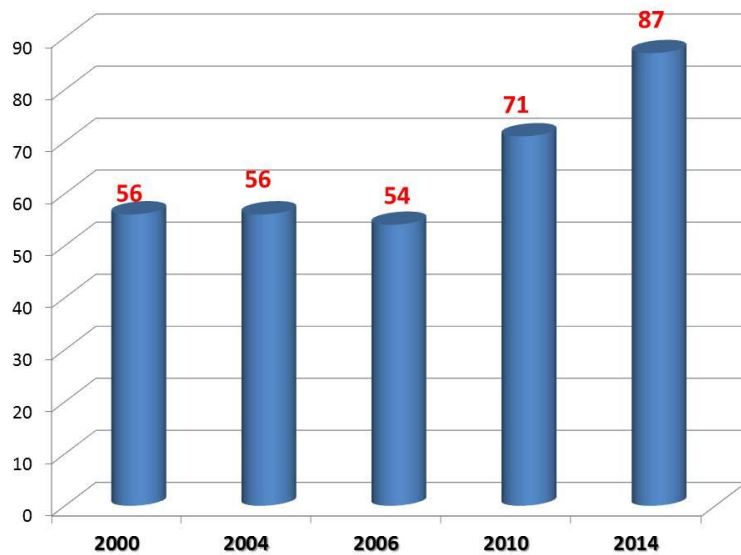


Figure 3. Skilled attendance at delivery in Malawi, 2000 -2014, by percent live births (UNICEF,WHO 2012, United Nations Statistics Division 2016 and National Statistical Office of Malawi 2015)

Skilled attendance at delivery in Malawi in 2014 was placed at 87% by the Malawi Government (National Statistical Office of Malawi 2015). One could attribute in part the faster progress made since 2006 to the impact of the various policies adopted by the Malawi Government to reduce maternal mortality (Republic of Malawi Ministry of Health 2012, Republic of Malawi Ministry of Health 2007b, Republic of Malawi Ministry of Health 2009), one of which- the Guidelines for Community Initiatives for Reproductive Health- is the Policy that this study is particularly concerned with (Republic of Malawi Ministry of Health 2007a).

1.2.2.3 The causes of maternal mortality in Malawi

Over half of maternal deaths in Malawi are caused by postpartum haemorrhage, puerperal sepsis, abortion complications, eclampsia and pre-eclampsia (Phoya 2014, Colbourn, Lewycka et al. 2013), similarly to a number of other sub-Saharan African countries (WHO 2015, Kassebaum, Bertozzi-Villa et al. 2014, WHO., UNICEF. et al. 2014). To address those causes, Malawi has signed up with a number of other countries to speeding up access to particular commodities proven to save the life of women in delivery, such as the provision of oxytocin and misoprostol for post-partum haemorrhage and magnesium sulphate for eclampsia (United Nations. 2015, p.53). Besides those direct causes however, a large percentage of maternal deaths (30%) are also attributed to other causes not directly linked to

pregnancy (e.g. pre-existing conditions such as diabetes, malaria, HIV). Deaths can also arise from delays in seeking care, in finding transport to facilities, or in accessing adequate care at the time required (Vink, de Jonge et al. 2013, Kassebaum, Bertozzi-Villa et al. 2014). This is particularly an issue in rural areas where there are fewer health centres available, as well as shortages of health personnel, and resources for health. The shortage of human resources for health in Malawi is well documented (Republic of Malawi Ministry of Health 2011, AHWO 2009, Thorsen, Tharp et al. 2011, UNFPA 2014). A recent article on human resources for maternal health in Malawi, placed the midwifery ratio at between 3 and 5 per 1000 pregnancies, and the obstetricians and gynaecologists' ratio at 0.15 (Koblinsky, Moyer et al. 2016). Moreover, most health workers are located in urban rather than in rural centres (AHWO 2009). Because of these constraints, there is a greater need to strengthen the continuum of care to effectively link the rural communities to the health system and make maternity and delivery services more effective.

1.2.2.4 The need to strengthen the continuum of care (CoC)

The concept of '*continuum of care*' (CoC) is not new and has been used since the 1970's to refer to "individual patient care and case management, and to promotion of appropriately directed care with a series of linkages to ensure that no patient is lost to follow-up." (Kerber, de Graft-Johnson et al. 2007, p.1359). In global maternal health, the concept has been used in the past decade in its larger sense, to bolster action in pursuit of the MDGS (Bustreo, Requejo et al. 2012), although primarily by referring to ways in which interventions to reduce maternal and child mortality can be better linked, in order to pool resources, save costs, and promote efficiency³. In its more practical sense, the concept of continuum of care refers however to linkages within the provision of care itself, and is "widely accepted as comprising of a sequential time dimension (from pre-pregnancy to motherhood and childhood) and of a space dimensions (from community-family care to clinical care)" (Kikuchi, Ansah et al. 2015, p.1). On the time continuum, this may refer, for instance, to how the use of antenatal care, skilled birth attendance, and postnatal care may be linked. On the space continuum it may refer to the manner in which care is provided at, and followed up from, home to hospital. Kerber et al (2007, p.1360) offer a simple visual representation of the CoC, inserted below, which has been chosen here because of its accent on linkages.

³ One example of this is the manner in which in 2005, the Safe Motherhood Initiative, and various child survival global partnerships were merged as the global Partnership for Maternal, Newborn and Child Health (PMNCH) (Bustreo, Requejo et al. 2012), to agree on policies and interventions to improve maternal, newborn, child and adolescent health.

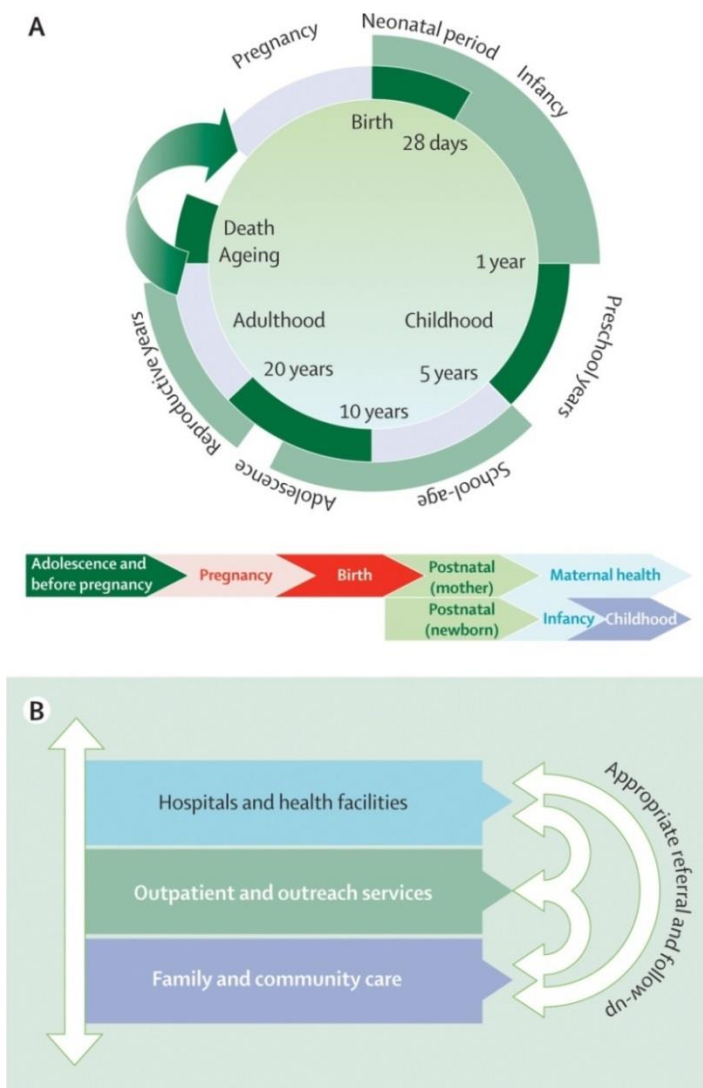


Figure 4. Continuum of Care Connecting care during the lifecycle (A) and at places of caregiving (B) from Kerber et al 2007

Because this study is focused on delivery care (rather than say antenatal care or neonatal health), it is focused mostly on the space dimension of the continuum of care (Kerber, de Graft-Johnson et al. 2007). Recent evidence shows both the time and space aspects of the continuum of care in Malawi are weak, particularly in terms of attending antenatal care visits in the last trimester, and for some women in terms of linking community care with skilled birth attendance and postnatal care (Singh, Story et al. 2016, Kikuchi, Ansah et al. 2015, Kongnyuy, Hofman et al. 2009). For instance, transport and ambulances are lacking, and a Government report stated that “At health centre level, 23%, 37% and 40% of Government, CHAM and private health centres reported availability of a functioning motor vehicle

ambulance” (Republic of Malawi Ministry of Health 2011, p.81). Communications systems, which are key to referrals, are also a problem, and the same report described a shortage of telephone landlines in maternity wards and expressed that although:

Two-way radio communication is an effective means of communication between primary and secondary level facilities, and yet only 45% of CHAM hospitals, 33% of Government rural hospitals and 20% of CHAM rural hospitals have two-way radio communication. At health centre level, only 64% of Government health centres and 60% of CHAM health centres have radio communication (Republic of Malawi Ministry of Health 2011, p.19).

In practice, because of these deficiencies in the CoC, this means that in rural areas, a number of different people still assist women with their deliveries: some who are medically trained (such as skilled birth attendants [SBAs]), and some who are not (such as traditional birth attendants [TBA], or relatives). As TBAs and SBAs feature prominently in this study, it is important to offer at the onset a working definition for both terms. The definitions used in this thesis are that: a skilled birth attendant (**SBA**) “refers exclusively to people with midwifery skills (for example, doctors, midwives, nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications” (WHO et al. 1999). Whereas a **TBA**⁴ is defined by the WHO as “ a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants” (WHO 1979; WHO 1992). Whilst SBAs assist women at health facilities, TBAs assist them usually at home in their own villages. Those two attendants are the main providers of delivery care, although not the only ones.

1.2.2.5 Who assists at deliveries in Malawi?

The Malawi Government Malawi MDG Endline Survey of 2014 (2015) offers the most recent disaggregated details of the places and types of attendants supporting deliveries in Malawi. This survey was based on a sample of 7,490 women who had had a live birth in the previous two years. It shows that 87.3% of births are taking place with a SBA (medical doctor, nurse/midwife or community midwife), whilst 3% of deliveries take place with TBAs, 5.8% with relatives or friends, and 2% occur with other people or no attendant whatsoever. A further 2% of deliveries are assisted by either a community health worker (CHW), another patient or ward attendant within the facility itself, presumably when SBAs are unavailable. The endline survey also shows that more women in rural areas and in the Central region

⁴ The literature review showed that TBAs may also be called lay midwife, empirical midwife, indigenous midwife, village midwife, traditional midwife, and in particular countries they have a local name, such as “ azamba” in Malawi or “dai”, “in India, “partera” in Mexico.

give birth with TBAs or with relatives (2015) , and that those women tend to be older (over 35), less educated, and also from the poorest wealth index quintile⁵. This suggests that this is possibly due to transport and referral difficulties as well as to other economic and socio-cultural factors.

The aim of this study is to find out is how, in the context of the Guidelines for Community Initiatives for Reproductive Health⁶ (Republic of Malawi Ministry of Health 2007a) which included a ban on TBA deliveries, and promotes health facility deliveries, women in rural areas weigh their options for delivery care, and make decisions on where to go.

1.3 The Research Problem

When the figures from the MDG Endline Survey of 2014 (2015) regarding the type and place of birth attendance are compared to the figures from 2007, provided by Colbourn, Lewycka et al (2013) in their review, a marked change can be noticed. This marked change is a shift from informal to formal birth attendance. In 2007- which is when the Guidelines for Community Initiatives for Reproductive Health (Republic of Malawi Ministry of Health 2007a) were issued- SBAs assisted 71.4% of deliveries, TBAs 14.4%, whilst relatives or others assisted 8.7%, and 2.6% remained unassisted (Colbourn, Lewycka et al. 2013). Since the 2007 Guidelines for Community Initiatives for Reproductive Health not only promoted institutional deliveries and skilled birth attendance, but also effectively banned the utilisation of TBAs for routine deliveries, one would expect that a marked decrease in the number of TBA-assisted deliveries would have ensued. This has been the case, however there appears to have been a less marked effect on the percentage of births assisted by relatives or unassisted, which this study will try to bring some light to. A closer look at the data from the MDG Endline Survey of 2014 also shows that today the percentages of births assisted by either TBAs, relatives or unassisted are higher in the Central and Southern region, where this study was conducted.

There has been in fact some debate about whether or not the 2007 Policy Guidelines and TBA ban are responsible for both an increased percentage of skilled birth attendance, and a decrease in maternal mortality. However, nearly a decade on, there has been little evidence produced. The perceived impact

⁵ The wealth index quintile are “ is a composite measure of a household's cumulative living standard. The wealth index is calculated using easy-to-collect data on a household's ownership of selected assets, such as televisions and bicycles; materials used for housing construction; and types of water access and sanitation facilities.” (<http://dhsprogram.com/topics/wealth-index/Index.cfm>, accessed 15 Feb 2017)

⁶ For ease of use the Guidelines for Community Initiatives for Reproductive Health (2007a) will be referred to in this thesis as either ‘the 2007 Policy Guidelines’ and/ or ‘the TBA ban’, or simply as ‘the Policy’.

of this policy has received little attention. Banda's mixed methods study which explored "key stakeholders' perceptions of the TBAs' changing role in order to understand the reasons why home births persist in the rural areas of the Central West Zone in Malawi" (2013, p.12) is critical of the manner in which the Policy was implemented and found it to be a mixed success in those particular rural areas. More recently, a study using secondary data from the 2010 Malawi Demographic and Health Survey (Malawi National Statistical Office (NSO), ICF Macro. 2011), and which was the first to investigate the impact of the Policy on increased facility use and on new-born mortality, has highlighted the Policy successes in reducing the use of TBAs. It stated that "the ban significantly reduced the use of informal providers — by about 15 percentage points" and "increased use of formal sector providers by about 11 percentage points" (Godlonton, Okeke 2016, p.124). Both of these studies were published whilst the current thesis was being written, and it is therefore timely to investigate the perceived impact of the 2007 Policy Guidelines from a different vantage point, that is by taking a view from the ground, and hearing the voices of those who have been most affected by the changes it brought.

This thesis uses a different methodology and angle to both those studies, and makes a novel and unique contribution by not only revealing how community actors perceive the Policy, but also their lived experiences of the implementation of the Policy, and how such perceptions may lead to particular actions and decisions regarding delivery care in rural areas. The community actors whose views were sought for this study were: women, men, TBAs, village headmen and health surveillance assistants. Because they are the most affected by the Policy, the study will focus more closely on women, and as required, on TBAs whose roles have been redefined. It will also contrast their views with those of other community actors and with those of SBAs- as the implementers of the Policy-, as required. The term 'community actor' is used in this thesis rather than the term 'community member' to place the focus on the agency of those whose lives interact with the implementation of policies that concern them (Buse, Mays et al. 2012, Veneklasen, Miller 2002). By approaching 'community actors' and particularly women's accounts in this way, the researcher explored whether, in spite of the many barriers they may face, those actors may exert their agency to make decisions regarding delivery care.

1.4 Research Aims and Research Questions

The principal aim of this grounded theory study is to explore community actors' perceptions of the 2007 Guidelines for Community Initiatives for Reproductive Health and TBA ban in Malawi. More

specifically the goal is to explore their lived experiences of the Policy implementation, and assess its perceived effects, particularly with regards on the continuum of care for women in remote rural areas. In doing so, the study seeks to understand how the 2007 Policy Guidelines are viewed by community actors, particularly women, and how their implementation has influenced their decisions regarding delivery care options. It also strives to show how TBAs themselves perceive their new redefined roles which are an integral part of the Policy, and how this conditions the support they may still provide to women in their communities. By placing the voices of those generally least heard at the heart of the study, this research aims to help fill a significant gap in maternal health policy implementation analysis. The larger rationale, given the significant barriers which the poorest rural women face, is to understand how policies influence- directly or indirectly- their delivery care-seeking options and behaviours.

Therefore, this study poses one main research question, followed by three sub-questions. The main research question frames the problematique tackled by this study. The sub-questions are laid out to probe specific aspects of the research problem and of the main question. They are presented below:

The Main Research question

What do community actors' perceptions of the 2007 Policy Guidelines and of the effects of its implementation, reveal about women's decision-making and delivery care-seeking behaviours in rural areas of Malawi?

The sub-questions

- 1) What are community actors' perceptions of the 2007 Policy Guidelines and TBA ban?
- 2) What are the perceived effects of the implementation of this Policy and how does this affect the way in which women in rural Malawi may be weighing their options for delivery care?
- 3) What is the impact of the Policy implementation on the links between community and health system for the continuum of care?

1.5 Outline of the thesis

Chapter 2 of the thesis provides a framework for understanding the phenomenon under scrutiny in its broader context. It provides the global context in which the 2007 Policy Guidelines and TBA ban were introduced in Malawi, a context where evidence-based policy making and effectiveness are the driving forces behind strategies to reduce maternal mortality in low income countries. In that context, SBAs and

their authoritative biomedical knowledge in childbirth are promoted at the expense of TBAs and their traditional knowledge. The consequences of the narrow focus on skilled birth attendance and the authoritative knowledge in childbirth are also discussed in this Chapter.

Chapter 3 provides the necessary theoretical frameworks to analyse the mechanisms of the Safe Motherhood policies transfer to Malawi, and particularly to the Guidelines for Community Initiatives for Reproductive Health (2007a). The context, content and process of this particular Policy are explained in details, as well as the respective roles of different actors within the process. The roles ascribed to each type of community actor by the 2007 Policy Guidelines are presented and insights from the actors interface analysis (AIA) are introduced which guide the analysis of multiple actors' perspectives on the phenomenon under study

Chapter 4 presents in details the methodology used in this study, which is the constructivist grounded theory as developed by Charmaz (2006). It highlights the philosophical underpinnings of this study, and how they influenced the choice of approach. It then details the study design, and describes the processes of data collection, and of data analysis.

Chapters 5, 6 and 7 present the findings which support the grounded theory, and reveals the interconnectedness of the main categories developed which build the theory.

Chapter 8 summarises the emergent theory, labelled *weighing the options for delivery care* in rural Malawi.

Chapter 9 returns to the theory to evaluate its fitness in answering the research questions posed at the start. It uses the most salient features of the theory to highlight the contribution of the study to the main theoretical debates in the field. It also discusses the thesis practical implications of the study and provides some recommendations for policymakers and maternal health development programs organisers.

2 Chapter 2: Safe Motherhood policies for maternal mortality reduction and authoritative knowledge in childbirth

2.1 Introduction

This study is concerned with mainly community actors'- and other important stakeholders- perceptions of the implementation of a policy change in Malawi- the Guidelines for Community Initiatives for Reproductive Health (2007a) –, which recommended the use of skilled birth attendance for deliveries, and prohibits the use of traditional birth attendants (TBAs). This Chapter provides a framework for understanding those perceptions, by introducing key concepts which run through the entire thesis. First, in order to understand the larger context of the 2007 Policy Guidelines and the move away from trained traditional birth attendants (TBAs) to skilled birth attendants (SBAs), it starts in section 2.2 by giving a brief overview of the global Safe Motherhood Initiative. It shows how a concern for evidence-based policy making and effectiveness helped narrow down strategies to those deemed to work best for maternal mortality reduction. It spells out in parallel, in section 2.3, the successive global positions adopted regarding TBA utilisation, and demonstrates that their contribution to maternal health strategies for the reduction of maternal mortality gradually diminished. This is aimed at helping the reader to understand why, in 2007, Malawi issued Guidelines banning the utilisation of TBAs. This Chapter defines the concept of authoritative knowledge in childbirth, which helped establish strategies for skilled birth attendance whilst devaluating alternative forms of knowledge such as that of TBAs. Finally, in section 2.4, the chapter discusses some of the problematic consequences of what has been a narrow focus on skilled birth attendance.

2.2 An overview of the Safe Motherhood Initiative and of 'what works' for maternal mortality reduction

The fight for mortality reduction has been a global concern for decades and has found focus in major milestones such as the Safe Motherhood Initiative (SMI) launched in 1987, or the Millennium Development Goals (MDGs) launched in 2001, which aimed to reduce the maternal mortality ratio worldwide by two thirds by the year 2015 (Goal MDG5). A timeline of the Safe Motherhood Initiative

(which later became the Partnership for Maternal, New-born and Child Health-PMNCH)⁷ is presented in Figure 5 below. The figure provides an original visual representation the Safe Motherhood campaigns from 1978, date of the Alma Ata Declaration, to 2015, which was the deadline for reaching the MDG5. This date range was also selected also because it coincided with major policy shifts regarding the utilisation of TBAs worldwide. The Declaration of Alma-Ata is the starting point. It was issued at the International Conference on Primary Health Care (PHC), in Kazakhstan in September 1978, and defined health for the first time as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1978). This view of health is particularly relevant to pregnancy and delivery, since those are neither diseases or infirmities. It is relevant also because the Declaration challenged all governments, particularly those in low income countries, to harness resources available in all sectors (formal and informal) to address health inequalities and help reach the goals of Universal Primary Health Care. It expressed:

Primary health care...relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community (WHO 1978, VII.7).

The date range is also fitting for this study because in 1979, Malawi was the first African country to start the large-scale training of its TBAs, and was the first in the region in 2007 to place a ban on their use (Wendland 2015). This timeline is built to show that the SMI has always implemented cycles of consultations, followed by global conferences and issued statements, followed thereafter by the setting of global targets for maternal mortality reduction, followed by their evaluation. In Buse et al's policy analysis terms, which will be returned to in Chapter 3, the SMI thus started with a "problem identification and issue recognition" (maternal mortality is too high) and then moved to "formulation, implementation and evaluation" (2012,p.14). The SMI itself was a global campaign launched in 1987, following a meeting in Nairobi of health experts, development professionals, and policymakers. Faced with a maternal mortality of half a million deaths a year at the time (problem identification), a call for action was issued, and the target of halving maternal mortality by the year 2000 was set. This call for action intended to make the fight against maternal mortality an international priority, through focused financing and increased political action (Mahler 1987). The following section presents the larger context and policy developments of the Safe Motherhood Initiative, which as Chapter 3 will show, transferred to

⁷ Although the Safe motherhood initiative (SMI) later was subsumed in the Partnership for Maternal, Newborn and Child Health (PNMCH), for the purpose of this study, the abbreviation SMI will refer to the continuum of Safe Motherhood policies from 1987 to 2015.

the Policy context of Malawi. They use the milestones from the figure presented below to show how through this timeline the SMI arrived at promoting strategies for maternal mortality reduction focused primarily on skilled birth attendance at the exclusion of other forms of attendance.

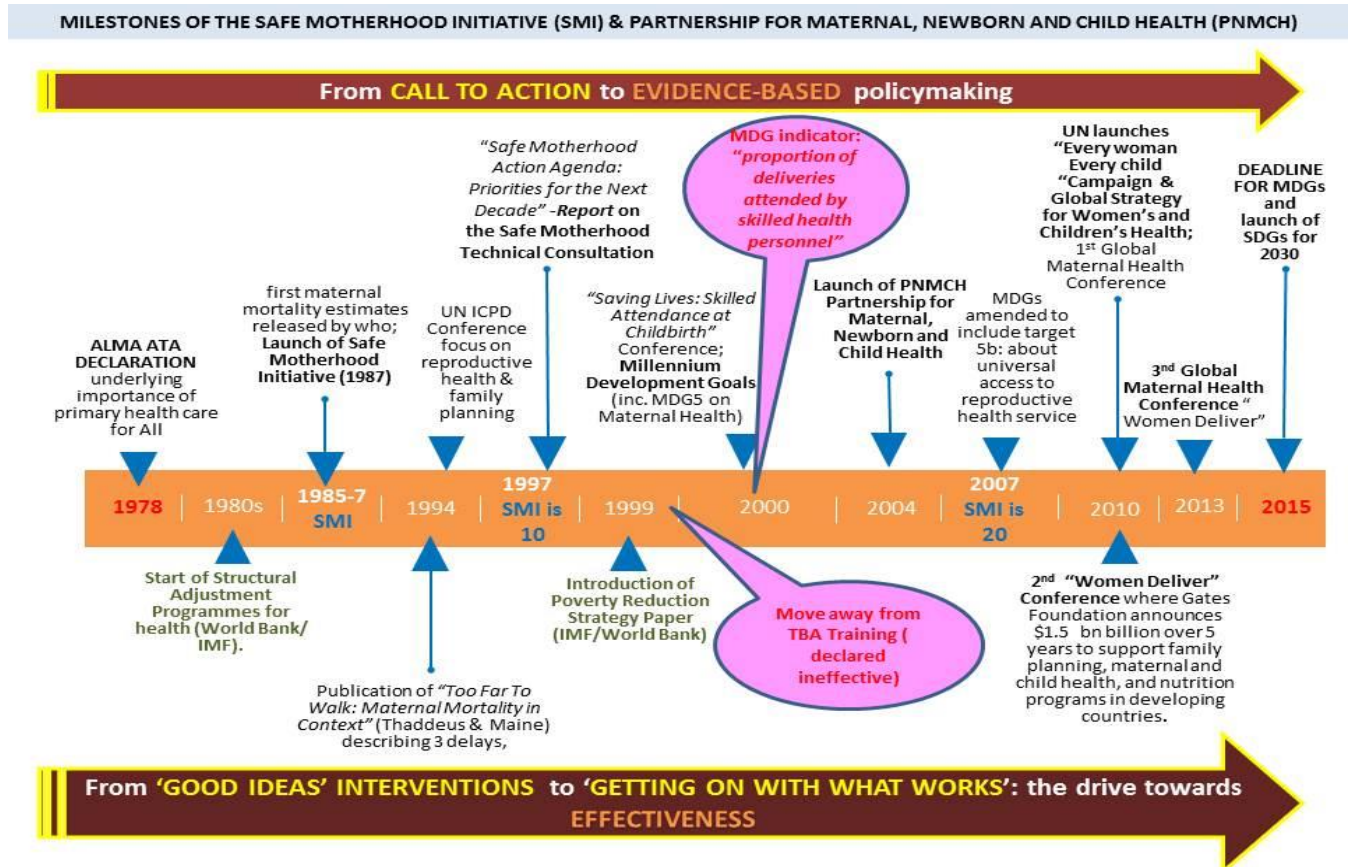


Figure 5. Milestones of the Safe Motherhood Initiative (SMI) & Partnership for Maternal, New-born and Child Health (PNMCH)

The next three sub-sections split the timeline in 3 sections: section 2.2.1, covering the lessons from the past which informed the launch of the SMI in 1987; section 2.2.2, which covers the period from 1987 to 2000 when the SMI transformed from an impassioned call to action to a global process of evidence-based policymaking for safe motherhood (Storeng, Behague 2014, Behague, Storeng 2007), expressed in the top arrow in the figure above; and section 2.2.3, which covers the period from 2001 to 2015, when the safe motherhood global policies became increasingly driven by preoccupations of effectiveness and focused on 'getting on with what works' (Campbell, Graham et al. 2006), namely strategies to promote skilled birth attendance for maternal mortality reduction. The 2 pink callout bubbles in the figure above

highlight the key decisions in the move from trained birth attendance (including TBAs) to skilled birth attendance (excluding TBAs), around the late 1990s, early 2000s.

2.2.1 Lessons from before the Safe Motherhood Initiative

It is generally accepted that maternal mortality (MM) is multi-factorial, and impacted upon by a number of social determinants (De Brouwere, Van Lerberghe 2001, Exworthy 2008). First MM is determined by the general social, political, economic, cultural and environmental conditions in which the people live. Secondly their socio-economic position (with regards to gender, social class, ethnicity or education), as well as their working conditions. Thirdly the people's living conditions also affect maternal health, their access to water, sanitation, sufficient food and appropriate housing (Exworthy 2008, WHO 2010). As a result, strategies to reduce MM are also likely to be multi-faceted, and to operate at once at government level, at facility level and downstream at community and individual levels. Previous to the launch of the SMI in 1987, strategies for maternal mortality reduction had focused on the determinants of maternal mortality reduction which can be broadly grouped under three main categories: *technical, political, and socio-economic determinants* (Koblinsky, Campbell et al. 1999, De Brouwere, Van Lerberghe 2001, Loudon 1992, Hogan, Foreman et al. 2010). All of those determinants, though particularly the technical and political, have an influence on policymaking. As defined by De Brouwere et al. (1998) the *political determinants* of maternal mortality reduction comprise of the level of awareness around the issue of maternal mortality (amongst policymakers) and of the political will to reduce it. This political will ensures health professionals are made accountable, it dictates the level of government investment in the health systems, and their long-term commitment- e.g. through legislation- to reduce inequalities and uphold human rights. The *technical determinants* of maternal mortality reduction include the evidence available on the number and causes of maternal deaths, the access to skilled attendants and professional obstetric care which can improve technical care, and whether services operating in functioning health systems (with functioning referral pathways). These are the determinants, as this Chapter will demonstrate, on which the SMI policies and strategies have prioritized since the late 1990s. The *socio-economic determinants* of maternal mortality reduction are harder to tackle by policy because they concern the broader context, such as the levels of poverty, or the standards of living of the population (Exworthy 2008).

Given the number of factors responsible for maternal mortality, it is difficult to credit significant reduction to one particular factor (Koblinsky, Campbell et al. 1999, De Brouwere, Van Lerberghe 2001, Loudon 1992, Hogan, Foreman et al. 2010). Accounts of past strategies to reduce maternal mortality-

mainly borrowed from the history of industrialised countries often cite a conjunction of favourable political contexts and improved socio-economic conditions, as the main positive factors in maternal mortality reduction (De Brouwere, Van Lerberghe 2001). However there is no complete consensus there, and other evidence argue that technical advances, and the improvement of the standards of obstetric care, were the significant factors in maternal mortality reduction after the 1930s (Tew 1998, De Brouwere, Van Lerberghe 2001). Obviously, correlations are hard to establish and drawing lessons from history can prove difficult. Nonetheless what those who launched the SMI drew from those historical accounts, was that maternal mortality reduction appeared best served by adopting policies of ‘professionalization of delivery care’ (Van Lerberghe, De Brouwere 2001, p.10).

What is meant here by the ‘*professionalization of delivery care*’ is the development of public policies promoting an increase in the number of deliveries by qualified birth attendants, and increased standards of obstetric care. Lessons seemed to show that, for instance, mortality reduced faster where the professionalization of delivery care was the quickest to be established, such as in Sweden⁸ (Van Lerberghe, De Brouwere 2001). Therefore for those looking back at history in 1987, the goal of halving maternal death by the year 2000, may have seemed plausible, since “the industrialised countries [had] faced this challenge in the past” and had overcome it (Mahler 1987,p.111). In fact increasing the proportion of deliveries by qualified birth attendants and increasing the availability and access to obstetric care was to become eventually the sole technical strategy focus for Safe Motherhood policies.

2.2.2 The Safe Motherhood initiative from 1987 to the 2000s: from call to action to evidence-based policymaking

The SMI call to action in 1987, inspired by the Alma Ata Declaration ten years previously was broad in focus: it aimed to address more than the technical determinants of maternal mortality reduction. It recommended “comprehensive, multi-sectoral approaches to tackling the social determinants of maternal mortality” (Storeng, Behague 2014, p.262). It was born out of the indignation caused by the realisation that half a million women worldwide were dying in childbirth every year (Starrs 2006), which seemed to those global policymakers an injustice. The Call had a strong feminist undercurrent and was underpinned by a belief that economic inequalities were affecting the health of the most vulnerable

⁸ They show it was fastest for example in Sweden because maternal mortality had been made a matter of public health sooner there but also because of the creation of a national midwives operating at community level (Högberg 2004). As a result in 1900, whilst the USA maternal mortality ratio (MMR) was still about 700, and in England & Wales around 450, much in line with the ratio many low income countries (LICs) today, in Sweden, it had already declined much further towards 250 (Högberg 2004, Loudon 2000).

in society. It was thus a rallying call to increase political and financial commitments for maternal mortality reduction. Though the SMI came from a relatively small coalition at first, it later grew to include more international non-governmental organisations, academics, and researchers. Like most global health coalitions of this nature, it aspired to use available evidence to advocate for particular interventions.

The rise of evidence-based policy gained ground in the late 1980s, with the publication of the first systematic reviews in health care, and the setting up of repositories such as the Cochrane Collaboration, where solid evidence could be stored, for health professionals and policy-makers to base interventions on. Those systematic reviews relied on quantitative scientific evidence, based on randomized control trials, and aimed to provide up-to-date, reliable, information (Chalmers 1993). Interestingly for this study, some key reviews of the effectiveness of TBA training which were later published (Sibley, Sipe et al. 2009) were published by Cochrane. Better evidence, better measurements and statistics in maternal health became key to advocating for effective strategies. This also coincided with a drive towards economic efficiency in health care, which became stronger from the 1980s, when the World Bank and the IMF introduced Structural Adjustment Programmes (SAPs⁹) for health. Overall, the global policy climate changed then to one where policymakers showed greater concern for cost-reduction and effectiveness (Storeng, Behague 2014). Effective strategies for maternal mortality reduction required better measurement of maternal deaths, which Graham and Campbell claimed, in their seminal article, had fallen victim of a ‘measurement trap’; by that they meant that maternal deaths thus far had not been properly measured and therefore largely neglected by policy (Graham, Campbell 1992). Later the WHO published the first Global Burden of Disease (GBD) data which quantified the health burden (in terms of deaths and disabilities by age and sex) of more than 100 diseases in all the world’s regions¹⁰. The 2004 GBD confirmed the low visibility of maternal deaths, the causes of which were lumped under the group of “communicable, maternal, perinatal and nutritional conditions” and which held the 12th place for

⁹ SAPs refer to loans set up in the 1980s by the World Bank and IMF – after the oil and economic crisis-which made access to loans for low-income countries conditional to certain adjustments in their economies or budgets. For example , lessening government controls and promoting free market economy. The WHO explains that “SAPs policies include currency devaluation, managed balance of payments, reduction of government services through public spending cuts/budget deficit cuts, reducing tax on high earners, reducing inflation, wage suppression, privatization, lower tariffs on imports and tighter monetary policy, increased free trade, cuts in social spending, and business deregulation. Governments are also encouraged or forced to reduce their role in the economy by privatizing state-owned industries, including the health sector, and opening up their economies to foreign competition” (Source: <http://www.who.int/trade/glossary/story084/en/>, accessed 03.02.2016)

¹⁰ The GBD project also introduced a new measurement– the disability-adjusted life-year (DALY) – as a single measure to quantify the burden of diseases, injuries and risk factors, which is based on years of life lost from premature death and years of life lived in less than full health (Source WHO website: http://www.who.int/healthinfo/global_burden_disease/about/en/)

leading causes of deaths for men and women worldwide (WHO. 2004). The GBD concept reinforced the idea that policies should focus on the diseases or conditions which accounted for the highest numbers of deaths, and that this was where most resources ought to be spent. With this kind of evidence, maternal mortality did not rank high, and the number of deaths deemed comparatively too low to justify focusing important resources on it (Shiffman 2007). The advent of the UN Millennium Development Goals in 2001 went some way into rectifying this, by making maternal mortality reduction one specific goal. However in doing so the MDG5 target further contributed to a focus on quantitative indicators against which progress could be measured. To achieve its goals, the SMI coalition had to learn, by 2000, to focus on effective, measurable solutions for maternal mortality reduction, in other words to play what Storeng and Behague call “the numbers game”. This meant to use “quantitative evidence to inform priority-setting and justify investments” (Storeng, Behague 2014,p.273). The now re-formed Partnership for Maternal, New-born and Child Health learned to compete with other large partnerships such as the Global Fund to Fight HIV-AIDS, who were gathering support for other GBDs. As Storeng and Behague express:

it is in part because of the growing sense of competition within the global health arena that, in the decades since the Nairobi conference, safe motherhood was strategically redefined (reluctantly by some) to refer to the more narrow and thus easier-to-advocate-for goal of reducing maternal mortality (Storeng, Behague 2014,p.263)

This goal they refer to is embodied in the single technical indicator chosen for MDG5: increasing the “*proportion of deliveries attended by skilled health personnel*” (MDG Indicator 5.2)¹¹. The next section shows how this shift to the promotion of skilled birth attendance occurred in the second period of the SMI, since 2000.

2.2.3 The evidence of ‘what works’ for maternal mortality reduction: the promotion of skilled attendance at birth since the 2000s

The previous section argued that lessons from the past had informed the SMI beginnings. These lessons continued to be used later on also, to explain the successes or failures by some LICs in reducing their own maternal mortality. Hogan et al. (2010), for example, conducted a systematic analysis of 181 countries and of their progress towards MDG5 between the years of 1980 and 2008. They highlighted the success in decreasing mortality in countries such as Indonesia, India, and Cambodia, where Governments opted to drastically augment the number of skilled birth attendants. Similar pleas for the

¹¹ <http://mdgs.un.org/unsd/mi/wiki/5-2-Proportion-of-births-attended-by-skilled-health-personnel.ashx>

scaling up of professional delivery care in LICs were made by Koblinsky et al in their article, based on the evidence from 40 different over the period from 1989 to 2003 (Koblinsky, Matthews et al. 2006). However one must be remain cautious in accepting at face value the correlation between increased skilled birth attendance and maternal mortality reduction. For instance, Scott and Ronsmans (2009), who reviewed literature relating numbers of births attended by a health professional and effects on maternal mortality, warn that “at the country level, there is a downward trend in maternal mortality with increasing proportions of births with a health professional but the nature or strength of this association is not clear “ (2009, p.1530). They ventured that a threshold of 40% of births attended by SBA may in fact need to be achieved, before a country can see a significant decline in its maternal mortality ratio.

The phrase ‘*skilled birth attendance*’ refers to the conjunction of a skilled birth attendant and an enabling environment where they can optimally function (usually an equipped hospital or health facility). This includes available drugs, transport for referrals, and accessible emergency obstetric care (Hussein, Clapham 2005, Adegoke, Van den Broek 2009). It is also sometimes used as a term to refer to overall policies promoting the training and increased deployment of SBAs (Graham, Bell et al. 2001). The phrase ‘skilled birth attendance’ was introduced in 1997 in the report on the Safe Motherhood Technical Consultation, which can be seen as a milestone on Figure 5. This consultation was a gathering of national and international organisations, policy-makers, and technical experts which took place to review the lessons from the first decade of the SMI and identify the most effective strategies for making motherhood safer. It sought to shift away from what Miller et al call the adoption of “good ideas” interventions (2003, p.10)- such as the training of TBAs- which had not demonstrated their effectiveness through scientific evidence, but had nonetheless been promoted in the past for large-scale implementation.

The 1997 report was structured around ten key action points, one of which recommended that “the single most critical intervention for safe motherhood is to ensure that a health worker with midwifery skills is present at every birth” (Starrs 1997, p.77). This message was reiterated at the 2000 “*Saving Lives: Skilled Attendance at Childbirth Conference*” in Tunis, which led to the adoption of the rate of skilled birth attendance as the main indicator for MDG5. Since then, the consensus has been that women are deemed to be the safest for their deliveries in health facilities and with an SBA. The main rationale for promoting institutional deliveries today is that since 27.7% of maternal deaths occur intrapartum/ immediately postpartum (Kassebaum, Bertozzi-Villa et al. 2014) or from complications at the time of

delivery (Berer, Sundari Ravindran 2000). Since most complications¹² are unpredictable, they are believed to best managed and accompanied by a SBA in a health facility setting. In their much cited article, *Strategies for reducing maternal mortality: getting on with what works*, Campbell and Graham (2006) surveyed all available strategies for maternal mortality reduction. They stated that although intrapartum strategies could in theory be delivered both in a facility or home setting (e.g. with the support of a SBA at home), “evidence shows that the best intrapartum-care strategy is likely to be one in which women routinely choose to deliver in a health centre, with midwives as the main providers” (Campbell, Graham et al. 2006, p.1291, emphasised).

The above sections have showed that the main shift, from the early policy development of the SMI to the 2000s, is towards a technocratic narrowing down on what can be measured (e.g. the proportion deliveries attended by SBAs) (Cross, Bell et al. 2010), and on strategies that have shown evidence they support maternal mortality reduction (e.g. skilled birth attendance). The focus on a single strategy (skilled birth attendance) at the exclusion of others because they are deemed ineffective is where the next section turns. It results from a shift occurring in 1997, away from ‘trained’ traditional birth attendants to promoting the use of ‘skilled’ birth attendants only for delivery. This part of the Chapter will show how, over the lifetime of the SMI, various policies and statements were also issued regarding the utilisation of TBAs. Gradually also, the biomedical knowledge in childbirth established itself as the authoritative knowledge. Understanding this shift and the power held by the biomedical authoritative knowledge in childbirth will enable the reader to understand the weight of the 2007 Policy Guidelines and TBA ban in Malawi.

2.3 Successive TBA policies through the Safe Motherhood Initiative

2.3.1 Defining and asserting authoritative knowledge in childbirth

¹² <http://www.cdc.gov/about/default.htm> . Maternal complications are defined by the Centre for Disease Control and Prevention (CDC) as events which “occur during pregnancy and can involve the mother's health, the baby's health, or both. Some women have health problems that arise during pregnancy, and other women have health problems before they become pregnant that could lead to complications”.

Research shows that women and their families rely on different sources of health knowledge - biomedical, traditional, embodied¹³ (Abrahams, Jewkes, and Mvo 2002; Cheyney 2008), and call on different practitioners, professional or lay, for their health needs (Banda 2013, Blaxter 2004, Helman 2007). This is particularly true in African countries where the ‘traditional’ and biomedical health systems have co-existed since colonisation and beyond (Vaughan 1991, MacLachlan 2006). Vaughan, in her seminal book *Curing their Ills: Colonial Power and African Illness*, explains how biomedical knowledge was introduced in Africa through the colonial encounter, and the assertion of power and control by colonisers (Vaughan 1991). Biomedical knowledge was introduced also as part of a modernisation agenda. Modernisation theory, part of the development theory framework, considered urbanisation, industrialisation, and advances in technologies (such as biomedical technologies) as emerging from and bringing progress to societies (Cornwall, Eade 2010). The idea of progress and dissociated traditional and modern perspectives, and in this theory, tradition was perceived as contrary to the modernisation necessary to bring development to societies (Scott 1996). This theory was particularly popular in the 1950s, and has been much contested since then, but key actors in government and donors have upheld ideas and assumptions in line with this theory, which has led to the displacement of indigenous forms of knowledge, such as that of traditional birth attendants (Xaba 2008), in favour of other ‘modern’ science-based sources of knowledge.

With regards to policies on safe motherhood presented previously, the process of modernisation has also manifested itself through the medicalisation of childbirth. Medicalisation is defined by Conrad as “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses and disorders” (Conrad 1992). Within this model, people are turned into patients, subordinated to medical authority, with little attention paid to their own lay or embodied health knowledge (Bury, Gabe 2004). It is through this medicalisation process that childbirth has been redefined in medical terms, and is now treated as a medical condition, to be dealt with in hospitals (Blaxter 2004). However, the medicalisation of childbirth is not solely the product of modernisation, it also took place because one form of knowledge (biomedical), took precedence over others (traditional, embodied), and became what is called the authoritative knowledge (Jordan 1997). Understanding the concept of authoritative knowledge (AK) is central to understanding the perceptions of TBAs and SBAs

¹³ Embodied knowledge in health refers to knowledge which is not distinctly explicit, conscious, mentally representative, or articulated. It is, however, well known by the body or through the body, when it is practiced, it is born of experience (Blaxter 2004).

knowledge in this study within the context of the 2007 Policy Guidelines and the delivery care options recommended.

The concept of **authoritative knowledge in childbirth** was defined by Brigitte Jordan, who studied birth in the 1980s and 1990s in a variety of settings. Some of those settings had low use of birth technologies (such as partograms), and some -like the USA- had a high use of technologies. Jordan aimed to discover how a dominant knowledge expressed and established itself around childbirth. Of course, conceiving of the biomedical system as a cultural system in itself was not entirely a new idea. Foucault in the 1970s wrote extensively about the authority of medicine, and explored the notion of control by certain authorities over the body (Foucault 1973). In *the Birth of the Clinic*, Foucault described how modern health facilities and teaching hospitals arose from a re-thinking of the basis of knowledge in the political, economic, and philosophical spheres, which led to new ways of thinking about disease and care for the sick. He introduced the notion of the ‘clinical gaze’ as an instrument of power and talked of the hospital as an examining mechanism where people could be surveyed and observed (Foucault 1973). Foucault also developed the theory that what could be construed as inherent ‘truths’ were actually constructed and supported by preponderant discourses, which made them appear so (Clews 2013).

Arguably Jordan followed on from Foucault’s work, applying it to birthing (Sargent, Bascope 1997). She observed that in hospitals and high-technology settings, biomedical knowledge had become the authoritative knowledge, whereas the knowledge of the woman herself had become discarded. What Jordan meant by ‘authoritative’ was not that this knowledge was right, but rather that it had authority, that it was the ‘knowledge that counts’ (Jordan 1997), on which decisions were made. She (1997) stated that:

for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both. In many situations, equally legitimate parallel knowledge systems exist and people move easily between them ... But frequently, one kind of knowledge gains ascendance and legitimacy [leading to] the devaluation, often the dismissal, of all other kinds of knowing (Jordan 1997, p.56)

There are indeed a number of ways in which the biomedical knowledge of childbirth has supplanted the traditional knowledge of TBAS in childbirth. Arguably, as I will later on argue, the authoritative knowledge in childbirth drew power from its locus (hospital) and the use of its artefacts (technologies

such as testing machines, labs), as well as from the biomedical knowledge of SBAs. The move towards promoting the use of skilled attendants at birth and the move towards institutional deliveries have in fact happened concurrently. This is often for reasons which are linked to safety and efficacy (Clews 2013), since it is where complicated deliveries can be attended by professionals who have the necessary know-how, and also where a larger number of women can be hosted at once (Tew 1998). Over the timeline of the SMI presented earlier in Figure 5, policymakers have reinforced the message that births in hospital are safer, and have used large media campaigns to do so (Tew 1998). Interventions such as caesarean sections can also only be delivered in hospitals, by the professionals able to operate the technology. Because authoritative knowledge is maintained not simply by those who promote and reproduce it (SBAs, policymakers), but also by women themselves, who believe they depend on SBAs for their safe deliveries (Dietsch, Mulimbalimba-Masururu 2011b). Thus women have come to believe in the superior knowledge of doctors, and the symbolic safety of hospital births. As Jordan puts it, AK is “persuasive, because it seems natural, reasonable, and consensually constructed...people not only accept authoritative knowledge (which is thereby validated and reinforced) but also are actively and unselfconsciously engaged in its routine production and reproduction” (Jordan 1997, p.57). Today, the ‘technological’ model of birthing, biomedically managed, quite naturally seems the safest when placed against the potential risks of childbirth outside the system, as presented by statistics, and media campaigns. Birth and birthing have become increasingly underpinned by a discourse of risk (Coxon, Sandal et al. 2014, Smith, Devane et al. 2012), a risk which is perceived and presented as best mitigated by professionals, in adequately equipped facilities.

The **discourse of risk in childbirth** contributes to asserting the authoritative knowledge. Although thinking of birth as risky is not a new phenomenon brought on by the ‘risk society’¹⁴, in fact pregnancy and childbirth have always been fraught with danger, and framed as such (Towler, Bramall 1986, Loudon 2000, Hallgrimsdottir, Benner 2014). It is telling that in Malawi, for instance, the Chichewa phrase for a woman being pregnant is “*ali ndi pakati*” which literally means that she is “*between life and death*”. However Giddens, in his seminal article on risk (1999), offered a useful distinction between the notions of danger and risk which are relevant to understand how authoritative knowledge in childbirth is presented as the solution to avert risk. Giddens explained that hazard and danger are notions pre-dating modern society, whereas risk is a notion which emerged in modern Western society. Risk, as defined by

¹⁴ The British sociologist Anthony Giddens defines a risk society as “a society increasingly preoccupied with the future (and also with safety), which generates the notion of risk” (Giddens 1999)

Giddens is defined as a preoccupation with the future, the probability of adverse occurrences. Risk is perceived as such despite the fact that there may or may not be dangers present. The concept of risk is intertwined with the notion of modernity and progress, and as Giddens states “is bound up with the aspiration to control and particularly with the idea of controlling the future” (1999, p.3). On the other hand danger is a notion issued from pre-modern societies, where it referred to the threat of unpredictable events, to be managed as and when they arose. As Giddens stated “dangers are experienced as given. Either they come from God, or they come simply from a world which one takes for granted” (1999, p.3). What has changed however over time, is that notion of danger has been replaced by what Chadwick and Foster aptly describe as a “technico-scientific model of risk, emphasising expert and evidence-based knowledge, prediction and control” (Chadwick, Foster 2014,p.70, emphasised). What this has meant for birthing is that the biomedical management of childbirth by SBAs is presented as the best way to avert risks in delivery. Moreover risk categorisations in pregnancy (such as labelling pregnancies high or low-risk), as well as the dissemination of risk information (e.g. statistics on how much more risky pregnancy is for older women), have become universally applied and disseminated. Davis-Floyd and Davis (1997) have shown, for instance, how the reliance on technology in labour, to carry out diagnostic tests in order to avoid risks, works to reinforce the authoritative knowledge. They argue that on the one hand it gives skilled birth attendants confidence that they know what is happening at each stage of pregnancy or labour (with tests, measurements and checklists), and that they are able to control the outcomes of a birth (as far as possible). On the other hand, technology and monitoring can make women themselves feel safer when facing the unknown, as if “a reassuring cultural order is imposed on the otherwise frightening and potentially out-of-control chaos of nature” that birth represents (Davis-Floyd, Davis 1997, p.316). Yet, there is a lack of understanding of how childbirth risks are perceived by childbearing women themselves (Smith, Devane et al. 2012, Rööst, Johnsdotter et al. 2004), as compared to professionals’. This study will offer one such distinct perception of risk and how it links with the implementation of the 2007 Policy Guidelines and in part with how women weigh their options for delivery care.

As a result of the establishment of the biomedical authoritative knowledge in childbirth as a likely risk mitigator, the hospital has come to hold symbolic safety, both in low-income and high-income countries. Even in poorly resourced environments, women view the hospital as the safest place to give birth, and the SBA as the one who can deal with any complication which may arise. As Sargent and Bascope explain:

While women recognize that many hospital births are unattended and technology unavailable, they nonetheless defer to the superior competence of hospital personnel and the symbolic safety of the hospital itself. Nurse-midwives and doctors retain a monopoly on authoritative knowledge, even in the absence of supplies, equipment, and medicines- the “artefacts” of birth (Sargent, Bascope 1997, p.204)

This is in spite of evidence asserting the contrary and in spite of women’s own prior negative experiences of institutional deliveries. For instance, a recent meta-analysis of perinatal and maternal mortality in Sub-Saharan Africa (SSA), shows that women attending at health facilities sometimes have an increased risk of dying during delivery at the facility, compared to home (Chinkhumba, De Allegri et al. 2014). Although this likely results from the fact that, in some contexts, women do reach hospitals late in their labour, already suffering from severe complications. A health facility delivery in itself –though it may make one feel safer- does not guarantee safety, especially in LICs where the enabling environment is not necessarily present (e.g. where there are few staff or drug shortages or unavailable referral systems). It may be the case that in some contexts, being assisted in an uncomplicated birth by a traditional birth attendant is safer than awaiting to be assisted by a skilled birth attendant late in labour, in an overcrowded ward. The difficulty however, is that the dominance of the biomedical authoritative knowledge has rendered this alternative impossible, because it has led to the devaluation and rejection of other available forms of childbirth knowledge.

2.3.2 Promoting skilled versus trained birth attendance

Whilst the above showed that AK in childbirth is asserted though its locus (hospital), and reinforced by a discourse of risk, the section below shows how it is also held and promoted by skilled birth attendants (SBAs), at the expense of TBAs and their alternative form of knowledge . Historically, there have always been tensions between different types of birth attendants even in HICs (Tew 1998, Towler, Bramall 1986, De Brouwere, Van Lerberghe 2001). The progressive medicalisation of childbirth in the industrialised world is often portrayed, for instance, as a process of masculinization of childbirth, where male doctors and obstetricians progressively took over the event of childbirth from female attendants (Towler, Bramall 1986, Marland, Rafferty 1997). However, arguably the battle was not just between male and female attendants, but also between more and less skilled attendants- e.g. doctors vs midwives, or registered midwives vs lay midwives-, with the former keen to establish their authoritative knowledge (Towler, Bramall 1986, Fahy 2007). The same happened over the timeline of the SMI, and there have been tensions as well as collaborations between SBAs and TBAs over time. As this study is concerned

with a Policy which radically changed the roles of TBAs in delivery care, the below section provides a framework to understand how TBAs have been conceptualised and instrumentalised in the past to serve the goals of safe motherhood (Pigg 1995, Pigg 1997b). In order to show how global SMI coincided with major statements about the utilisation of TBAs, those are juxtaposed in Figure 6 below.

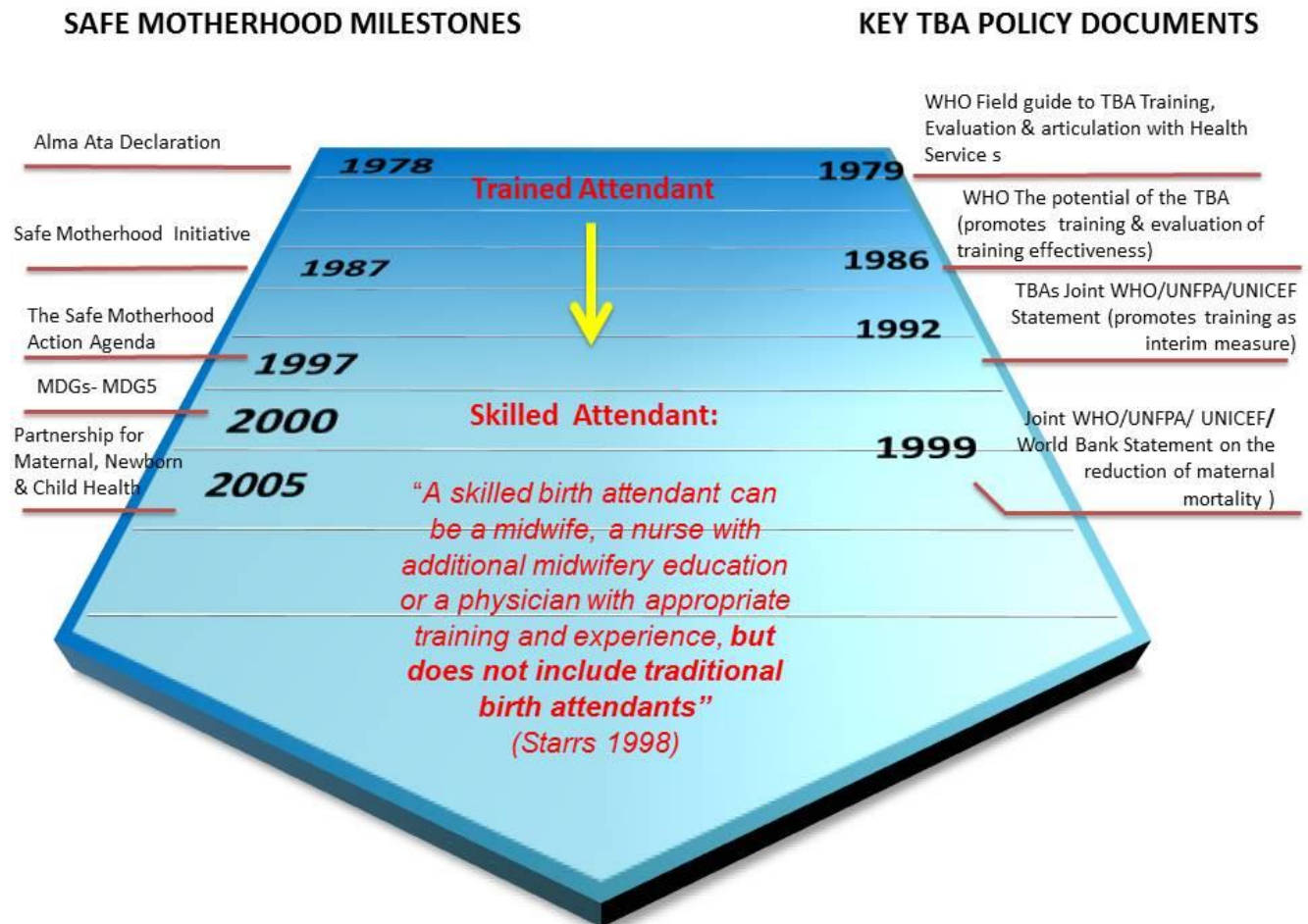


Figure 6. Key SMI milestones juxtaposed with key TBA policy documents issued by WHO

Going from top to bottom, the figure starts in 1978 with the Declaration of Alma Ata (WHO 1978) which coincided with the 1979 *Field Guide to TBA training* (WHO 1979) . As explained previously, the focus of the Alma Ata was to extend affordable primary health care to all, through community participation and the use of already available resources, such as that of TBAs. (Lawn, Rohde et al. 2008, Rosato, Laverack et al. 2008). In the particular case of TBAs this was to be done through training, which

was then seen as a low-cost, seemingly culturally adequate, way of bridging the gap for underserved communities. The WHO defined in many ways who the ‘useful’ TBAs were:

Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community...It is therefore well worthwhile exploring the possibilities of engaging them in primary health care and of training them accordingly” (WHO cited in Pigg 1997a, p.261)

In reality the practices and contexts where TBAs operated worldwide varied vastly the acronym of TBA. TBAs were people known locally by other local names rather than as TBAs (e.g. *dai* in India, *partera* in Mexico, or *mzimba* in Malawi). Most were female, but some (e.g.in Senegal) were also male (Wendland 2015). Yet giving these local attendants an acronym helped build what Pigg calls a “coherent model of the traditional” (Pigg 1997b, p.239), and of traditional knowledge in childbirth, a standardized form of traditional knowledge which could be placed in contrast to the standardized biomedical knowledge. By using those available human resources, development operators simultaneously showed a respect for traditional culture, whilst at the same time embedding new forms of biomedical authoritative knowledge into communities, through training TBAs is the more ‘modern’ knowledge. After all, practically, it made sense to use TBAs since it was estimated they were already attending “60% to 80% of all births” worldwide (Pigg 1997a, p.261). The 1979 WHO definition of the TBA is the one that remains today, that of “a person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other traditional birth attendants” (WHO 1979, p.7) . It served to identify the type of community member who could be put through training. The goal of such training was:

ensuring that, within the TBA as a person, modern and traditional concepts and modes of practices are so integrated as to eliminate only traditional practices and rituals that are clearly shown to be harmful, and to instil only modern concepts and techniques that are absolutely essential to the safety of the persons under the care of the TBA (WHO 1979, p.8)

Although the quote above acknowledges that not all the traditional practices of TBAs were viewed as harmful, it shows also that training them was part of modernisation project, a way to replace some traditional knowledge and practices by safer practices derived from the biomedical authoritative knowledge. Generally speaking, the training of TBAs was short lasting from a week to a few months depending on programmes. It consisted of basic instruction on safe and clean delivery, on the danger signs of pregnancies and on the referral of complications, as well as on basic postpartum and neonatal

care, nutrition, family planning and sometimes record keeping (Sibley, Sipe et al. 2004a, Kamal 1998, Prendiville 1998, Conway-Turner 1997, Bergstrom, Goodburn 2001, Wendland 2015).

After a decade of large-scale TBA training worldwide, the WHO issued a new policy document in 1986 (see Figure 6). This document was more in line with the evolving international context of the SMI presented earlier in this Chapter, and concerned somewhat with the cost, practicalities and effectiveness of training TBAs:

The training of the traditional birth attendant is an example of the daunting problems encountered in attempts to change long-established customs amongst the poor in developing countries...Evidence in support of the training and utilisation of traditional birth attendants is still very limited...A common reason why progress has not been faster is simply the logistic difficulty of mounting a large-scale programme for the training and deployment of such attendants.(Maglacas, Simons 1986)

The generic concept of the TBA remained the same and the goal of their training mostly unchanged (Lartson 1987, Larsen, Msane et al. 1983, Leedam 1985). By then, TBAs were being trained all over the world. As Sibley and Sipe explained, whereas only 20% of countries in the early 1970s had had TBA training programmes, by 2000 they could be found in 85% of developing countries (2006). However by the late 1980s concerns about the TBA training effectiveness were being raised.

The 1992 Traditional Birth Attendants WHO/ UNFPA/ UNICEF Joint Statement (1992) is the next important document placed on Figure 6. It was recognised after nearly two decades of large-scale TBA training programmes that there was a diversity of TBAs on the ground. The statement opened with a set of distinct definitions for TBA, family TBA and trained TBA (TTBA)¹⁵. Not surprisingly, a higher value was placed on the TTBA, who was seen to have been upskilled by their training. However by then, even being a TTBA, was no longer going to be enough, as the era of promoting skilled birth attendance to reduce maternal mortality dawned. To relate this to section 2.2 The 1997 Safe Motherhood Technical Consultation stated: "there is no documented case of a society relying heavily on TBAs – trained or untrained - to attend deliveries, that has succeeded in lowering its maternal mortality" (Starrs 1997,p.30). The 1999 *Joint WHO/UNFPA/ UNICEF/ World Bank Statement on the reduction of maternal mortality* that followed, made the shift from trained to skilled –or TBA to SBA- very clear:

¹⁵ The TBA is defined in the document exactly as in the 1979 field guide, the family TBA as a TBA chosen by a family to attend to births within that family, and the trained TBA as a TBA or family TBA who has undergone training to “upgrade her skills”; the statement goes as far as saying :” a family TBA may deliver up to 24 babies in a year although 5 or 6 is more usual.. Non family TBAs can deliver between 2 and 20 per year , although some renowned TBAs may attend up to 120” (WHO 1992,p.4-5).

The term “skilled attendant” refers exclusively to people with midwifery skills (for example, doctors, midwives, nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications... In many countries, TBAs have received training in order to promote safer birth practices, including clean delivery and avoidance of harmful practices. However, to fulfil all the requirements for management of normal pregnancies and births and for identification and management or referral of complications, the education, training, and skills of TBAs are insufficient (WHO 1999, p.31, emphasised).

The change of WHO semantics from ‘trained’ to ‘skilled’ represented on Figure 6 is important to this study which conducted interviews with TBAs, TTBAs and SBAs. The shift represents the superiority of the skilled biomedical authoritative knowledge in childbirth over the competing but ‘traditional’ knowledge. By the 2000’s evidence was now emerging which suggested that TBA training- once considered a “good idea” (Miller, Sloan et al. 2003)- was deemed ineffective for maternal mortality reduction. Although skilled birth attendants were from then on to hold superiority, it is important to note here, that more recently some doubt has also been cast on their level of skills and proficiency. Indeed, some alarming variations in competence between SBAs across countries have been highlighted, not least in Malawi (Bayley, Colbourn et al. 2013, Campbell, Calvert et al. 2016, Thorsen, Meguid et al. 2014). One recent study conducted in Malawi, which reviewed the components contributing to 14 maternal deaths occurring at facilities in the district of Lilongwe cited as one of the main components failing SBAs skills comprising of “inadequate clinical workups and monitoring, missed and incorrect diagnoses, delayed or incorrect treatment, delayed referrals and transfers, patients not being stabilized before being referred and outright negligence” (Thorsen, Meguid et al. 2014, p.22). Some have been calling for a competency-based type of training for SBAs (Adegoke, Broek 2009, Harvey, Blandón et al. 2007, Carlough, McCall 2005) as the quality of some of their training today is in question much like TBAs was in the late 1990s. Although the key WHO documents of the period (WHO 1999, Starrs 1997) asserted the ineffectiveness of TBA training for maternal mortality reduction, they did not at the time quote particular evidence. The era of evidence-based policy making was only in its infancy at that point, but solid evidence was to emerge in the early 2000s, which then acted as a justification for stopping the large-scale training of TBAs.

A close look at the literature evaluating TBA training effectiveness shows that the evidence was never completely categorical. Sibley and colleagues, who have written extensively since 2004 on various impacts of TBA training, are regularly quoted as evidence of the TBA training ineffectiveness (Sibley, Sipe et al. 2004a, Sibley, Sipe et al. 2009, Sibley, Sipe 2006, Sibley, Sipe 2004, Sibley, Sipe et al. 2012). Their latest review, a meta-analysis of studies showed positive impact on neonatal mortality but

“ambiguous” impact on maternal mortality (Sibley, Sipe et al. 2012), the authors added that it was not possible to attribute causality given the incomplete or the poor quality of reporting in the studies synthesised. This is demonstrated in the table below which summarises the findings of their reviews.

Table 1. Evidence from Sibley et al regarding the ineffectiveness of TBA training

Outcomes expected from TBA training	Impact of TBA training
<p>Positive pregnancy outcomes</p> <p>(e.g. impact on maternal or neonatal mortality)</p>	<p>In 2012, Sibley, Sipe et al updated their previous Cochrane review (Sibley, Sipe et al. 2009). and stated the following results:</p> <p>3.3 Trained TBAs versus untrained TBAs:</p> <ul style="list-style-type: none"> • Significantly lower rates of stillbirths, neonatal and perinatal death in the trained TBAs group. • One study reported lower maternal mortality (not statistically significant) and a statistically significant reduction in pre- and post-partum haemorrhage, puerperal sepsis and referral to any health care facility for any complication in the intervention group. <p>3.4 Additionally trained TBAs versus trained TBAs:</p> <ul style="list-style-type: none"> • No significant difference in perinatal and late neonatal death rates between groups. • Meta-analysis on stillbirth and early neonatal death did not find any significant difference (Sibley, Sipe et al. 2012)
<p>Uptake of antenatal care</p>	<p>Authors reiterated they could not prove a causal link but concluded there seemed to be a positive impact of the training (Sibley, Sipe et al. 2004b)</p> <p>Another of their study cited “small but significant increases” in the uptake of antenatal care by women (Sibley, Sipe 2006, p.474)</p>
<p>Referral of women with complications for skilled birth attendance</p>	<p>The authors concluded that there was “a medium, positive, non-significant association between training and TBA knowledge of risk factors and conditions requiring referral with small, positive, significant associations between TBA referral behaviour and maternal compliance and service use” (Sibley, Sipe et al. 2004a, p.1767)</p>

Indeed the direct impact of TBA training on maternal mortality reduction is difficult to establish, given how little is known of the training components of each programme, and given how poorly such programmes are reported on. Yet some studies have, since then, found positive outcomes of TBA training, for instance, on the uptake of antenatal care by women and on their use of facilities and obstetric care for delivery (World Bank 2003, Hussein, Mpembeni 2005, Byrne, Morgan 2011, Rowen,

Prata et al. 2011, Bulterys, Fowler et al. 2001, Abodunrin, Akande et al. 2010) Other studies have reported positive impacts on the prevention of postpartum fever and postpartum haemorrhage (Smith, Coleman et al. 2000, Prata, Quaiyum et al. 2012), and even on perinatal mortality (Jokhio, Winter et al. 2005). However a number of studies have found TBA training mostly ineffective in addressing delivery complications and Maternal mortality reduction (Kamal 1998, Prendiville 1998, Goodburn, Chowdhury et al. 2000, Smith, Coleman et al. 2000, Bergstrom, Goodburn 2001, Bailey, Szászdi et al. 2002, Gloyd, Floriano et al. 2001). Nonetheless, what transpires from the literature is that the low impact on maternal mortality reduction attained by training TBAs does not necessarily mean there is no impact on other maternal health outcomes. This warrants a reflection on why, if that is the case, the training and utilisation of TBAs was rejected wholesale, which is what the next section discusses.

2.3.5 Revisiting the perceived ineffectiveness of TBA training

The first major reason cited for the failure of TBAs training links to the authoritative biomedical view that practice “conditioned by strong cultural and traditional norms” cannot be changed (WHO 1999, p.31). In other words, training TBAs failed to transform them into the ‘modern’ practitioners it was felt once they had the potential to be. Evidence showed that even though they had learnt in their short training about conducting safer and cleaner deliveries, they were also keeping with traditional practices (giving herbal remedies, advising against eating certain foods in pregnancy); this inability to leave the ‘old ways’ behind was attributed by the detractors of TBA training to their illiteracy, and the fact that they were usually older women whose traditional beliefs were deep-rooted and immutable (Prendiville 1998, Anderson, Anderson et al. 2004, Vyagusa, Mubyazi et al. 2013, Mboho, Eyo et al. 2012). Yet on the other hand, it has been argued that the reasons for which the training was not fully assimilated by TBAs was that it was often based on Western ways of teaching and not necessarily conducted in the TBAs own language; Often, it disregarded their traditional cultural beliefs and empirical ways of knowing about birth (Pigg 1997b, Mathole, Lindmark et al. 2005, Saravanan, Turrell et al. 2012). Some recent studies, however, have demonstrated that despite being illiterate, trained TBAs can learn new skills, for example in support of the prevention of mother to child transmission (PMTCT) or post-partum haemorrhage (PPH) (Mchunu, Bhengu 2004, de Vaate, Coleman et al. 2002, Hamela, Kabondo et al. 2014).

By contrast, the most likely reason this study advances for the fact that TBA training was deemed a failure is that, over the lifetime of the SMI, the ‘goal post’ of TBA training changed. In the 1970s and 80s the goal of TBAs training was to help them perform their duties in a safer way (by eliminating harmful practices). They were to be supervised by SBAs to ensure their training was effective. The intention was not an integration of the TBA into the formal system, rather an articulation with it. By the 1990s, the training of TBAs had become a strategy “to bridge the gap until all women and children have access to acceptable, professional, modern health care services” (WHO 1992, p.2) in LICs. They were meant to perform certain tasks only (e.g. clean deliveries and post-natal care), educate their communities by “dispelling ignorance, decreasing harmful practices” (WHO 1992, p.16),. They were also asked to urge and refer women to attend at facilities. Soon however, it was acknowledged that there were limitations to their training efficiency, not only owing to their own traditional ways, but also to their lack of resources for conducting safe deliveries such as delivery kits, or hygienic labour rooms (WHO 1992, p.14). This WHO statement was realistic about the co-existence of different types of childbirth knowledges and about the fact that women would continue to use both TBAs and SBAs. But it dispelled notions that any integration of TBA into the health system was possible. Instead it promoted the idea of a link with the formal health system, confident in stating that “it is envisaged that the utilisation of TBAs will diminish as the goal of safe motherhood is approached” (WHO 1992, p.17). This is clearly what happened, particularly as the shift to promoting skilled birth attendance in the 2000s, which mostly excluded TBAs from the active management of births.

Ultimately too much was asked of the trained TBA in pursuit of the SMI goal of reducing maternal mortality in the early days. Ultimately, TBAs lacked the enabling environment to do the work that was asked of them. They did not always have infrastructures available to enable referrals (ambulances, radios) of women with complications, or even means to link with those (e.g. phone). This only became worse as their large-scale training was halted in a lot of countries in the early 2000s. After this, TBAs were no longer provided with safe delivery kits¹⁶, which once again made clean safe deliveries nearly impossible. This absence of an enabling environment seen as so essential to the success of skilled birth attendants in reducing maternal mortality, was lacking for the TBAs, who were now facing an impossible task, and doomed to failure (Kamal 1998, Prendiville 1998, Eades, Brace et al. 1993, Rozario 1995, Wendland 2015). In a sense their limited training and lack of resources conspired against them.

¹⁶ Those pre-assembled kits usually contained: a razor blade for cutting the baby’s umbilical cord, some soap, clean cord ties, a plastic sheet to deliver a mother on, and some pictorial instructions about complications or such (Path-Program for Appropriate Technology in Health 2001).

Goodburn et al's study (2000), who investigated the impact of a "three cleans"¹⁷ TBA training programme on reducing postpartum infection in Bangladesh exemplify this starkly. They concluded that the training was ineffective not just because TBAs could not put this training into practice, but also because women came to attend at TBAs with already pre-existing infections that could not be treated, and because deliveries in unhygienic environments promoted transmission of infections and diseases. Similarly, Pigg, who has written extensively on the training of TBAs in Nepal, revealed fundamental flaws in their training. For instance, she explained that TBAs interpreted the washing of hands in a different way than that the trainers intended (eg they failed to re-wash hands between tasks when handling labouring women). Moreover, whereas for the SBA trainers who had trained them, and who worked in a hospital environment, the washing of hands may have seemed like a simple enough act, it was not easy to operationalise for TBAs who had no clean hot water in their house (Pigg 1997b). These two examples show plainly, how difficult it may have been for some TBAs to put their new training into practice, even if they were able to set aside their own beliefs and cultural practices.

Even though since 2000, support for the large scale training of TBAs has all but dwindled, TBAs continue to be trained in small scale programmes in some countries such as Bangladesh, Kenya, Nigeria, Ethiopia (Tomedi, Stroud et al. 2015, Rowen, Prata et al. 2011, Abodunrin, Akande et al. 2010, Yousuf, Mulatu et al. 2010). One factor which has been cited in recent literature as a factor which can make TBA training effective and successful, is that of establishing a linkage between TBAs and health system staff. Banda's (2013) recent PhD thesis on perceptions of the changed roles of TBAs in Malawi shows that their training partly failed because of their lack of supervision and support by SBAs, who only tended to visit them when deliveries had gone wrong in their compounds. She explained that TBAs were therefore "left to operate without any meaningful support from the formal health care system and felt detached, unappreciated and unrecognized" (Banda 2013, p.172). By contrast, a number of studies of late-particularly from Africa-have have showed that continuous re-training of TBAs (e.g. refresher courses), added to regular support and collaboration with SBAs can make a difference (Abodunrin, Akande et al. 2010, Keri, Kaye et al. 2010, Temesgen, Umer et al. 2012). Such collaboration fosters the building of mutual trust and good communications (Yeboah-Antwi, Hamer et al. 2014) and can yield positive outcomes such as: more timely referrals of women with complications to facilities (Abodunrin, Akande et al. 2010, Keri, Kaye et al. 2010, Yousuf, Mulatu et al. 2010), increases in skilled birth attendance

¹⁷ The term 'three cleans' refers to a training which emphasises: hand-washing with soap prior to delivery, clean cord care and cutting and promotes the use of clean surfaces for delivery.

coverage (Byrne, Morgan 2011), enhanced provision of advice, and better post-natal care (Yousuf, Mulatu et al. 2010, Yeboah-Antwi, Hamer et al. 2014). Even in countries like Malawi where the TBA policy has been radically changed in 2007 positive outcomes have been recorded from some isolated, privately funded, training of TBAs (Chen, Wang et al. 2011). This recent evidence points to the fact that TBAs could still have a role to play in supporting the goals of Safe Motherhood, and this study will discuss this further in section 9.6. This is possibly particularly important in settings such as Malawi where there is still a shortage of SBAs and of EmOC facilities, and where many rural women are still out of reach of the formal health system.

Since the SMI made skilled birth attendance its focus in the 1990s, great progress has undoubtedly been made: the global ratio of skilled birth attendance has increased from 59% in 1990 to 71% in 2014, and the maternal mortality ratio has declined by 45% worldwide (UN Inter-Agency and Expert Group on MDG Indicators 2015). However 29% of births still remained unattended by a SBA, or at all, and a large number of those do take place in Africa in remote rural communities (2015). This points to an important gap in provision and calls for further linkages between community-based provision of maternal health care and health systems, for better CoC. Since the late 2000s, there has been a renewed interest in community-based interventions, and there is a view that the gap could be filled by shifting tasks to community health worker (CHW), which the next section discusses.

2.3.6 If not TBAs, then who?

The TBA policies presented above signal that community-based human resources have been seen in the past as ‘stop-gap’ solutions in the pursuit of skilled birth attendance for all. In the late 2000s, the slow progress towards achieving the MDG targets, and the realisation that, for weaker health systems, the delivery of primary health care for all may still be still a long way off, sparked a revisiting of the Alma-Ata ideals. The notion of close-to-community (CTC) service provision was developed and the “*Ouagadougou Declaration on primary health care and health systems in Africa: Achieving better health for Africa in the new millennium*” reaffirmed the principles of Alma Ata (African Health Observatory, WHO 2008). In the same year *The Lancet* published a series of papers under the title *Alma-Ata: Rebirth and revision*, with a number of papers focused on maternal and child health. Those papers called for fostering further linkages between community and health system to support the continuum of care (Lawn, Rohde et al. 2008, Bhutta, Samana et al. 2008, Rosato, Laverack et al. 2008).

This was to be encouraged by community-level participation in maternal health, in all its forms. There was a renewed realisation that certain care services may have to be brought to the most remote populations, rather than be delivered at facilities. And with this realisation, there were renewed calls for ‘task-shifting’, a policy which addresses shortages of health personnel by reallocating particular tasks usually delivered by higher qualified health workers to less qualified-or community-based- health workers in order to make the delivery of services more efficient (Lassi, Das et al. 2014). Task-shifting is practiced in both high and low income countries. In Asia and Africa, a number of the neonatal and maternal health care tasks shifted have been shifted in the last decade to CHWs, who have, in some ways, replaced TBAs.

National **community health worker** programmes have existed since the 1970s, in the same way as TBA programmes. However it is important to mention that TBAs have not usually been considered CHW (Lehmann, Sanders 2007). The idea behind expanding CHW programmes was to enable primary health care to be delivered by lower cadre health workers in the community they originated from, and who understood the needs and culture of such communities. Like the TBAs in the past, they have been seen as a link between community and the formal health sector (Lehmann, Sanders 2007). Most have had a few years of schooling, although some have none; they are supposedly recruited by their community and accountable to it, whilst being supported at the same time, by the health system (Lehmann, Sanders 2007). The Global Health Workforce Alliance systematic review of 266 studies regarding CHWs, shows their role to have been wide-ranging in the past, covering “some aspects of maternal health care, although not usually conducting of deliveries, but rather promoting antenatal, intrapartum and postnatal care, initiation of early and exclusive breastfeeding... and growth monitoring of children” (2010, p.27). Singh and Sachs claim that CHWs “are now viewed as an integral and formal part of the health system, with reporting lines, training, supervision, and feedback” (Singh, Sachs 2013, p.363). Perhaps this is the element which distinguishes the scaling up of CHWs programmes today from that of TBA training programmes in the past. CHWs are now fully integrated into the health system and sometimes receive Government payment, and are enabled, with access to drugs and technologies for referrals. In fact, in Sub-Saharan Africa, a campaign has been established to recruit, train and deploy one million CHWs to become part of the health system (Singh, Sachs 2013). Nonetheless, the main difficulty with replacing TBAs with CHWs is that those are not usually involved in delivering babies in their community, which is what TBAs did. This therefore still leaves an important gap in the provision of maternal health care at community level.

In order to help bridge that gap and to encourage institutional deliveries, a new kind of community-based intervention has thus been brought to the fore: that of **women's groups for safe motherhood**. Their role is to encourage community actors- principally women- to meet and regularly discuss maternal health issues which need to be addressed in their communities. Ideally they also are meant to help educate women about pregnancy risks and about the need to seek skilled birth attendance. Those programmes are relatively new, but their success-particularly with regards to decreases in neonatal mortality- and cost-effectiveness has been shown in studies in Bangladesh, Nepal, India and Malawi (Prost, Colbourn et al. 2013). Incidentally, the most relevant and comprehensive studies on the impact of women's groups mobilisation to improve maternal health outcomes are from Malawi (Rosato 2012, Colbourn, Nambiar et al. 2013).

The benefits highlighted by such interventions are that women's groups mobilise those most concerned with issues of maternal health, and foster their involvement in finding solutions to those (Rosato 2012). One such intervention was The Maikhandanda Programme (2007-10) in Malawi, the largest community mobilisation programme for maternal health of at the time in Africa. It juxtaposed two large-scale interventions: one with 729 participatory action women's groups (set across 879 communities in three districts of Central Malawi), and the other a programme to improve the quality of obstetric care in nine hospitals and 29 health centres in the same areas (Colbourn, Nambiar et al. 2013). It estimated as a result a 30% reduction in maternal mortality in the areas (Colbourn, Nambiar et al. 2013). Its authors stated in their report's conclusion that:

the evaluation makes an important contribution to the debate about whether the greatest reductions in maternal and new born mortality in low income countries can be achieved by educating and empowering communities, or by improving healthcare systems. The evidence clearly points to an answer that, by simultaneously doing both, and addressing the linkages between them, more can be achieved (Colbourn, Nambiar et al. 2013, p.3, emphasised)

This type of intervention makes clear the importance of linking health system provisions with communities and securing community members' involvement (Colbourn, Nambiar et al. 2013, Dynes, Buffington et al. 2013, Fehling, Nelson et al. 2013). However, women groups- like the task-shifting onto CHWs- do not offer a direct solution to the gap in the provision of delivery care for the most vulnerable and out of reach populations, which has been left by the non-utilisation of TBAs.

2.4 The problematic consequences of a narrow focus on Skilled birth attendance for rural women

2.4.1 Barriers to health facility deliveries

The technocratic narrowing down and focus on skilled birth attendance, at the expense of other types of home or community-based attendance revealed in this Chapter, has led to favouring mainly what Pyone et al call “centripetal strategies”. Centripetal strategies are strategies where women are asked to bring themselves, or are to be brought to, health services (Pyone, Sorensen et al. 2012, p.1029). These strategies are problematic for women in remote rural communities, such as those featured in this study, because they face a number of barriers to access services. Those women may therefore be better served by “centrifugal strategies” for delivery care, meaning strategies where the services are being brought to them in their own communities (Pyone, Sorensen et al. 2012, p.1029).

The literature on the **barriers** which delay or prevent women altogether from seeking skilled birth attendance is extensive. Those barriers have been discussed at length in the past (Bohren, Hunter et al. 2014, Thaddeus, Maine 1994, Gabrysch, Campbell 2009, Brighton, D'Arcy et al. 2013). They are multi-faceted: some are **geographical**, for instance regarding lack of transport and long distances to facilities (Edmonds, Paul et al. 2012, Palamuleni 2011, Titaley, Hunter et al. 2010, Campbell, Calvert et al. 2016, Nesbitt, Lohela et al. 2016); some are **economic**, for instance regarding the lack of money to procure transport, to pay fees, or cover the cost of delivery (Oyerinde, Harding et al. 2012, Pfeiffer, Mwaipopo 2013, Sipsma, Thompson et al. 2013, Nesbitt, Lohela et al. 2016); and some are **socio-cultural**, and related to intra-household decision-making powers, gender inequalities, or other customs (Palamuleni 2011, Treacy, Sagbakken 2015, Edmonds, Paul et al. 2012, Mbweza, Norr et al. 2008, Barber 2004). All the above barriers have also been confirmed by a recent study as applicable to the specific context of Malawi (Marks, Dietsch et al. 2016).

The idea that there are barriers preventing women from accessing delivery care is not new and was articulated by Thaddeus and Maine in their seminal article *Too far to walk: Maternal mortality in context. The ‘Three delays model’* (1994). There, they argued that there were three main delays which may prevent women from accessing the care they needed in childbirth: I) the delay in deciding to seek care (owing to the poor or low status of women, costs involved and previous experiences with the health care system); II) the delay in reaching the appropriate health facility (owing to road conditions, availability of transport, and distance to facilities); and III) the delay in receiving adequate care at facilities (owing to the lack of resources and skilled personnel, lack of functioning referral systems, or

poorly trained of staff). In 2009, Gabrych and Campbell revisited the '*three delays model*' and reviewed the determinants of skilled delivery service use in over 80 articles worldwide. They identified a wide array of determinants of non-attendance to facilities, and weighed their relative importance to women's care-seeking behaviours. They confirmed that the economic, geographical and socio-cultural barriers were still important barriers, but also stressed that other factors, such as women's awareness of childbirth risks, and their previous experience of institutional delivery care, were also significant and less researched (Gabrysch, Campbell 2009).

Since then, there has been a growing body of literature concerned with the manner in which some women are treated in childbirth at health facilities, particularly in LICs, and how this may represent another barrier to facility attendance. Studies show that although many SBAs do treat women with respect and dignity (Rosen, Lynam et al. 2015), some behave in ways that are seen to be neglectful, disrespectful or in direct violation of women's human rights. The first definition of **disrespectful and abusive (D&A) care** in childbirth was provided by Bowser and Hill, who proposed seven categories: "physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities" (Bowser, Hill 2010, p.9). Since then, such instances of D&A care have been documented, both in some HICs such as Australia (Dietsch, Shackleton et al. 2010, Bohren, Vogel et al. 2015), and in LICs (Chadwick, Cooper et al. 2014, Ith, Dawson et al. 2013, Kruk, Kujawski et al. 2014, Moyer, Adongo et al. 2014). This also includes, importantly for this study, Malawi (Seljeskog, Sundby et al. 2006, Chanza, Chirwa et al. 2012, Simwaka, de Kok et al. 2014, Kumbani, Chirwa et al. 2012). To date, the only systematic review of the mistreatment of women in childbirth has been conducted by Bohren et al (2015), which included 65 studies, located in 34 high and low income countries. The authors developed a typology aimed at supporting interventions to reduce occurrences of D&A care in childbirth. In their review, they reviewed Bowser and Hill's typology (2010) but went further by exposing also some of the external constraints which may condition D&A care. They concluded:

in many settings worldwide, women's childbirth experiences in health facilities are marred by instances of mistreatment, including physical and verbal abuse, a lack of supportive care, neglect, discrimination, and denial of autonomy. Our findings indicate that while these various forms of mistreatment can occur at the level of the interaction between the woman and provider, a complex range of systemic failures at the levels of the health facility and health system contribute to its occurrence, including poor supervisory structures, insufficient staffing, inadequate supply chains, poor physical conditions, and policies, facility cultures, and power dynamics that systematically disempower women (2015, p.21)

D&A care often takes place in under-resourced, under-staffed and overcrowded facilities where staff may be demotivated. However it is this study's view that it may also have become more problematic because of centripetal strategies of skilled birth attendance, which have pushed ever greater numbers of women to come to facilities for their deliveries, where the equipment and SBAs they expect to attend to their needs, are simply not there (Banda 2013). The exclusion of TBAs from the routine management of births may have been perceived to enhance safety, but it has also led to the disappearance of the form of continuous labour support and interpersonal care they used to provide, and which was appreciated by women. Therefore one of the problems of the narrow focus on skilled birth attendance is that it focuses on the technical aspects of delivery care, at the expense of other aspects of care. The section below explores this argument and with it concludes the Chapter.

2.4.2 Quality of Care (QoC) in childbirth is more than just technical care

Renewed calls have been made, in the post-MDG era, to re-focus global safe motherhood policies and programmes on quality of care, rather than on solely on availability or accessibility of care (Graham, Varghese 2012, Koblinsky, Moyer et al. 2016, Freedman, Kruk 2014, de Kok 2015). There is no universally accepted definition of quality of care (QoC) in health but various models do exist (Donabedian 1988, Raven, Tolhurst et al. 2012). What seems clear from the literature on QoC models, is that quality is viewed to relate to both the provision of technical care and also to patients' experiences of that care (Hulton, Mathews et al. 2000). This Chapter has shown that maternal health, in terms of clinical care, is seen to be the best where there are enough skilled birth attendants, and available, fully equipped EmOC services with functioning referral (Adegoke, Van den Broek 2009, Graham, Bell et al. 2001, De Brouwere, Van Lerberghe 2001). But quality of care is not simply the provision of an optimal technical care (focused on the SBA performance), it is also found in the quality of the interpersonal relationships between the woman and the attendant. This sub-section introduces particularly two main concepts related to the quality interpersonal care in childbirth which are of use in this study: women-centred care, and labour support

Leap explains that the notion of **woman-centred care** has evolved from the 1960s feminist movement, which aimed to shift power and decision-making from the health practitioner to the woman (Leap 2009). Woman-centred care implies a focus on the woman's individual needs, and "addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations" (Leap 2009, p.12). It also stresses the importance of the continuity of carer in labour and pregnancy, carers who both knows the woman and supports her throughout. Yet in many LICs, woman-centred care it is not yet a reality

(Maputle 2010). Ideals of an optimum interpersonal relationship between birth attendant and woman are often shaped by discourses on human rights, and the mistreatments in childbirth described previously, are thus seen as human rights violations. This right to respectful care in childbirth has been formulated in a charter (White Ribbon Alliance 2011) and this formulation has been grounded in existing human rights declarations such as ‘*General Comment 14*’. This ‘*Comment*’ affirmed the universal "right to the highest attainable standard of health" (UN Economic and Social Council 2000) and was enshrined in the rights-based approach to the MDGs (UN 2008). However it could be argued that often this notion of a right to health care fails to go beyond the issues of the basic rights of women to access SBAs and affordable EmoC services, or to the right to a safe delivery (Raven, Tolhurst et al. 2012, Freedman 2001). As key as those may be, the debate on quality of care also needs to turn to the quality of the interpersonal care women receive in childbirth and to their experiences of birthing. As Freedman (2001) argued, if it is to serve women best, a human-rights based woman-centred care must reach further into the health facility setting, and help shape more respectful interpersonal relationships between care providers and patients. This study aims to unveil the cost of not doing so.

The other aspect of quality interpersonal care in childbirth most relevant to this study- because it relates to aspects of both TBA and SBA care- is the concept of **labour support**. Barrett and Stark definition of labour support- developed from different contexts- is used here, which encompasses “emotional support, physical comfort, and advocacy” (Barrett, Stark 2010, p.13). Emotional support signifies “a continuous presence, positive reassurance, and praise”, physical comfort refers to activities such as “therapeutic touch, massage, warm baths or showers, and encouraging fluid intake and output”, and advocacy “consists of communicating the woman's wishes and offering information about the progress of labour, coping methods, or relaxation techniques” (Barrett, Stark 2010, p.13). **Continuous labour support** thus means being close to the woman, attentive to her needs, and communicating with her. This form of labour support has been shown not only to matter to the experience of birth women have, but some evidence suggests that it also produces positive outcomes in pregnancy. Hodnett et al.’s comprehensive review (2013) of 23 randomised controlled trials, which draws on a number of sources in high and low income countries, has assessed the impact of continuous support on over 15,000 women from 16 countries, including some LICs. Their review demonstrated that women who received continuous labour support were less likely to require interventions or C-sections, better able and more confident to have spontaneous vaginal deliveries, reported a more positive experience of childbirth, and had new-borns who were more likely to have better Apgar scores. Similar accounts of the benefits of continuous labour support are also well documented in a number of other recent studies (Ross-Davie 2012, Dahlberg, Aune

2013, Yuenyong, O'Brien et al. 2012, Das, Kumar et al. 2014). Interestingly for this study, Hodnett et al.'s review (2013) showed that women benefited most from continuous labour support administered early in labour by people other than hospital staff (such as partners, family members or doulas¹⁸). Those were usually people who belonged to the woman's own social network- as TBAs do- and who "have no obligation to anyone other than the labouring woman and who have an exclusive focus on this task" (Hodnett, Gates et al. 2013, p.16). This evidence could point to a potential role for TBAs in supporting deliveries, including in facilities, in low income settings.

Recent research shows that in both high and low-income settings, perceptions of the quality of the relationship with the birth attendant, not only make for a positive or negative experience of childbirth, but also influences women's subsequent delivery care-seeking behaviours (Chandler, Kizito et al. 2013, Hunter 2006, Larkin, Begley et al. 2012, Morrison, Thapa et al. 2014, Rosen, Lynam et al. 2015, O'Donnell, Utz et al. 2014). Although, as explained earlier, the TBA has been found lacking in respect of the technical care required to deal with childbirth complications, they have often been praised and sought after for the emotional support and continuous labour support they provide (Dietsch, Mulimbalimba-Masururu 2011a, Ryan, Hamela et al. 2015, Byrne, Caulfield et al. 2016, Mahiti, Kiwara et al. 2015, Choguya 2015). In fact this aspect of the care provided by TBAs has been cited as a reason why women, in some areas, keep turning to them even when skilled care is available to them at health facilities and when they believe that facilities are safer overall (Mbaruku, Msambichaka et al. 2009, Dietsch, Mulimbalimba-Masururu 2011a, Ebuehi, Akintujoye 2012, Oyerinde, Harding et al. 2013, Ryan, Hamela et al. 2015). For instance, in a very recent study of Malawian women's experiences of delivery, women justified going to the TBA not simply because they were facing transport barriers, but because they "felt that healthcare facilities did not always provide a social and emotional environment as comforting to the women as that provided by a TBA" (Ryan, Hamela et al. 2015, p.40). Dietsch and Mulimbalimba-Masururu have conducted several qualitative studies on TBAs in Kenya, and a rare description of interpersonal relationships between TBAs and with women, in TBAs' own words. They described this aspect of interpersonal care. Those TBAs reported that "being a traditional midwife is about being in relationships with women...[and] is about caring: being patient, kind, humble, and calm" (Dietsch, Mulimbalimba-Masururu 2011a, p.163). They described following the pregnant women's cues, encouraging her to labour with kind words, providing nourishment and drink as necessary, and

¹⁸ A doula is a woman (trained or not as such) who is present at birth to give physical and emotional support to the laboring woman. She does not usually perform any medical task but is there to reassure the woman (and companion if any) and advocate for her needs if necessary.

letting her take time to deliver (Dietsch, Mulimbalimba-Masururu 2011b). Similar interpersonal care has been portrayed in recent studies on TBAs in Tanzania (Mahiti, Kiwara et al. 2015), and Nigeria (Ebuehi, Akintujoye 2012). In Malawi there is a gap in studies describing the interpersonal care relationships which exist between TBAs and women (Barber 2004, Ryan, Hamela et al. 2015). Instead, most focus on describing the limited skill-set of TBAs, or the changes in their roles (Bisika 2008, Banda 2013, Godlonton, Okeke 2016). Yet, in Malawi as elsewhere, the perceived quality of interpersonal relationships with birth attendants- whether TBA or SBA- must be better understood if one is to understand why women choose to deliver with one or the other attendant, at home or at facilities. As a qualitative study which focused on women who had delivered at home rather than at a facility in Malawi expressed...“none of the participants talked about technical aspects of care during labour and delivery. However, they focused on how they should have been received and treated at health facilities.” (Kumbani, BJune et al. 2013). Those lived experiences of women do indeed matter and the above points to the fact that quality of care is not confined to simply the quality of technical care, as this study will demonstrate.

2.5 Conclusion

This Chapter has provided a framework for understanding how the global safe motherhood strategies have come to narrow down on skilled birth attendance as the technical solution promoted for maternal mortality reduction. This Chapter has also showed how TBAs, once considered to hold some potential for bridging the gap in maternal health care provision between health systems and communities, have been rejected. This is key to understanding the policy this study is concerned with, which is a policy promoting a centripetal strategy urging all women to attend facilities for their deliveries, and banning the use of TBAs. The Chapter has also defined and explained the concept of authoritative knowledge in childbirth, and how it has underpinned the promotion of skilled versus trained attendance, and has led to the devaluation of other knowledge. This concept is key to understanding the findings from this study. This Chapter has finally highlighted two major gaps: first the gap in provision and in linkages posed by the non-utilisation of TBAs. In rural remote communities, losing this proximal support for delivery, particularly where women are the poorest, may prove problematic. Secondly, it highlighted the gap in the interpersonal care in delivery care provided at facilities. The exclusive focus on technical or clinical aspects of care, at the expense of the emotional labour support, may risk alienating some women who have a negative experience of childbirth at facilities, which is also investigated in this study.

Very recent literature – including a *Lancet* series- has been reviewing the adopted strategies of skilled birth attendance worldwide, and the progress made in maternal mortality reduction (Campbell, Calvert

et al. 2016, Joseph, da Silva et al. 2016, Graham, Woodd et al. 2016, Kendall 2015). This literature stressed that although the decrease in maternal mortality has been steady in the past two decades, it remains unequal across regions and sub-nationally (Graham, Woodd et al. 2016, Campbell, Calvert et al. 2016). One cross-sectional survey of 80 LMICs has been reviewing inequalities in the coverage of place of delivery and skilled birth attendance and concluded that:

except for institutional deliveries carried out by SBAs, all other types of assistance were more common among the poor and rural populations. Analyses that take into account both place of delivery and type of attendant are important to help scale up safe delivery attendance for all women, and specially in remote areas where SBAs are scarce (Joseph, da Silva et al. 2016, p.11)

The recent literature signals that in certain contexts, such as the one in this study SBA assisted institutional deliveries may not be the most appropriate in every location, and there is a need to think out of the box and to take what Freedman calls “ a view from the ground” (Freedman 2016, p.1), which is what this study’s findings do.

However in order to understand the findings in their context, the reader has to understand how the policies and strategies described in Chapter 2 have transferred to Malawi and led to the introduction of 2007 Policy Guidelines and TBA ban (2007a), which is what the next chapter does. Chapter 3 will also stress the importance of conducting a bottom-up analysis of this Policy implementation grounded in community actors’ perceptions.

3 Chapter 3: The transfer of the Safe Motherhood Policies to Malawi and the context of the 2007 Policy Guidelines

3.1 Introduction

Chapter 2 offered a framework to understand the evolution of the global Safe Motherhood Policies and their gradual focus on skilled birth attendance strategies at the expense of traditional birth attendance. Chapter 3 on the other hand, starts, by introducing the notion of policy transfer which enables the reader to grasp how those global SMI policy positions have transferred to Malawi (section 3.2). Secondly it presents a framework for policy analysis called the health policy Triangle by Walt and Gilson, 1994 (cited in Buse et al. 2012, p.9), which has been selected here because of the importance it places on the roles of actors in the policy process, which are central to this study's bottom up analysis of the 2007 Policy Guidelines. Section 3.3 applies the policy triangle framework to the particular context, process and content of the Guidelines for Community Initiatives for Reproductive Health (2007a). It draws attention to the fact that in order to better understand the perceived effects of the implementation of this policy- which is what the study intends to do- it is key to understand its context , content, the role actors some actors played in its design, as well as the roles others were assigned by the Policy itself.

3.2 Frameworks for policy implementation analysis

3.2.1 The mechanisms of the Safe Motherhood Initiative policy transfer relevant to this study

As illustrated in Chapter 2, the policy development process is neither static nor straightforward (Exworthy 2008). In this policy process, evidence is gathered, calls for action are issued, targets are set, evaluation takes place, and then the whole cycle starts anew (as was shown in Figure 5). By gathering experts together from many countries in networks such as the SMI or the PMNCH, those facilitate common understandings and common perspectives on policies which result in a form of policy transfer called “convergence” (Stone 2001, pp.7-8). Although the literature on policy transfer often looks at state-to-state activity within the international context, there are many other actors involved in such transfer such as INGOs, NGOs, international coalitions, states themselves, and regional, district and local authority (Stone 2012, Benson, Jordan 2011).

Stone, who has written extensively on policy transfer in health, explains that policy transfer occurs in different ways and at different levels. Health policy is often diffused from international policy statements (e.g. the SMI Call to Action in 1987), but it is also becomes translated into the national political and social context where it transfers (Stone 2012). Policy transfer here is defined also by Dolowitz and Marsh, as “a process by which knowledge of policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of similar features in another” (Dolowitz and Marsh 1996, cited in Benson, Jordan 2011,p.366). In Malawi, for instance, with regards to the Safe Motherhood Initiative (SMI), there has been a transfer of broad policy goals (to reduce maternal mortality in line with MDG5), of concepts (such as the use of skilled rather than trained birth attendants) and of strategies to reach those goals (the adoption of a skilled birth attendance strategy, with women delivering in facilities with SBAs). As Dolowitz and Marsh express, the transfer of policies is both “voluntary” and “coercive” (Dolowitz and Marsh 1996, cited in Benson, Jordan 2011,p. 367). It is voluntary in the sense that, for instance, some LICs adopt policies because they wish to be seen “to emulate ‘best practice’” (Stone 2012, p. 485) such as those set by the WHO and other policy-setters. Although those multi-lateral organisations do not directly implement policies at national level themselves, they do set targets (such as the MDGs) which they rely on states governments and on the forces of donor aid to achieve and evaluate. Policy transfer can be the result of “penetration” (Stone 2001, pp.7-8), where a country imposes their policies on another (e.g. as happened through colonisation for instance). Powerful multi-lateral organisation- such as the International Monetary Fund and the World Bank – can also coerce LICs to adopt certain policies by placing strict conditionality on the lending funds to LICs or debt relief (Benson, Jordan 2011). Although one cannot say that the SMI was coercive in this way, it can be argued that in its transfer to other countries, a certain amount of what Stone calls ‘indirect coercion’ was applied, in the manner described below:

Institutions such as the World Bank, World Trade Organisation (WTO) and IMF have set up research departments or hold conferences and consultations to advocate the ‘scientific’ validity of their objectives, and have engaged in various outreach activities, data gathering and monitoring to promote compliance. Such long-term persuasion exercises can be depicted as ‘indirect coercion’ (Stone 2012, p.492)

In this case ‘indirect coercion’ could be described as presenting strategies for maternal mortality reduction as evidence-based, effective, proven to yield the results intended (see sections 2.2.2 and 2.2.3). The WHO and similar policy-trend setters also hold a certain authoritative knowledge in that respect. They also have the power to evaluate progression towards agreed targets, and they hold the “global accountability mechanisms” (Behague, Storeng 2013). As such they can flag up countries which

have been ‘off-track’ with internationally agreed targets such as MDG5 (as was done for instance the various ‘countdown’ to 2015 publications (UNICEF, WHO 2014)). The other mechanism of indirect coercion in the policy transfer process is that of donor dependency. International aid, and even global philanthropic foundations, such as the Gates Foundation, can yield considerable influence in the implementation of certain policies. To relate this to the transfer of the SMI to Malawi for instance, one can take the Foundation generous award in 2013 of \$8 Million to the Presidential Initiative on Safe Motherhood of Malawi (PISM)¹⁹. Those funds were earmarked to support the training of nurse midwives, obstetrician and gynaecologists who are so desperately needed in the country, as well as to support the building of maternity waiting homes²⁰ adjacent to facilities, in support of the particular goals of the PISM. However, the funds also represented a fairly large portion of the overall \$94 Million Malawian health budget for that year²¹, and thus gave this donor a certain oversight at least with regards to maternal health policy. It has been shown that donors do exert substantial amount of influence on policy directions and diffusion in donor dependent country such as Malawi (Fagernas, Schurich 2004). The WHO Health System Financing Country profile for 2014 for Malawi states that in the country 88% of health care is funded by funding from abroad whereas 12 % comes from domestic funding. It is therefore possible to question the weight that donors may have in the making of policies such as the Guidelines for Community Initiatives for Reproductive Health (2007a). However, it is important also to note that policy transfer is not simply a case of passive compliance on the part of LICs (Stone 2012). LICs also adopt particular policies (or indeed change policies) for other different reasons. For instance, a policy may coincide or converge with the country’s own internal political preoccupations at the time (e.g. the SMI coincided with the PISM in Malawi and the President’s own concerns). Before exploring in details how the transfer of the SMI policies interweaved with the process of the 2007 Policy Guidelines and TBA ban, section 3.2.2 and 3.2.3 below offer some reflection on the role of policy analysis in LICs, and introduce the framework of the policy triangle used in the study.

3.2.2 The role of policy analysis in LICs

policy making is a process of continuing interaction among institutions (the structures and rules which shape how decisions are made), interests (groups and individuals who stand to gain or

¹⁹ see <http://philanthropynewsdigest.org/news/gates-foundation-awards-8-million-to-improve-maternal-infant-health-in-malawi> [accessed 20/12/2016]

²⁰ A waiting home is a room or house built next to the hospital or health facility to enable women coming from afar to come an await their delivery at the hospital, which enables those particularly at high risk to be monitored by SBAs.

²¹ <http://www.nyasatimes.com/2014/09/03/health-allocation-malawi-zero-aid-budget-inadequate-mehn/>

lose from change) and ideas (including arguments and evidence) (John 1998 cited in Gilson, Buse et al. 2008, p.291)

In their editorial of the special issue of *Health Policy and Planning* in 2008, Gilson et al stressed that even though the field of policy analysis was still developing in low income countries, such analysis is needed to help policymakers comprehend the effects of certain policy decisions (Gilson, Buse et al. 2008). The recent literature expresses that policy analysis on the whole remains situated at macro level, and concerned mainly with the policy process, global policy trends, and the role of international policy networks (Exworthy 2008, Shiffman, Quissell et al. 2016). When policy analysis is situated at the more meso and micro level, it is usually concerned with the national context and the local implementation processes in terms of their effectiveness (Sato, Gilson 2015, Gilson, McIntyre 2005, George, Rodríguez et al. 2015).

Erasmus, Orgill et al (2014) recently mapped the literature on policy implementation in LICs in the period from 1994 to 2009 and demonstrated that it remains patchy, focused mostly on health systems factors, and on the lessons that can be learnt to improve particular programmes implementation. Gilson and Raphaely (2008) undertook a review of health policy analysis in low and middle income countries (LMICs) for the period 1994 to 2007 using 164 relevant articles (Gilson, Raphaely 2008). They found that the literature was relatively small and fragmented, and mainly descriptive. They found also that articles were often authored by Northern²² researchers, rather than indigenous researchers. They looked particularly at those articles which focused on the policy development and policy implementation stages and found that most were concerned with how the process of policy making unfolded at Government level rather than ground level. The few articles they found which focused on the roles of actors in the implementation process, focused mostly on “public health care providers and managers” (Gilson, Raphaely 2008, p.299), who are at the frontline implementers of policies. On the whole policy implementation analysis in LICs rarely focuses on the role or perceptions of patients or users, that is on those on whom policies are ‘implemented upon’, which is a gap this study aims to address.

One important question for policy analysis in LICs is whether policy analysis theories developed in HICs can be applied to LICs contexts (Walt, Shiffman et al. 2008). Walt, Shiffman et al suggest they can if they take into accounts issues of context, such as of weaker health systems and financing, donor dependency, and the fact that as far as policy analysis is concerned LICs have lesser monitoring and

²² The world ‘Northern’ is used here to refer to the most industrialised countries in the Northern hemisphere (specifically countries in North America, Europe)

evaluation capabilities (2008). Walt, Shiffman et al call for further use of already established framework theories in LICs policy implementation analysis, and list a number of available theories. Among those *stages heuristics framework* (which “divides the public policy process into four stages: agenda setting, formulation, implementation, and evaluation”) ; *networks framework* (which focuses on the networks and relationships between those involved in the policy process); and the most used framework, *the policy triangle framework*, which was developed by Walt in 1994 particularly for policy analysis in the health sector (Walt, Shiffman et al. 2008). This is the framework chosen for this study, because it places the focus not only on context, content and process, but also on actors, which are so important to the analysis in this thesis.

3.2.3 The policy triangle and bottom-up policy analysis frameworks

In order to understand how various actors - particularly at community level- perceive policy, one has to understand the process of health policymaking. In their seminal book, *Making Health Policy*, Buse et al (2012) state that health policies are formed through the interactions of context, process and actors. This is visualised in the health policy triangle reproduced below:

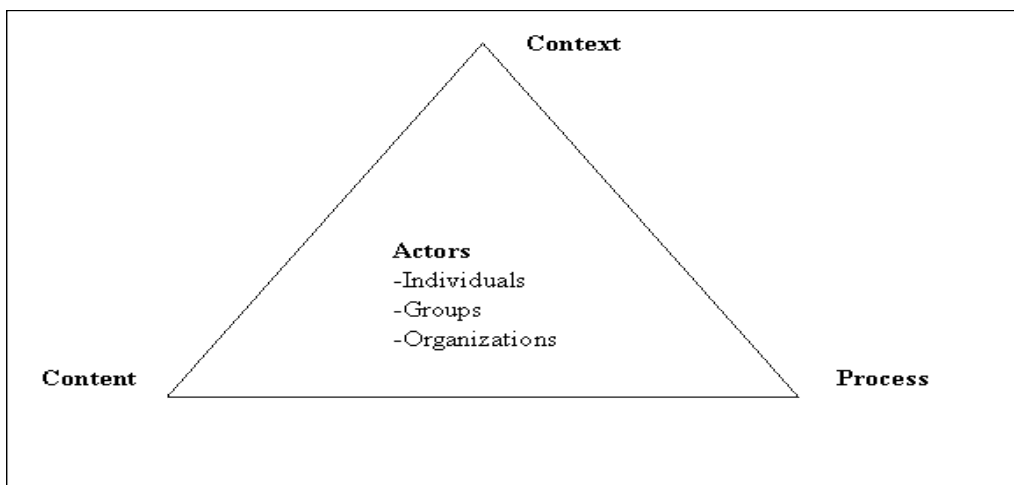


Figure 7. Health Policy Triangle by Walt and Gilson, 1994 (cited in Buse et al. 2012, p.9)

The **context** in this triangle refers to the political, economic, social or cultural factors, both at the local and international levels which influence policymaking²³. Some of those factors are what Buse et al. call the “*international or exogenous factors*”, and refer to the fact that some policies evolve under the influence of national, regional or multi-lateral coalitions, such as that of the MDGs (Buse, Mays et al. 2012, p.12). In the triangle, above, the **content** refers to the policy itself and what it covers. In a case such as the 2007 Policy Guidelines in Malawi, this is of importance because it represents a major policy change, namely the banning of the utilization of TBAs for routine deliveries. The next section 3.3 returns to this in details. The word **process**, in the policy triangle presented above concerns the way in which policies are developed, where they originate, how they are formulated, disseminated, implemented, and evaluated. Finally, the term **actors**, placed in the middle of the triangle in Figure 7, refers to the individuals, civil society, interest groups, the media, state governing bodies, donors and funders, multilateral agencies and all others whose actions affect policy making, or whom are affected by it. All elements of the triangle are in constant evolution, contexts change overtime, for instance, in Malawi, since the PISM was issued in 2012, a change of President has occurred, and the initiative has appeared less prominent since then (e.g. the dedicated website on the PISM is no longer available online).

The content of policies can be revised, and Malawi, for example, has issued a number of Road Maps for the Acceleration of Reduction of Maternal and Neonatal Morbidity and Mortality in the last decade (Republic of Malawi Ministry of Health 2007b, Republic of Malawi Ministry of Health 2012). Moreover, what is not readily visible in the policy triangle in Figure 7, and what will be made clear in section 3.3, is that not all the actors have the same amount of power when it comes to policymaking, whether in regards to its design or to its implementation. Some of those who hold the authoritative knowledge on which decisions are made with regards to the management of childbirth (Government, policymakers), are also often those who hold the policy-making power. For instance, the Ministry of Health maternal health policy officials interviewed in this study who were in charge of designing the 2007 Policy Guidelines, PISM and other policies, were also often SBAs by trade.

This study is particularly interested in the role of actors within the implementation of the Policy, and in conducting a bottom-up type of analysis. Walt, Shiffman et al (2008), in their methodological review of

²³ Some of those are referred to by Buse et al as “*situational factors*”, temporary conditions, such as conflict or disaster, which may impact policymaking. Others are described as “*structural factors*”, which are more enduring elements of society (such as the political system, the type of economy, or demographics). Other factors within context are described as “*cultural factors*”, such as ethnicity, gender, or religion.

health policy analysis, explain that implementation theories have been dominated by the *top-down versus bottom up theory* theorised by Sabatier (Sabatier 1986). This theory states that where implementation is approached in a top-down manner, it is viewed as a process which is the responsibility of the Government and disseminated downwards through local implementers. As Erasmus also explains:

The top down model of implementation emphasizes power as the co-ordination and control (of others) by those with authority located at the upper reaches of the bureaucratic or organizational hierarchy, in pursuit of pre-determined policy objectives. These objectives are established through political processes, and implementers are simply tasked with executing plans to achieve them. (Erasmus, Gilson 2008, p.362)

By contrast, the bottom-up approach sees policy implementation as a dynamic process negotiated by those involved as implementers at the local level (e.g. health staff, health administrators), and by the manner in which they interpret the policy message disseminated to them (Scott, Mathews et al. 2012). However, bottom-up policy implementation analyses in LICs often tend to focus on the views of local implementers (such as district managers or local health staff), rather than on those at the receiving end of the policies which affect their daily lives (Scott, Mathews et al. 2012). This is a key gap which this study is aiming to help fill, by seeking to hear the voices less heard, those of the actors who have most to lose from a policy change such as the one enacted by the 2007 Policy Guidelines and TBA ban: that is women and TBAs particularly. In order to do so, this study will use some insights from actor interface analysis, which is described below.

3.2.4 Focusing on community actors perceptions of policy implementation using AIA insights

In order to undertake a bottom-up policy implementation analysis, this study gained insights from Norman Long's concept of actor-oriented interface analysis which will be referred to here in short as actors interface analysis (AIA) . Long presented the concept in 1999, in a background paper for UNESCO (Long). It was conceived within the field of development intervention and articulated around the notion of interfaces, which he defined as follows:

Interfaces typically occur at points where different, and often conflicting, life worlds or social fields intersect, or more concretely, in social situations or arenas in which interactions become oriented around problems of bridging, accommodating, segregating or contesting social, evaluative and cognitive standpoints. Interface analysis aims to elucidate the types and sources of social discontinuity and linkage present in such situations... it requires a methodology that counterpoises the voices, experiences and practices of all the relevant social actors involved (Long 1999, p.1)

These AIA principles have been used in the building of this grounded theory because they are constructivist in nature, mindful of the different perceptions of different actors and embedded in their lived experiences and interactions. AIA was also particularly useful here because of its focus on the notion of linkages which the study wanted to apply to policy implementation analysis from the ground up. Moreover, with AIA, the focus is on bringing together voices from different actors around their interfaces with particular interventions, and this study wished to use this type of approach to explore the 2007 Policy Guidelines. In fact, early on, Long predicted that AIA had potential for policy analysis in the sense that:

policy debates, including policy formulation, implementation and evaluation, are permeated by interface discontinuities and struggles. Indeed the whole process consists of an intricate series of socially constructed and negotiated transformations relating to different institutional domains and differentially affecting a variety of actors. (Long 1999, p.23)

However a brief review of the literature on the use of AIA approaches in the health research discipline shows that it has seldom been applied to the field of health policy implementation, with some recent and notable exceptions (Lehmann, Gilson 2013, Barasa, Cleary et al. 2016). Lehmann and Gilson applied AIA to their study of the implementation of a national policy regarding community health workers (CHWs) in an area of South Africa. They used it “to understand better how different exercises of power in engagements between actors, and with policy implementation processes, renegotiated and reshaped policy outcomes” (Lehmann, Gilson 2013, p.360). However they used AIA to explore interfaces between the policy and mainly one group of actors: health staff (CHWs, and district and province health managers). In another very recent study, Barasa et al used AIA to analyse power and actions in the setting of policy priorities and resource allocation in a hospital in Kenya (Barasa, Cleary et al. 2016). The approach revealed power imbalances between “1) senior managers and middle level managers 2) non-clinical managers and clinicians, and 3) hospital managers and the community” (Barasa, Cleary et al. 2016). This recent application of AIA principles is more relevant to this study because it goes further and explores the interface of policy setting with both health staff and community members. Barasa et al’s analysis revealed that in that interface, community members’ presence was either ignored altogether, or simply tokenistic. They showed that in terms of policy setting and resource allocation, community members felt powerless to challenge the decisions of the hospital managers, and therefore often only rubberstamped any decision made. These two examples of AIA approaches and insights as applied to the field of policy implementation analysis seemed to offer some promise for the current study, whose focus is on multiple actors perceptions of a particular policy for maternal mortality reduction.

3.3 The context and process of the 2007 Policy Guidelines in Malawi

In Malawi, the Ministry of Health is responsible for setting up policies and monitoring progress towards key international and national targets. It also develops and upholds standards, and allocates resources to various parts of an Essential Health Care Package which includes maternal and neonatal health (Banda 2013). In the past decade, it has adopted a number of policies for maternal mortality reduction, the main ones being the successive Road Maps for the Acceleration of Reduction of Maternal and Neonatal morbidity and mortality in Malawi (Republic of Malawi Ministry of Health 2007b, Republic of Malawi Ministry of Health 2012). Those have promoted skilled birth attendance- the use of SBA in facilities- as the main strategy. In its introduction, the 2012 Road map in fact states that it is “in conformity with the now universally accepted fact that availability of EmONC and skilled attendance at birth is key to reducing maternal and neonatal morbidity and mortality” (Republic of Malawi Ministry of Health 2012, p.xi), which shows a direct convergence with global SMI policies. The stated aim of the latest Road Map was to: “increase the availability, accessibility, utilisation and quality of skilled obstetric care during pregnancy, childbirth and postnatal period at all levels of the health care delivery system” (2012, p.xi). The evidence it used was Malawi Government’s own assessments of its Emergency Obstetric and Neonatal Care (EmONC), but the policy itself was “developed with financial as well as technical support, from WHO, UNFPA, USAID and UNICEF” (Republic of Malawi Ministry of Health 2012, p.vii), all major funders and trend-setters in SMI global policies. It is possible this has also in some way influenced the direction of the Road Map. In fact Banda described the Road Map as “a goal driven result-based strategy with targets and timelines advancing the MDGs agenda” (Banda 2013, p.35), which shows Malawi’s concern both with emulating best practices, and with remaining in harmony with globally agreed goals.

The Guidelines for Community Initiatives for Reproductive Health (2007a), which is the Policy this study concentrates on, were designed to support the first Road Map and maternal mortality reduction by promoting “the implementation of community interventions as a major strategy towards achieving this”(Republic of Malawi Ministry of Health 2007b, p.iv). This section uses an amended version (Figure 8) of the policy triangle presented earlier (Buse, Mays et al. 2012) to explore the context, the process and the content of the 2007 Policy Guidelines and TBA ban.

Understanding the context of this Policy will allow the reader to understand how the community actors who took part in this study perceive it, as well as how they may ‘live’ its implementation. The figure

keeps the basic triangle structure of context, content, process and actors in policy making, but adds complexity and arrows which show relationships of influence between the various elements.

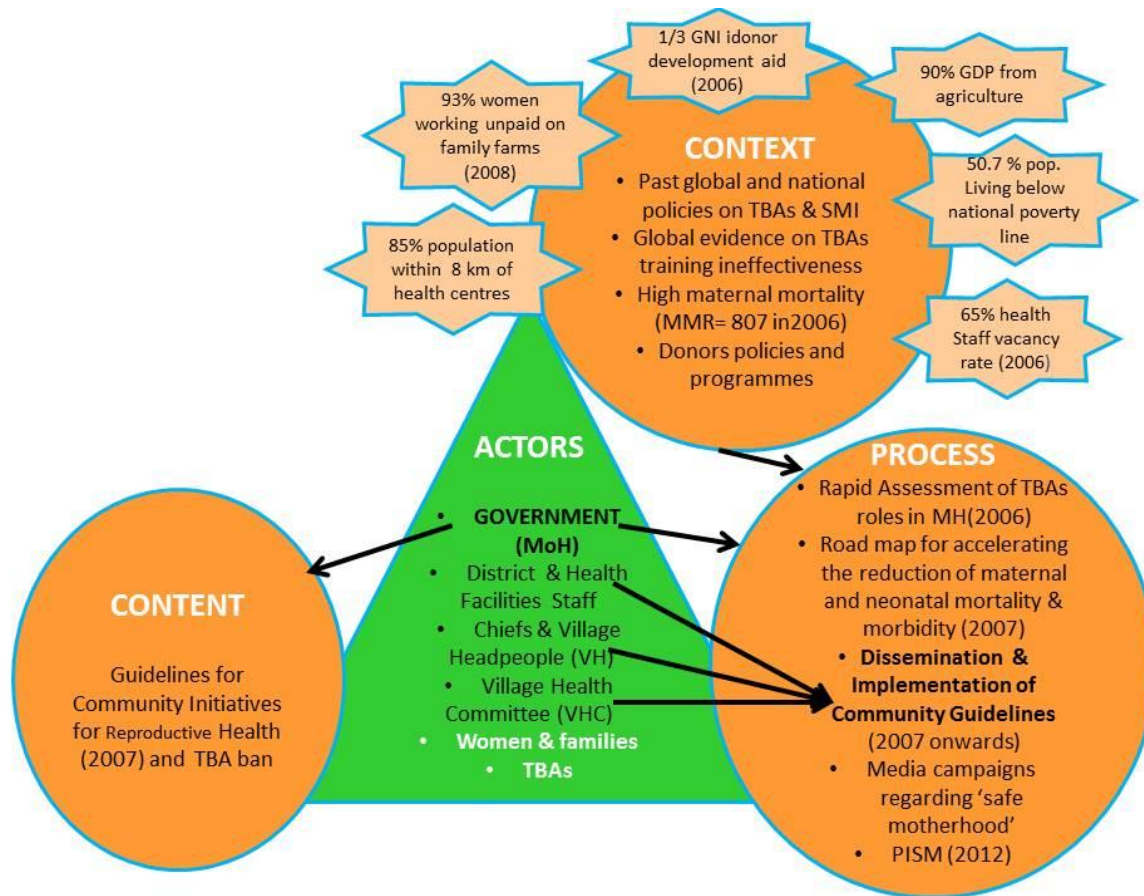


Figure 8. Policy triangle adapted for the 2007 Policy Guidelines and TBA ban

The **context** of the 2007 Policy Guidelines comprises of the systemic, historical, national and international factors which influenced its design, placed in the top bubble. Some of the international factors are the one described in Chapter 2 and 3 and pertain to the transfer of the SMI and TBA policies. In this bubble is placed also the context of Malawi’s donor dependency (Fagernas, Schurich 2004, Sarelin 2014). The international context of this Policy was also that of the middle point for the MDG 5 targets in 2007, for which Malawi was shown as having made substantial progress, but was labelled as risking being off-track (Bhutta, Chopra et al. 2010) . The national context was one of a high MMR for Malawi- 807 in 2006- (Phoya 2014, National Statistical Office of Malawi 2015, Colbourn, Lewycka et al. 2013) as laid out in Figure 2, and of low human development. In fact the UNDP Human Development Report of 2007, described Malawi as:

A country marked by high levels of vulnerability, including poor nutrition and among the world's most intense HIV/AIDS crisis: almost one million people are living with the disease. Poverty is endemic. Two in every three Malawians live below the national poverty line. The country ranks 164 out of the 177 countries measured in the HDI. Life expectancy has fallen to about 46 years. (2007, p.93)

As far as the health system was concerned, Malawi was under pressure with a high health staff vacancy rate (e.g. 64% for nurses and near 100% for certain types of specialists and surgeons (Record, Mohiddin 2006) as well as of a shortage of available, and equally distributed health facilities, particularly those equipped with EmOC (Kongnyuy, Hofman et al. 2009, Kongnyuy, van den Broek 2008, Kongnyuy, Mlava et al. 2008). Another main factor was that of successive contradictory positions from the Governments vis-a-vis TBA utilisation. Between 1976 and 2008, Malawi had trained approximately 2000 TBAs, that is 40%, of its estimated 5000 (UNFPA 2011). However in 2007, the Road Map stated it aimed to review and redefine the role of TBAs in line with WHO guidelines (Republic of Malawi Ministry of Health 2007b).

The Guidelines for Community Initiatives for Reproductive Health (2007a) were not issued in a vacuum, but were part of an overall policy **process** promoting skilled birth attendance. The first Road Map was published in March 2007, whilst the 2007 Policy Guidelines were published in May. It had been informed by the 2006 *Final Report on the Assessment of Future Roles of Traditional Birth Attendants (TBAs) in Maternal and Neonatal Health in Malawi* (Republic of Malawi Ministry of Health, WHO Malawi 2006). This report had used data from a rapid assessment conducted in three districts (Mangochi, Mchinji and Mzimba) on convenient samples (2006, p.12). It was also based on a non-systematic review of the literature on the effectiveness of TBA training for maternal mortality reduction (2006, p.12). Within the qualitative part of the assessment, 6 focus groups with trained and untrained TBAs (n= 72) had been conducted. The aim of the assessment was “to provide quick information to inform policy...[and] To redefine the role of TBAs and communities in improving maternal and neonatal health outcomes in Malawi” (2006, p.11-12). This assessment endorsed in its conclusions the WHO position of moving away from trained TBAs in favour of SBAs. The assessment clearly stated that the Government felt that TBAs skills were insufficient to support deliveries, particularly when complications occurred (Republic of Malawi Ministry of Health, WHO Malawi 2006).

The next year, the Government issued the Guidelines for Community Initiatives for Reproductive Health (Republic of Malawi Ministry of Health 2007a), which were:

Intended to be used by District Health Management Teams (DHMT) and Health Centre staff to assist them to empower the community to take a leading role in identifying, planning, implementing, monitoring and evaluating interventions in Reproductive Health issues at community level for the reduction of maternal and neonatal morbidity and mortality in Malawi (2007a, p.3)

The **content** of this Policy comprises of advice and guidelines for district health staff to make contact with the community and mobilise community members the improvement of maternal and reproductive health. The ‘TBA ban’, as it is often referred to by the population and media, is contained within those Guidelines for Community Initiatives for Reproductive Health. Although the Guidelines are wider than just the change in policy regarding TBAs, they marked a radical change with regards to TBA utilisation, which is why they are seen as the latest TBA policy in Malawi (Banda 2013). In order to mobilise the community, those Guidelines were targeted at a wide range of actors: such as TBAs, community actors, traditional healers, religious leaders, village headpersons, village health committee, community-based organisations. Community mobilisation was to be achieved through assigning particular roles to each group of actors, including the TBAs. For instance, the local leaders (VH, GVH) were tasked with conducting meetings to disseminate the new Policy, and amongst other things with:

developing and enforcing bylaws on Reproductive Health issues, developing bylaws to consider providing rewards for Traditional Birth Attendants promoting delivery at health facility...ensuring active participation of community members in Reproductive Health activities, ...monitoring activities of Traditional Birth Attendants (2007a, p.13).

The next section will return to the powerful role chiefs and village headpersons (VH) were given with regards to the implementation of the 2007 Policy Guidelines. It is worth noticing here that the Policy itself suggested that VH could use bylaws to reward TBAs for good behaviour, whilst in the end the bylaws were –and are still-used to sanction and fine TBAS who still deliver women despite the ban. The findings will return to this in details.

The TBAs were also assigned roles in the content of the guidelines, or rather their previous roles were radically redefined, which is why the Policy has stuck as being called the ‘TBA ban’²⁴. The redefined TBA roles assigned to them by this Policy were as follows:

²⁴ In her thesis, Banda (2013) refers to the 2007 Policy Guidelines as a ‘moratorium on TBAs’, although she does not explain why she used that term. A moratorium suggests that the TBAs would have been prohibited from conducting deliveries temporarily. In this study, the word used is ban, because it describes better the manner in which the Policy is perceived, as the findings will show, and because there is no sign of this Policy being reversed, a decade later.

- Advising women on health matters (IEC)
- Providing information to communities on danger signs of pregnancy, childbirth and of the postpartum period
- Educating couples on birth preparedness
- Referring women with problems during pregnancy, childbirth and after delivery
- Referring any woman who presents to her for delivery to the nearest health centre and report the case to the Village Health Committee /Village Head Man
- Referring new born babies with problems soon after delivery and during the postnatal period
- Encouraging mothers to go to the health facility for antenatal, delivery and postnatal care
- Conducting deliveries only in unavoidable circumstances and should accompany the mother to the nearest health centre as soon as possible
- Keeping records and producing reports
- Acting as link between health facility and community
- Family Planning motivation (2007a, p.11, emphasised).

Rather than conducting routine deliveries as they had done for decades in communities, TBAs new roles were now to advise women in their communities on maternal health issues, refer them to health facilities, and not to conduct deliveries except “*in unavoidable circumstances*”. Those circumstances were not laid out in the Policy Guidelines, and no examples were given of when it would be unavoidable for a TBA to help a woman deliver. Banda, whose study also surveyed the perceptions of key stakeholders of the redefined roles of TBAs in three areas of central Malawi, held that this vagueness in terms may have contributed to TBAs being confused as to whether they could conduct some deliveries or none at all (2013). This confusion was also aggravated by the ambivalence displayed by the late President Bingu wa Mutharika upon his return from a UN Summit on Millennium Development Goals in New York in 2010, when he appeared to revert the ‘ban’ by stating “we need to train traditional birth attendants in safer delivery methods. We should not completely stop them because their work is very important. We should train them to assist us in addressing the health challenges that we are facing”²⁵. The next president President Joyce Banda however launched in 2012 the Presidential Initiative for Safe motherhood (PISM), just as this study was starting. The PISM clearly and strongly re-stated a ‘ban’ on TBA deliveries, and signalled a re-focusing of funds towards the building of waiting homes and community midwife technicians training rather than towards any further TBA training. Since then, only some external funders have continued to fund the sporadic training of TBAs in some areas of Malawi for specific purposes (Hamela, Kabondo et al. 2014). This power of the President to set, or dictate policy

²⁵ This was reported at home, and in the Press abroad : <http://www.mhtf.org/2010/10/18/traditional-birth-assistants-in-malawi/>; <http://www.theguardian.com/global-development/2010/oct/12/malawi-birth-assistants-ban-lifted>

does speak to their role within the policy triangle in Figure 8. There were no document outlining the PISM, but the campaign was visible in the national and international media and on billboards in Malawi when field work was taking place for this study, as the figure below attests:



The translation from Chichewa reads “*Chiefs and Leaders -Take part in the protection of the life of the pregnant woman*”. This billboard was highly visible on one of the busiest roads to the capital in 2013 (© Photo –I. Uny)



A Traditional Chief Slashes Maternal Deaths in Malawi
by Barbara Crossette • April 18, 2013 • Africa, Health and Population, Women • 3 Comments



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Figure 9. National media campaign and example of international coverage of the PISM Malawi, both from 2013.

The PISM reinforced the message of the 2007 Policy Guidelines. It had three main prongs: to promote the use of facilities and SBAs for deliveries- whilst stopping the use of TBAs-, to build waiting homes adjacent to health facilities where women could go and await for their deliveries whilst being monitored, and to train additional community midwives assistants to increase the number of SBAs, particularly in rural areas. In terms of the context of the Policy under scrutiny here, this demonstrates a convergence with the global SMI policy, as well as with the global evidence on TBA training ineffectiveness. This convergence played a significant role in the way the Policy was drafted, how it dispatched different roles

to different community actors for the dissemination and implementation of the Policy. The next section now closely explores this.

3.4 The content of the 2007 Policy Guidelines: the roles assigned to each actor

Actors are at the centre of the amended policy triangle shown in Figure 8. Community actors' perceptions particularly are the focus of this study, which is why their respective roles and power in the policy process is investigated. Actors in the 2007 policy Guidelines triangle include at the top the Malawi Government and Ministry of Health, below the District and Health Facilities staff, the Traditional Authority and Village Headpersons, and at the bottom women and other community members as well as the TBAs. As Buse et al (2012) explain, not all actors in the policy triangle have the same amount of power in the policymaking process. Actors can only influence policy making in so far as their perceived or actual power enables them to. Buse et al refer to the notions of agency and of structure, that is on the one hand the ability actors have to act freely, and on the other the provisions or structures which prevent those actors from acting freely (Buse, Mays et al. 2012, p.10). For instance, in this context, women may be able to choose whether to deliver at a health facility or to seek alternative attendance, but the forcefulness of the new Policy, and associated fines which may come with failing to deliver at facilities (Godlonton, Okeke 2016, Banda 2013), may constrain their actions. Issues of power in the policy implementation process are seldom investigated, as Lehmann and Gilson state:

there remain few examinations of power in the general health policy literature for low- and middle-income countries ... Detailed, nuanced studies of the micro-level practices of power of the diverse frontline actors engaged in policy implementation processes are even rarer (Lehmann, Gilson 2013, p.359)

Some authors have argued that in the policy process, power is exerted at all levels, not simply from the top (Rowlands 1995, Lehmann, Gilson 2013, Surjadjaja, Mayhew 2011, Gaventa 2006). As expressed in section 2.3.1, the authoritative knowledge in childbirth established itself through the stronger power base of policy making, backed up by evidence. As a result, the Government did hold most of the power in the design of the 2007 Guidelines. In fact, criticism has been levelled at the process which led to the design of the Policy, because the Government carried out little consultation at community level before imposing the TBA ban (Banda 2013). In this case the Ministry of health was exerting what some authors have been calling "power over", that is controlling power over other actors, which is usually responded to with compliance, resistance or manipulation (Rowlands 1995, Veneklasen, Miller 2002). Banda, for instance, stated in her study that: "participants in all phases concurred that key stakeholders were not

consulted when the decision to stop TBAs was made. Even though some meetings were held, the purpose was to disseminate the new guidelines rather than debate the TBA services” (Banda 2013, pp.144-145). The fact that the policy was enacted in this way is likely to have consequences on the way it is perceived at community level, and complied with. These consequences are explored in the chapters 5, 6 7 and their implications discussed in the theory presented in chapter 8. This study explores also if the manner in which the Policy was implemented may have reinforced some power imbalances at community level, by attributing particular roles to certain actors.

Despite the stated intent of the 2007 Policy Guidelines to “contribute to empowering women, their partners, families and the community to make appropriate decisions and take timely actions especially when there are complications in pregnancy and childbirth” (2007a, p.3), the manner in which it was disseminated and implemented betrays more of a top-down approach (Walt, Shiffman et al. 2008, Sabatier 1986) This means that in this Policy process the authoritative power- backed by authoritative knowledge, as well as the control of resources- “flowed largely vertically downwards” (Lehmann, Gilson 2013, p.362). This flow is represented in Figure 10, based on information from Banda’s study (2013) and on the content of the Policy Guidelines themselves (2007a):

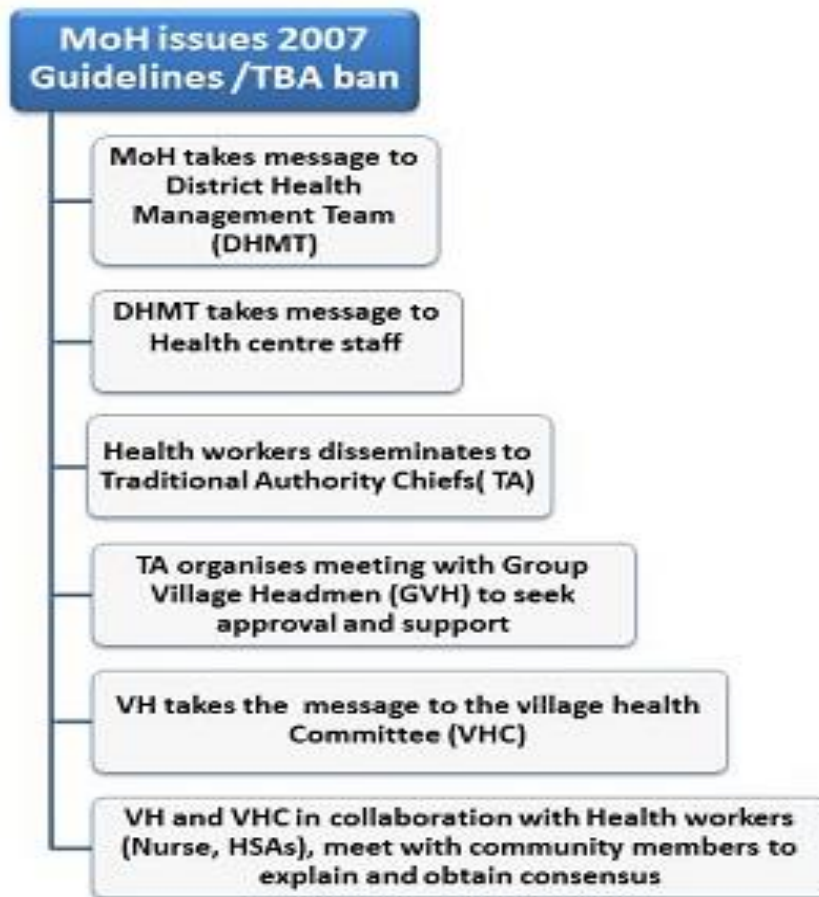


Figure 10. Dissemination & Implementation of 2007 Guidelines on TBA utilisation- a top down approach

As the above shows, the process of disseminating the new policy was firmly placed in the hands of the health staff -district health management team health workers- and at community level, in the hand of those with the most power-village headpersons and Chiefs (VH)-. There are approximately 22,000 VH and chiefs in Malawi (according to a key Ministry of Health official interviewed in this study [OMS06], but no exact number could be found in any reference). VH hold high status and power in their communities. It is normally community members who select them, although their titles can also be transferred at their death to their eldest child (Cammack 2011). VH have some control over land management, settle customary disputes in their villages, oversee village health committees where they exist and, since 2008, some have held paper registers for deaths and births in their communities (Singogo, Kanike et al. 2013, Cammack 2011). Village headpersons' roles, as described in the 2007 Policy Guidelines was to support their implementation and undertake some monitoring. In this way one

could argue they too became what Lipsky called “*street-level bureaucrats*”, a term usually used to talk about Government paid health workers. Lipsky defined street level bureaucrats as:

the frontline workers in government bureaucracies, e.g. teachers, nurses and police officers, who regularly interact directly with citizens in discharging their policy implementation duties and who have some discretion over which services are offered, how services are offered and the benefits and sanctions allocated to citizens. (Lipsky cited in Erasmus 2014, p.iii71).

Although VH are not part of the Government nor have direct oversight on the provision of health services, in the past decade, the Government has started paying them a honoraria, in recognition for the role they play in the delivery of community development projects in their areas (Singogo, Kanike et al. 2013, Cammack 2011). This reinforces the feeling that they, SBAs, and the Government, are one, and form the authority implementing this Policy, as the findings will demonstrate. In 2012 President Joyce Banda made the Chiefs and VH an integral part of the Presidential Initiative for Safe Motherhood (PISM). One Chief in particular, Chief Kwataine, of the Ntcheu District, became famous for his track record of preventing maternal deaths in that district through encouraging women to seek skilled birth attendance. President Banda made him Chair of a Chiefs Committee for Safe Motherhood, whose role was to sensitize women to safe motherhood, and use their influence to promote institutional deliveries with SBAs.



Figure 11. Joyce Banda, president of Malawi, and Chief Kwataine promoting the PISM © Photo - J. Carry

But this is not the only tool which chiefs have used to convince women to deliver at facilities. They also have - in certain districts- used bylaws to impose fines on women who deliver at home, or at TBAs instead of at a health facility. VHs have been allowed to enforce bylaws since the Decentralisation Policy (Republic of Malawi 1998) which gave authority to the District Councils- of which chiefs are members- to set up those to regulate what can and cannot be done in communities. Those bylaws enable VH to use penalties as necessary. In the case of those which have been used to reinforce the implementation of the 2007 Policy Guidelines, they have carried fines in the amount of either a chicken,

a goat, or varying amounts of money (Banda 2013, Overseas Development Institute 2012, Godlonton, Okeke 2016). These amounts can be considerable prices to pay in rural areas of Malawi, as the monetary value of a goat is roughly £10, and a chicken can cost up to £2. Although the practice has not been officially condoned by the Government, and may not be applied everywhere in the country, evidence does suggest that it is now a widespread practice in Central and Southern regions (from personal correspondence with De Kok and E. Banda, 2015). Sometimes, the woman, the husband and any other person who have assisted a home delivery without cause, have to individually pay a goat. Although little has been written of yet on the effect of such punitive measures, they have also been put in place in other SSA countries and have raised some concerns (Treacy, Sagbakken 2015, Greeson, Sacks et al. 2016, Chamberlain 2013). A recent study from Zambia states that “the imposition of penalties is thus a punitive adaptation that can impose new financial burdens on vulnerable women and contribute to widening health, economic and gender inequities in communities“(Greeson, Sacks et al. 2016, p.1). Ironically, as stated earlier policymakers who designed the 2007 Policy Guidelines in Malawi had envisaged a more positive use for the bylaws, that is “providing rewards for Traditional Birth Attendants promoting delivery at health facility” (2007a, p.13). However, data from this study as well as the recent article from Godlonton and Okeke do show that the use of bylaws have been punitive, and “though systematic data on enforcement is not available,... largely left to the sub-district and village heads” (Godlonton, Okeke 2016, p.114). Undoubtedly this reinforces the power and authority of village headpersons, whose discretion it is to assess whether women and their families deserve to be fined for delivering at home rather than at health facilities. The issue of fines and their impact will be addressed by the findings in section 5.2.1 , and deserves further investigation.

Moreover, with regards to the content of this Policy, the wording used to assign specific roles to particular actors may have also deepened some power imbalances within communities. For instance, the 2007 Policy Guidelines made it part of their expected roles that some members of the community would have a role of surveillance regarding others, particularly TBAs. Local leaders and village health committees (VHC) were, for instance, given the role of “monitoring activities of Traditional Birth Attendants” (2007a, p.10). Village Health Committees (VHC) were created in the context of decentralization to foster community ownership and participation (Republic of Malawi 1998). Their members –usually men and women in equal numbers- were meant to be members elected by their community, usually serving for 3 years, supposed to identify health issues in their villages (inc. maternal

health), and to help address those²⁶. With regards to maternal health, they were meant to be there to encourage women to go to ANC clinics and to deliver at facilities. Assigning them a role of surveillance regarding the implementation of the 2007 Policy Guidelines role of surveillance may have been born of a certain pragmatism on the part of policymakers who knew that some TBAs- with long-standing practice and status- may continue to practice ‘underground’ (Banda 2013). Nonetheless, it ran also the risk of placing some community members in a position of surveillance over others. It betrayed also a wider culture of blaming of the TBAs for deaths and complications, as has been explained earlier and risked portraying TBAs as community members who cannot be trusted to comply with the Policy, and thus who need to be monitored (Wendland 2015). This too may have some consequences for the manner in which this Policy is perceived and complied with. It must be stressed at this point that the 2007 Policy Guidelines also stated that the VHC themselves should be monitored, by “HSAs, Community Nurses and DHMT” (2007a, p.21). This may mean that perhaps the Government only trusted the community-level bureaucrats to a certain extent.

Thus far, the Chapter has demonstrated, as Buse and al (2012) explain, that the policy process is not a rational process. The Malawi government formulated policies- including the 2007 Policy Guidelines- to answer a concern with high maternal mortality, by weighing their own and internationally acclaimed evidence. However, their agenda was influenced also by the political and financial context (such as the PISM, donor-driven policy setting, limited amount of resources). With regards to the implementation of this policy, this Chapter has shown that power was unevenly distributed. Yet, health policy implementation analysis in LICs is rarely focused on how it is viewed by, or affects, those at the receiving end of policy, such as women, and their families or communities (Erasmus, Orgill et al. 2014, Gilson, Raphaely 2008). This study is addressing this gap by exploring the 2007 Policy Guidelines and TBA ban in Malawi from the point of view of those actors, those placed at the bottom of the policy triangle, who had little or no influence on the policy design process. It seeks to hear their voices and, understand their realities. To do so, it uses insights from AIA (Long, Jinlong 2009, Long 1999), which are presented below. By bringing Long’s AIA approach into the field of health policy implementation analysis from a bottom-up perspective, it focuses on exploring concurrently multiple actors perspectives and perceptions of the policy implementation It analyses how different actors interfaces with the 2007 Policy Guidelines and TBA ban conflict, are bridged and negotiated, and ultimately lead

²⁶ References could not be found regarding the role of VHC, but information was gleaned from various participants in this study.

to potentially unexpected policy outcomes. This multiple actors perspective is used in the analysis and to build the grounded theory presented in Chapter 8, by focusing most heavily- though not exclusively - on the perceptions of women and TBAs, and on how their “responses and knowledge frames” of this Policy “are constructed and reconstructed on the basis of their ongoing interface encounters, struggles and segregations” (Long 1999, p.1). Interestingly, in their content the 2007 Policy Guidelines did not assign any particular roles to women. It urged district health teams to consult and have a dialogue with women, in order to mobilise them to take action regarding maternal and reproductive health. The Policy mentioned women’s groups as a likely target “for orientation and sensitization” (Republic of Malawi Ministry of Health 2007a, p.10). The main aims of the implementation of the Policy were to lead to “increased number of pregnant women delivering at health facility” and “reduced maternal and neonatal morbidity and mortality” (Republic of Malawi Ministry of Health 2007a, p.2), thus were focused on women. Yet the Guidelines did not dwell on the active role women may play, as community actors, in the Policy implementation, which makes it all the more important to hear their perspectives.

Conclusion

This Chapter has presented the mechanism through which the SMI policy goals and strategies have transferred to Malawi and led to the issuing of the 2007 Policy Guidelines and TBA ban, amongst other policies aimed at reducing maternal mortality. A framework for understanding the process, context, and content of the Policy has also been presented in the form of the policy triangle, and this triangle has been used to begin analysing this policy. The perception of this Policy and of its perceived effects will continue to be analysed in the empirical chapters. In this entire study, the analysis will draw on multiple actors’ perceptions, focusing particularly on community actors, and specifically on women and TBAs. The next Chapter therefore describes in details how those actors were selected, by laying out the study design and methodology.

4 Chapter 4: Methodology and study design

Chapter 4 presents the methodology and the research design used in this study. In the first part of the chapter, the philosophical underpinnings of the study are introduced (4.1), followed by a description of the methodology selected and the rationale for using this particular method (4.2). This study is a qualitative study concerned with multiple actors perceptions of a particular social phenomenon, and has its design grounded in interpretivism and symbolic interactionism. The role of the researcher in the process of interpreting and analysing the data is discussed (4.3), as well as the use of reflexivity in the study. The next part of the chapter (4.4) describes in details the methods used to collect the data; detailing the fieldwork sites context, the sampling and recruitment methods. The limitations of the data collection (4.6) and some ethical reflections are considered (4.7) and finally the Chapter closes with details of methods used for the analysis of the data (4.8).

4.1 The philosophical underpinnings of the study

Qualitative researchers brings to their research a set of assumptions, a worldview, which frame the way in which they conceive the nature of reality (referred to as *ontology*) and the way in which knowledge can be attained (*epistemology*). This means they are drawn to specific topics, methodology and methods (Crotty 2003, Creswell 1998, Corbin, Strauss 2008). Those philosophical underpinnings matter to the research because they relate to whether one believes that there exists an objective reality, or whether the actors in the social world construct the reality they exist in. The worldview influences also the way in which the researcher relates to the participants, shapes the manner in which data is interpreted and how results are produced, (Carter, Little 2007). Although there is a considerable amount of debate amongst social researchers on the subject, there are basically two main ontological stances: objectivism and constructivism (Denscombe 2010).

Bryman describes objectivism as a worldview implying that “social phenomena and the categories that we use in everyday discourse have an existence that is independent or separate from actors” (Bryman 2012, p.33). It does not fit with this study which investigates the various ways in which different actors within their own contexts and interactions, perceive the implementation of a policy. Rather, this qualitative study adopts a constructivist worldview which assumes that the world around us is constructed and that “meanings are constructed by human beings as they engage in the world they are

interpreting” (Crotty 2003, p.43). Often the terms *Constructionism* and *constructivism* are used interchangeably. For the purpose of this study, the word constructivism is used, which contends that if meaning is constructed by those engaged in the world they live in and in their interactions, this implies that the researcher too is involved, alongside participants, in the co-construction of meaning. Within this worldview, the study therefore adopted a constructivist grounded theory (CGT) methodology, as developed by Charmaz (2006).

CGT is situated also in the philosophical tradition of interpretivism, which contends that there is no objective truth in the social world but “a reality that only exists through the way people believe in it, relate to it, and interpret it” (Denscombe 2010, p.122). This study focuses on those interpretations by attempting to make sense of the way actors view a particular policy, the manner in which it affects them, and the decisions they make accordingly. Interpretivism underpins analytical approaches which aim to understand human behaviours, such as phenomenology and symbolic interactionism (Crotty 2003, Babbie 2007). Phenomenology, first developed by philosopher Edmund Husserl, aimed to understand social phenomena from the stand point of the ‘lived experience’ of participants, but usually using a first person point of view (Dyson, Brown 2006). Symbolic interactionism is rather where this study is rooted, because its principle are that “Humans act toward things on the basis of the meanings that these things have for them; [and] The meaning of such things is derived from, or arises out of, the social interaction that one has with others and one’s fellows (Blumer 1969, cited in Crotty 2003,p.74). Social interaction is what shapes meaning for participants, as well as the manner in which those interactions are influenced by the social context, cultural practices, and experiences of previous interactions (Crotty 2003).

Although the above makes clear the philosophical underpinnings of the study, positionality also dictates that the researcher state what they brings to the process of their study. As a social scientist, whose prime interest is in attempting to uncover and interpret the way in which people construct and express their own realities, it would be unlikely for this researcher to adopt the positivist stance. Such stances are too often evident in studies regarding TBAs, which tend to focus on TBAs characteristics and practices, or measure the impact of their training on maternal mortality reduction (Itina 1997, Goodburn, Chowdhury et al. 2000, Smith, Coleman et al. 2000, Sibley, Sipe 2004, Chen, Wang et al. 2011, Mbaruku, Msambichaka et al. 2009). Health-related issues are often studied from positivist perspectives, focusing on measuring outcomes. But medical sociology and medical anthropology since the 1970s have gone a long way to show that health is also a socially constructed concept

(MacLachlan 2006, Kleinman 1978). Childbirth is a subject that particularly lends itself to this epistemology as it is an event and social phenomenon at once universal, deeply personal, intensely culturally marked and gender bound, and also deeply embedded in social interactions. The methodology adopted -the constructivist grounded theory (CGT)- is therefore the most suited to the topic. The very notion of ‘grounded theory’ was developed by interpretivists, in opposition to the non-grounded, a priori formed theories, developed by positivists in the past. By its very nature, CGT is inductive rather than deductive, because the theory is built from the data up.

4.2 The Choice of methodology: constructivist grounded theory

The methodology that was selected to carry out this study is that of constructivist grounded theory developed by Charmaz (2006). It derives from Grounded Theory (GT) as first defined by Glaser and Strauss in their book *The Discovery of Grounded Theory* (1999), who had applied the methodology to the study of death and dying in hospitals in the USA. The main steps to carrying out the GT methodology can be summarised as: data collection and analysis taking place simultaneously, constructing analytic codes and categories from the data, using the constant comparative method, developing a theory through the process of both data collection and analysis, and memo-writing to develop categories, their properties, and their relationships (Glaser, Strauss 1999, Glaser 1978). Each of those steps will be referred to in this Chapter, in relation to how they were conducted in the study. GT requires the researcher to be steeped in the data, comparing at first data extracts, then cases, and ultimately interpretations which emanate from the categories.

Glaser and Strauss, who first wrote about GT later diverged, mainly because of their different approaches to data analysis in GT (Charmaz 2006). Glaser critiqued Strauss for making GT too prescriptive and formulaic, for incorporating elements of deduction in the analysis and allowing existing theories to influence researchers, making it in a sense more ‘positivist’ (Willig 2008). Here the constructivist grounded theory methodology (CGT) as devised by Charmaz (2006) was chosen as an alternative version of the GT methodology, embedded in a constructivist worldview:

A social constructionist approach to grounded theory allows us to address *why* questions while preserving the complexity of social life. Grounded theory not only is a method for understanding research participants’ social constructions but also is a method that researchers construct throughout inquiry. Grounded theorists adopt a few strategies to focus their data gathering and analysing, but what they do, how they do it, and why they do it emerge through interacting in the research setting, with their data, colleagues, and themselves (Charmaz 2008, p.397-98)

CGT is in line with the symbolic interactionist perspective because it sees both participants and researchers as co-creating meaning in their interactions, and bringing to such interactions their own experiences and worldviews. It is the role of the reflexive researcher to maintain perspective, by being aware of how their own position and interests may influence the interaction, and thus the data collected. In CGT, the researcher does not start with any a priori hypothesis, but seeks to reveal the meaning grounded in the data, to build up a theory from the data up.

Charmaz described **the process of CGT** in the figure reproduced below. She expresses that it starts with data collection, then coding, followed by the elaboration of categories and concepts through the writing of early memos, further theoretical sampling, and continued coding as well as the writing of more theoretical memos, leading eventually to sorting and writing the first draft of the theory. Throughout the process, the constant comparative method is used to compare data, cases, and categories. The analysis continues from the very first data gathered to the writing of the theory (Charmaz 2006).

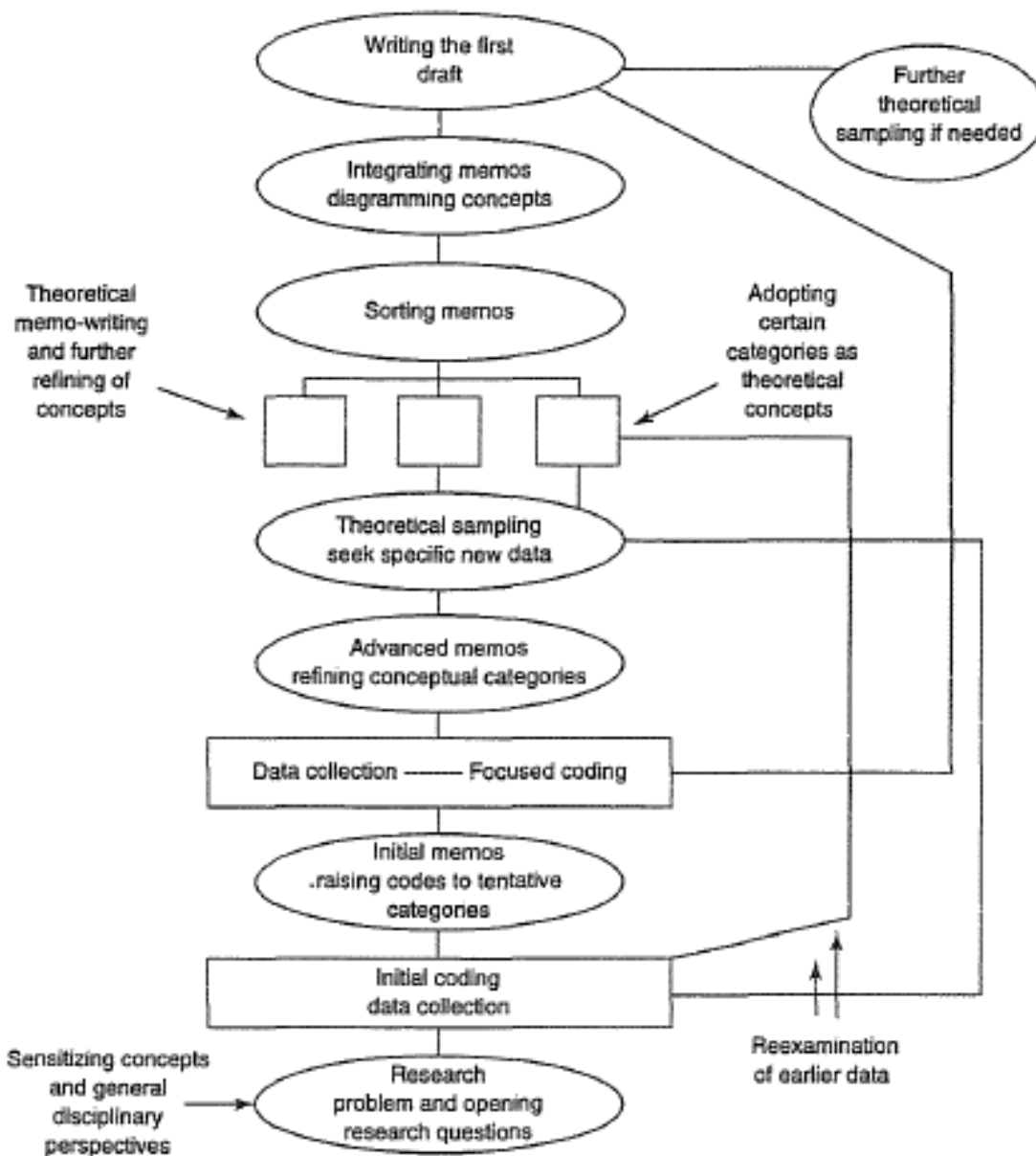


FIGURE 1.1 The grounded theory process

Figure 12. The Grounded theory process by Charmaz (2006, p.11)

The initial coding is a line-by-line coding which enables the researcher to make sense of the data. This is followed by focused coding which Charmaz describes as “using the most frequent earlier codes to sift through large amounts of data” and making “decisions about which initial codes make the most analytical sense to categorize your data incisively and completely” (Charmaz 2006, p.57). Memo-writing starts early on and helps develop more conceptual categories out of the focused codes selected.

Memo-writing is the writing of informal notes and emerging ideas coming from the focused coding, which supports the analytical development of the categories. Memos themselves become refined as the analysis progress and eventually help shape the first draft of the theory writing. In CGT, the building of **categories**, or '*categorising*' is essential. In this study, the building of categories is understood and used as Charmaz does, that is as:

the analytic step in grounded theory of selecting certain codes as having overriding significance or abstracting common themes and patterns in several codes into an analytic concept. As the researcher categorizes, he or she raises the conceptual level of the analysis from description to a more abstract theoretical level. The researcher then tries to define the properties of the category, the conditions under which it is operative the conditions under which it changes and its relation to other categories. Grounded theorists make their most significant theoretical categories into the concepts of their theory.(Charmaz 2006, p.186)

A category is in some ways similar to what defines a theme or a concept. The Theory that a CGT builds is then the core category, the concept or theme to which all others relate. Categories have subcategories, which express the properties of each of the main categories, and are linked amongst themselves and with the core category (Charmaz 2006).

4.3 Reflections on the Researcher's positionality and reflexivity

The researcher's positionality in qualitative research, and its impact, are ongoing sources of debate, particularly in ethnographic and feminist research (Maxwell, Abrams et al. 2016, Denzin, Lincoln 2005). They refer to the identities, values and biases (e.g. ethnic, religious, cultural, gender-based) researchers bring to their studies, and to the implications this can have. Thinking about positionality requires researchers to be reflexive about their own cultural and social contexts (Bryman 2012), and how those affect their conduct and how they are perceived in the field. Positionality does not stop at the gathering of the data, and researchers need to reflect on their positionality throughout the whole of the study process. As Maxwell expresses: "the multiple identities researchers assume can significantly affect the conduct of qualitative interviews – impinging on not only *what* is communicated, but *how* it is communicated and *how* it is interpreted as well" (Maxwell, Abrams et al. 2016, p.96).

The researcher in this study is a white, educated, middle-class female, from a 'Western industrialised country'. This position has implicit power within a context such as Malawi, where white people are usually working in NGOS, or as doctors or university professors. Given that the interactions in interviews and focus group discussions were about a well-mediatised policy change-which TBAs,

women and men were expected to comply with- this power differential has to be acknowledged. It placed the researcher in a powerful position, one where participants may wonder whether she was there to check if they were complying with the new Policy (even though they were reassured she was not).

Positionality can also shift throughout the process of a study. As Soni-Sinha expresses: “the power position of the researcher is not monolithic and static, and may shift during the research period between the researcher and the ethnographic subject/s” (Soni-Sinha 2008, p.518). For instance, here the researcher realised through the process of the focus groups with women that she brought to the exchange also her identity as a mother who had herself experienced a complicated childbirth, which gave her some empathy with the circumstances of some of the mothers in rural areas (e.g. having to deal with complications and no means of referral to hospitals). The researcher also brought to the study their previous qualitative research experience in Malawi (Uny 2008). Having a previous interest in what motivate the actions of community actors’ in Malawi was a strength. By giving again a forum to the voice and concerns of those less often heard (e.g. women, TBAs), the researcher was hoping to somewhat redressed the power imbalance between her and the community participants.

Field work, however, is an all-consuming activity, demanding both physically and emotionally. For that reason, the researcher ensured that the three periods of data collection were each followed by periods of transcription and dedicated data analysis, where all the positionalities described above could be suspended, and the data considered afresh. Reflexivity was applied to every aspect of this study, as expressed by Charmaz:

The researcher’s scrutiny of his or her research experience, decisions, and interpretations in ways that bring the bring the researcher into the process and allow the reader to assess how and to what extent the researcher’s interests, positions and assumptions influenced inquiry (Charmaz 2006, p.188)

4.4 Preparing for data collection in Malawi

4.4.1 The use of existing literature in this constructivist grounded theory

The role of a literature review in grounded theory (GT) in general has been disputed from the start. Glaser and Strauss originally recommended delaying any such review until the analysis had been completed (1999) so as to ensure that it did not direct the theory in a particular direction. However Strauss and Corbin later recognised that researchers do not start their research with a blank slate

(Strauss, Corbin 1997). Charmaz recognised this debate but offered more flexibility. She expresses that, as researchers develop their proposals and prepare for data collection, they are bound to read some literature. Charmaz’s recommendation is to use the literature review to build and demonstrate an understanding of the field in which the study topic is situated, perhaps identifying gaps that the study’s theory will address. She also suggests that literature can be woven into the study’s arguments, to show how the developing theory compares with previous literature (Charmaz 2006).

In keeping with Charmaz’s recommendations, a decision was made in this study to conduct a number of purposive, iterative literature searches and reviews before the fieldwork, and throughout the writing stages. At several stages, for instance, focused searches on TBAs and their roles were conducted, which are included in the table below.

Table 2. Example of focused search on the roles and perception of the roles of TBAs

Dates of iterative searches	Source	Search terms	date limiters	Exclusion
January 2012, repeated Sept 2016	Databases:Cinahl,Medline, Pubmed, Scopus; QMU Library Catalogue	Traditional Birth Attendants OR Traditional Birth Assistants OR Lay Midwife OR Village midwives OR traditional midwives		<ul style="list-style-type: none"> • Include studies in LIC/MICs • Include studies in English - exclude other languages
		AND role OR perception* OR view*		
		AND Low income count* OR Developing OR Africa OR Malawi	1980 to now	
repeated Sept 2016	Same databases	same search terms	2007 to 2016	same exclusions

In the early stages, this focused purposive search showed that TBA literature revolved mainly around the perceived ineffectiveness of their training for maternal mortality reduction, their personal characteristics, and the nature of their knowledge. It also showed a gap in studies conducted from TBA’s own perspectives, or from the perspectives of community actors, which provided a further rationale for the study. In later stages, the search served to critique and compare existing literature with

the theory's findings. Other searches using similar approaches as the above were conducted around the terms 'authoritative knowledge', 'policy analysis', 'skilled birth attendance' and other key concepts used in this study.

4.4.2 Research Preparations

The research design process involved the writing of a proposal and applications for ethical approval both at Queen Margaret University and also in Malawi, with the National Health Sciences Research Committee (NHSR), which is part of the Ministry of Health. After obtaining QMU approval and meanwhile awaiting approval from the NHSR Malawi, preparations were made to select sites to carry out the study and contacts were made in advance of departure (a fieldwork timeline is included in Appendix 1). Given the general Malawi context described in 1.2.1 and that women and TBAs from rural areas were the focus of the study, it was decided the study would focus on a number of rural sites (2 or 3). The decision to select multiple sites was to add a form of triangulation (Bryman 2012) to the study, to allow for cross-checking and constant comparison of different perceptions of the Policy implementation between sites.

4.4.3 Study Sites selection

Section 1.2.1 showed that despite Malawi's strategies promoting skilled attendance at birth, women residing in rural areas were less likely to deliver at health facility with a skilled birth attendant. It highlighted also that access and utilisation of facilities was most problematic rural areas. Although there are three main regions in Malawi, the decision was made to focus on sites in the Central and Southern region only. The reason was purely practical. It was anticipated that interviews and focus groups discussions (FGD) with TBAs and community members in rural areas would take place in one of the native languages (Chichewa or Chiyao), as people in villages usually do not speak English; if a study site in the North were to be included, those interviews and FGD would have to be conducted in another native language (Tumbuka), making it very difficult to manage translations and transcription across three languages, in a study of this size.

Therefore, contacts were made electronically with various NGOs and people known to the researcher²⁷ in the Central and Southern region, prior to departure from Scotland. Data collection itself took place

²⁷ The researcher has conducted previous research in the Central Region of Malawi, and has worked also for over a decade with development NGOs in Scotland which work with Malawi. Scotland and Malawi have a long history of working together, dating back from the work of early missionaries in the 19th Century. The Scottish Government and the Scotland-

between February and May 2013. A fieldwork and research timeline is provided in the following locations: Nkhoma (**Site 1**, district of Lilongwe), Mchinji (**Site 2**, Mchinji District) both in the Central Region, and finally in Malosa (**Site 3**, Zomba district) in the Southern Region, as shown on the map below:

Malawi partnerships work with the Malawian Government to support development efforts and exchanges between the two countries.



Figure 13. Map of the 3 study sites

Nkhoma (Site 1), was decided upon because the local hospital was a CHAM facility, and extensive rural area to serve with some difficult terrain. This enabled the researcher to compare interviews and FGDs around a private facility and those around a Government facility. **Mchinji (Site 2)**, was selected because it had a fairly large district government hospital, and also a widespread surrounding rural area. **Malosa (Site 3)** was selected whilst in the field, because it was in a different region (it also had a mission hospital run by CHAM), and served an extensive rural area with some very remote satellite rural health

centres. Having three sites for data collection, in two out of the three Malawian regions, adds weight to the study. The sites characteristics are described below so that a better understanding of the context in which the participants are situated can be gained.

4.4.3.1 SITE 1: Nkhoma Hospital and Nathenje area (Lilongwe District)



Figure 14. Pictures of the Site 1 area-© Isabelle Uny

Nkhoma village is situated about 50kms from Lilongwe, the capital of Malawi, in a hilly area where facilities can be hard to reach particularly in the rainy season. The distance from Nkhoma hospital to its central referral hospital in Lilongwe is 55 kms. As the city of Lilongwe has a central hospital which offers both secondary and tertiary level care for the Central region, the Nkhoma Hospital helps to relieve some of the pressure, and acts as a district hospital. It has 220 beds and is linked to ten local health centres²⁸; it delivers health services to circa 300,000 community members (Nkhoma CCAP Hospital 2014). It is a CHAM facility, and signed a service level agreement (SLA) with the Government in 2006 to offer free care for maternal and under five patients. At the time of the study, the hospital only had two working ambulances used for pick up and referral to the central hospital in Lilongwe. Nkhoma hospital conducts over 250 deliveries a month. It does not have a waiting home. The hospital carries out a Safe Motherhood Programme, which community mobilization component is delivered through ‘safe motherhood groups’ who educate local women. This may have meant that women in this area had a higher knowledge of the danger signs of pregnancy and a more medical perspective on what is safe motherhood (the need to be prepared, and to attend health facilities for delivery).

²⁸ For some of the numbers provided about each site no formal reference could be provided. Those details were obtained in discussion with local health staff during the fieldwork, and are cited here.

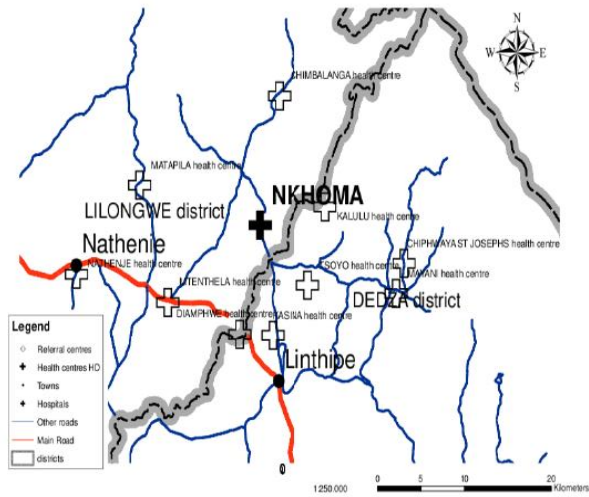


Figure 15. map of Site 1 and photo of Nkhoma CCAP Hospital (photo © Isabelle Uny)

4.4.3.2 SITE 2: Mchinji area (Mchinji District)



Figure 16. Pictures of Site 2 area (village and local health centre) © Isabelle Uny

Mchinji is situated in the Central region of Malawi, 109 kms from the capital Lilongwe and the central referral hospital, at the border with Zambia. The District’s population is of circa 500,000, with a very scattered population. Health services are provided by one Government district hospital in Mchinji and twelve health centres situated between 14 and 62 kms from the District hospital. The hospital has 242 beds (79 beds in the maternity ward). It carries out an average of 500 births per month. The Mchinji district also has a well-developed Safe Motherhood programme delivered by the Maimwana project (a

NGO created in 2005 as a collaboration between the Malawi Government Ministry of Health and University College London) which runs circa 200 safe motherhood women's group (Lewycka, Mwansambo et al. 2013). It is through the contacts of Maimwana and of the District hospital that the participants for this study in this site were recruited. The ex- TBA co-ordinator, a mature nurse midwife technician from the hospital, stated upon arrival in an informal conversation that at the 2009 count, it was estimated that there were 432 TBAs in the District of whom 128 had been trained in the past by the Government. She also stated that 186 had been officially oriented by the hospital on their new roles as contained in the 2007 Policy Guidelines. This hospital had an adjacent waiting home (WH).



Figure 17. Pictures of Site 2 (Mchinji District Hospital)-© Isabelle Uny

4.4.3.3 SITE 3: Malosa and surrounding area (District of Zomba)



Figure 18. Pictures of Site 3 area (local road and local health centre)- © Isabelle Uny

Malosa is a small trading centre which sits at the foot of the Malosa Mountain range, on the main road, 27 kms from Zomba and serves a population of circa 90,000 people. St Luke Mission Hospital is a CHAM facility, its referral tertiary hospital is Zomba Central hospital. It is the referral hospital for five surrounding health centres, the furthest of which is situated 130 kms away. St Luke's Mission hospital has 145 beds in four wards (male, female, paediatric, maternity) and performs over 150 deliveries a month. Next to the Mission hospital is St Luke's College of Nursing and Midwifery which trains student Nurse Midwife Technicians (NMTs) and the new Community Midwife Assistants²⁹ (CMAs).

²⁹ In 2012 the Malawi government, in order to increase the numbers of SBAs, particularly in rural areas, introduced a new CMA training (18-month training programme instead of the 3 years for NMTs, for midwifery only; to be posted in rural health centres); Though 3 were interviewed in this study, they were not included in the data as they did not meet the criteria of having practised as SBA for more than a year.



Figure 19. Pictures of Site 3 (St Luke's Hospital)-© Isabelle Uny

4.4.4 Sampling and recruitment

As discussed in section 3.2.4, bottom-up policy implementation analyses in LICs tend to focus mainly on the views of local implementers (such as district managers or health staff), rather than on those at the receiving end of the policies which affect their daily lives and choices (Scott, Mathews et al. 2012). This study wished to address this gap, and the decision was made early on to study the phenomenon from a multiplicity of perspectives at the micro level. The researcher was keen to explore how the Policy was disseminated and perceived not only by the actors in charge (e.g. skilled birth attendants, village headpersons) but also by other actors at community level. Because of this, the researcher decided to interview both SBAs and TBAs. Women were recruited to take part in focus group discussion (FGD), because they were the ones most affected by the Policy, and also had used the services of both TBAs and SBAs for deliveries in the past. FGD were also conducted with men, to capture the perspective of those who normally support women in their delivery care seeking options. FGDs with village headpersons (VH) were conducted because of the key role they were given by 2007 Policy Guidelines and the Presidential Safe Motherhood Initiative as expressed in section 3.4. FGDs with Health surveillance assistants (HSAs) were conducted because of their role at the cusp between health system and communities (their particular role is discussed in section 4.4.5.6). Other main stakeholders (OMS) interviews such as with Ministry of Health Officials and NGO representatives, helped forge a better understanding of the policymakers' perspective. Because of this multiplicity of

perspectives, this study contains a very unique data set. To the researcher's knowledge studies are rare where that many actors are consulted at once and in such depth with regards to policy implementation.

4.4.4.1 Eligibility criteria and sampling methods

The eligibility criteria set for the participants in this study are laid out in Table 3 below. They include participants' types, sample size, exclusion criteria and a note of the methods chosen to collect data from each kind of participant. In the case of TBAs, SBAs and HSAs, only those who had practiced for more than 1 year were included to ensure that they would have sufficient experience of working with women, or of deliveries. A broad range of TBA types was included for two practical reasons. Firstly, with the TBA 'ban' in place, it was anticipated that it may be more difficult to locate TBAs, therefore focusing on one type only would have been difficult. Secondly, since the Policy effectively redefined the roles of all TBAs, there seemed to be no valid reason to limit the sample to only one type (e.g. TTBA). The sample sizes mentioned in the table below were the anticipated sample sizes, rather than the final numbers achieved.

Table 3. Eligibility criteria for all participants in the study

Participant Type	Sample size (number of interviews or number of FGDs)	Description & exclusion criteria	Method Chosen (& team to undertake; R: researcher; RA: research assistant)
Traditional Birth Attendants (TBA)	20	Self-identifies as a TBA (whether family, trained or untrained TBA, TBA/herbalists). <u>Exclusion criteria:</u> TBAs who have practiced for less than a year.	Semi- structured Interviews (R with RA; in Chichewa)
Skilled Birth Attendants (SBA)	20	Nurse midwife technician, doctor or obstetrician, community midwife technician, community midwife assistant or clinical officers; practicing in either rural health centres or district/ hospitals. <u>Exclusion criteria:</u> SBAs who have practiced for less than one year.	Semi- structured Interviews (R; in English)
Women (W)	5	Adult women with experience of childbirth. <u>Exclusion criteria:</u> women younger than 18.	Focus groups discussions (R with RA; in Chichewa)
Men (H)	5	Adult male living in the local rural area. <u>Exclusion criteria:</u> men younger than 18.	Focus groups discussions (R with RA; in Chichewa)
Village Headperson (VH)	5	Adult man or woman VH living in the local rural area. <u>Exclusion criteria:</u> men or women younger than 18 (although unlikely)	Focus groups discussions (R with RA; in Chichewa)
Health Surveillance Assistants (HSA)	2	HSAs male or female working in the local communities. <u>Exclusion criteria:</u> HSAs who have	Focus groups discussions (R with RA; in Chichewa or English)

		practiced for less than one year.	as required)
Other main stakeholders (OMS)	10	Maternal health policy officials in the Government, or in regulatory bodies, representatives of national organisations working in maternal health	Semi- structured Interviews (R; in English)

Purposive sampling was used to begin the data collection. This is a non-probability sample that is selected by the researcher, based on their judgement and on the objectives of the study (Bryman 2012, Creswell 1998, Marshall, Rossman 2006). The initial purposive sampling was guided by what Palys calls “*stakeholder sampling*”, a type of sampling:

particularly useful in the context of evaluation research and policy analysis, this strategy involves identifying who the major stakeholders are who are involved in designing, giving, receiving or administering the program or service being evaluated , and who might otherwise be affected by it (Palys 2008, p.697).

Stakeholders are defined as actors or organisations who have an interest “in producing, consuming, managing, regulating, or evaluating the activity” (Hyder, Syed et al. 2010, p.160), which is the case of all the participants selected for the original sample.

In the first instance contact was made with people previously emailed at the hospital in Nkhoma (Site 1), and with an NGO working in maternal health in Mchinji (Site 2), who introduced the researcher to other local key contacts and also provided useful local context. Through those initial contacts the first participants were located. Following on from this snowball sampling was used to identify additional participants. Snowball –or referral- sampling is a technique by which existing study participants help recruit or recommend further participants for the study (Atkinson, Flint 2001, Noy 2008). Snowball sampling is particularly suited to studies wishing to recruiting hard-to-reach participants, such as the TBAs or remote rural men and women.

Later theoretical sampling was applied, partly to look for deviant cases and to sound the properties of tentative categories (Patton 2002). For instance, when the preliminary category of “*varying degrees of compliance with the policy*” started to emerge- and the researcher developed the concepts of “*compliance, concordance and resistance*”- particular TBAs displaying particular behaviours were recruited whose account may help the concepts

develop further; this may help understanding why TBAs may or may not comply with their new roles and the TBA ban. For instance, the researcher heard of a TBA who was thought of by the local hospital as a ‘model’ TBA very compliant with her redefined roles, and the researcher interviewed her. Another TBA was recruited who was said to be in open breach of the ban and still routinely delivering women. The goal of theoretical sampling, as Charmaz explains is different from the original purposive sampling, it is not about extending the population, or making it more diverse, it is about conceptual development, which is why it is used later in the CGT process (Charmaz 2006). Theoretical sampling also links to the issue of credibility, in the sense that it goes against a tendency in qualitative research to look for “congruity”- that is for cases which tell the researcher the same thing-, and therefore force the researcher to consider alternative perspectives or explanations (Booth, Carroll et al. 2013). The researcher aimed to follow as closely as possible the process of CGT as described in Figure 12, however the data collection period was relatively short, and time to conduct further theoretical sampling was curtailed.

4.4.5 Background to the Recruitment and Data collection

A total of 149 participants took part in this study. In all cases, participants were first approached either verbally or by email. An example of the information sheet in both English and Chichewa and a consent form are provided in Appendix 3. Those were tailored to the type of participants and were given to all, with sufficient time to review and discuss with the researcher before deciding whether to take part in the study. Prior to each interview and FGD, ample time was spent going over the information sheet with participants, and explaining the goals of the research, as well as answering any query. For rural community members particularly, some of whom were illiterate, this meant also explaining that the researcher and research assistant were not SBAs, nor representatives of from the Government. Issues of anonymity and confidentiality were also covered. Consent was sought from each and every participant in writing prior to the interview or focus group. Where participants were illiterate, their express consent was noted with a cross or drawing by themselves on the consent form, and witnessed by the research assistant, as a means to protect against coercion. The aims of the study was explained verbally again to each participant prior to the interview or focus group taking place, thus allowing for questions or concerns to be answered. Consent to record the interactions on a digital recorder was also sought and participants were reminded of their rights to withdraw from the study at any point, prior to any interview and FGD.

Given how much of this study is focused on multiple actors' perspectives- as explained in section 3.4- it is crucial to introduce the broad characteristics of each group of participant who took part in the study. This will enable the reader to gain further understanding of each actor's position, relationship and context, which are so important to the theory. The more specific details of the number interviewed and location of all the interviews and FGDs conducted in each of the three sites is provided in the next section in Table 4 .

4.4.5.1 Women

Women are at the centre of this study because the 2007 Policy Guidelines and TBA ban has affected them most. FGD were used to reach more women and seek a variety of perspectives (young and old women, primigravida, multiparous, etc.). The women's focus group discussions were conducted in-or near- the rural villages where the women lived, usually at the local community gathering place or at one of the women's houses. Only 2 of the FGDs were conducted at the local hospital. The picture below shows one of the groups, in its typical rural setting (all of the women pictured consented for their photo to be used):



Figure 20. Pictures of women focus group participants with research assistant © Isabelle Uny

The women who took part in the FGDs were of all ages, some in their 20s, most in 30s, a few in their 50s or 60s. They related that they came from distances of up to 15kms from their nearest rural health centre and some lived as far as 35kms or more from their nearest hospital. A large number of these women had little transport available to them to attend at facilities for delivery, other than walking or using a minibus or bicycle taxi. Those who took part in FGD

had had from 1 to 11 children, with the biggest families in FGD Site 3 (which could be attributed to an area with a larger Muslim population where it is customary for younger girls to marry early). A fair number of women who took part in the 7 FGDs had delivered their babies in the past both at home and at health facilities. Some had experienced the loss of one or several of their children or babies. However, only one in one FGD became very emotional talking about the loss of her baby in discussion, which is a much more common event in LMICs than in HICs. The researcher offered that she take time off the FGD or even stop taking part altogether if she felt she needed to; however she asked to pause the discussion, and when she was ready, the discussion resumed. Women's groups for Safe Motherhood were active in Site 1 and 2 of this study, which means that potentially women from those areas had more knowledge of the danger signs of childbirth and of the need for birth preparedness. The implications of this are discussed in the findings.

4.4.5.2 Traditional Birth Attendants (TBA)

The second most important actor of this study is the TBA, given how radically the 2007 Policy Guidelines changed their roles (banning them from conducting routine deliveries). In Malawi they are also referred to in Chichewa, as *mzamba* (sg) or *azamba* (pl). TBAs are normally female, often older, of modest means, and practice at rural village level. Those in this study expressed that they had learnt their trade in mentorship to other women or TBAs (mothers, elder sister, or grandmother). Some also related that their vocation of *mzamba* had come to them through a revelation from God. Some had done their work of performing deliveries with rural women in the surrounding area for decades. The number of deliveries conducted by the TBAs interviewed, when they were allowed to do so in the past, varied from a few to about 10 or 15 a month. For doing this work, they had normally received small amounts of money³⁰, or in-kind donations (food items, cloths). Some had been trained (TTBA) by the Government until the early 2000s, whilst some had not. They seemed firmly embedded in the cultural and belief systems of their communities, and some held some status as recognised TBAs. Very few TBAs with whom data was collected resided near a health centre or hospital. Most of those who participated in the FGDs lived in very basic houses - some in poor conditions-, and also practised subsistence farming. Although one particular

³⁰ Participants expressed that usually a higher amount was paid for a boy's delivery than a girl's. Although some SBAs did suggest that TBAs were paid K500 [50p] for a boy and K1000 [£1] for a girl, the data from TBA interviews [some of whom showed the register in which they recorded deliveries they performed] suggest it was more in the vicinity of K100 [10p] or K200[20p].

TBAs interviewed was in her 20s (serving as apprentice to an older TBA), most were in their 50s or 60s, and a few in their 80s (it must be noted that in rural areas in Malawi, few people know their exact birthday or how old they are, so these are estimates).

Some of the TBAs interviewed were also traditional healers, which meant that they also offered care to women and their families with traditional herbal remedies and spiritual healing. Although the 2007 Community Guidelines had prevented them from performing deliveries, they were not banned from practising as traditional healers (e.g. they could still provide help to women with spiritual matters and around matters of infertility). Those interviewed who were TBAs and healers appeared to have larger compounds and had some helpers at their disposal.

4.4.5.3 Men

FGDs were conducted with men because they were potentially the closest source of support for women in their delivery care-seeking decisions. As such, the researcher was keen to see how they perceived the Policy. Most of the men's FGDs were conducted in-or near- the rural villages where they lived, usually at the local community gathering (save for 2 conducted at a hospital antenatal clinic). The men who took part in the FGDs were mostly in their 20s and 30s, with a few older in their 40s or 50s. They had come from distances of up to 15kms from their nearest health centre for FGDs. Like the women, some lived as far as 35kms or more from their nearest hospital. The men in the study had had from 1 to as many as 15 children, with the biggest families in Site 3 also. Some of those men had escorted their wives in the past to deliver at health facilities, or at TBAs, some to both. However most stated that this was usually the role of female relatives.

None of the men in the FGD had been present at their wives' deliveries, whether at the health facility or in the home of the TBA. Male attendance at deliveries in Malawi is still rare and mostly an urban occurrence, even though few recent studies report some efforts at encouraging male companionship in labour (Kululanga, Sundby et al. 2012, Kalembo, Zgambo et al. 2013).

4.4.5.4 Skilled birth attendants (SBA)

In Malawi, delivery and post-natal care is provided at health facility level by nurse-midwives (NM), or nurse midwife technicians (NMT), clinical officers, and since 2013, by the new cadre of Community Midwives Assistants (CMA). Nurse midwife technician have not only trained as nurses for 3 years, they have also trained as midwives. There has been a debate

regarding the status of CMAs, who are trained as midwives only for 18 months and therefore technically are not SBAs (which requires 3 years training at least). Medical and patient assistants are not normally seen as SBAs but provide primary care and undertake administrative tasks, usually in rural health centres (AHWO 2009). Clinical officers and doctors perform surgical procedures, including caesarean sections or repairs for ruptured uteri, and usually work in district hospitals. The youngest SBA interviewed in this study was in her 20s with only a few years of practice, but most were very experienced, some even in their 50s or 60s. Some had worked as midwives for over 30 years in hospitals and health centres in several different districts, and had encountered TBAs in their careers and followed the changes in their roles over time. Two of the NMTs interviewed had been TBA co-ordinators³¹ in the past at the time when TBAs were still being trained by the Government, and still had some occasional contacts with those. All SBAs were interviewed in their place of work either at hospitals or in rural health centres, such as the one pictured below:



Figure 21. Pictures of labour ward in rural health centre (with C. Beya, Research Assistant) © Isabelle Uny

Clinical officers with time to be interviewed were hard to find, as they are the ones who handle severe complications and operations and tend to often be in theatre during the day.

³¹ Those co-ordinators were midwives at the district hospital who were charged with visiting TBAs regularly to supervise them and provide them with delivery kits; when the 'ban' came into place their role became to make the TBAs aware of the change and alert them that they should stop conducting deliveries

Some of the midwives interviewed in rural health centres were visibly tired and explained they had worked several shifts in a row, owing to staff shortages, which are also evidenced in other studies (Bradley, Kamwendo et al. 2015). Their dedication to serving women in their communities was remarkable. The SBAs who took part in this study performed between 3 and 15 deliveries in any single shift depending on whether they worked in a hospital or a smaller rural health centre. However not all health facilities were necessarily busy at the time that the interviews and discussions took place.

4.4.5.5 Village headpersons (VH)

The views of village headpersons (VH) were sought in this study, not only because of their key traditional and historical roles as leaders in their communities (Cammack 2011), but also because of the key role attributed to them in the Community Guidelines and by the recent Presidential safe motherhood initiative (2012), as mentioned in section 3.4. Those who took part in the FGDs were both female and male, which is common in Malawi. Most were village headpersons (VH), whilst some were group village headpersons (GVH), one was a traditional authority chief. Most appeared to live in as basic a condition as the men and women they served, most were also farmers. One female Traditional Authority (TA) Chief interviewed was responsible for 40 villages and their local VH and GVHs. Her house was more opulent, and she seemed to have an important position, and a steady flow of community members gathering at her house, seeking her counsel. A few VHs in the FGDs were in their 30s, but the rest were much older. They were for the most part very approachable, and seemed genuinely invested in the well-being of mothers and babies in their villages.

4.4.5.6 Health Surveillance Assistants (HSAs)

HSAs are a lower cadre paid workers based at the hospital but their views were sought at each site because of their roles as links between communities and the health care facilities' and the tasks which have been shifted to them, as was covered in section 2.3.6. The researcher felt they were the health worker most likely to have had contacts with TBAs. There are approximately 4500 HSAs based in communities in Malawi (McCoy, McPake et al. 2008). Their training requires only secondary school education, and lasts 10 weeks. They are not trained in maternity care. HSAs have been responsible for carrying-out a number of preventative and curative health tasks (e.g. vaccinations, distribution of anti-malarial tablets, checking on TB treatment defaulter) particularly with regards to child health (McCoy, McPake et al. 2008). They are not SBAs, and are mostly not involved in maternity care or

deliveries (save in conducting antenatal clinics). The HSAs in the FGDs conducted had from between 3 and 18 years of work experience in local communities. Some of the HSAs who took part in the study were involved in antenatal care (doing ANC outreach clinics for women who could not come to facilities for ANC visits), however most were involved primarily in vaccination programmes and other community health tasks.

4.4.5.7 Other main stakeholder (OMS)

The views of a number of other main stakeholders (OMS) were sought to gain background on the 2007 Policy Guidelines from a policymaker's perspective. Some OMS were Ministry of Health officials, some were regulatory body representatives, others worked in national NGOs in the area of maternal and child health, one was a local Safe Motherhood Programme co-ordinator, and one a lecturer at a key nursing college.

4.4.6 Methods for data collection

The researcher had general knowledge of all the types of participants described above and also extensive experience of conducting interviews in the Malawian context, having undertaken prior qualitative research in Malawi a few years before. The **interviews** were **semi-structured**, meaning that they were more open than structured interviews and allowed the researcher to probe interviewees when they wished to follow a topic of interest (Bryman 2012). An interview schedule was prepared in advance for each type of participant (and translated in Chichewa as necessary) to be used both in interviews and in focus group discussions. All the interview schedules are included in Appendix 4. The interviews ranged between 30 and 80mins in length, with most lasting 45mins to an hour. When entering the field initially, the interview schedules and their Chichewa translations were double-checked the Research Assistant for accuracy and also tested so changes could be made. The interviews and FGDs were digitally recorded and details of each interaction recorded into a field journal by the researcher, which helped the researcher maintain reflexivity, keep notes of decisions and supported the analysis. Two of the interviews (TBA02-03 and VH02-03) were group interviews, where 2 people were interviewed instead of one.

Focus group discussions differ from interviews in the fact that they are used to bring together a group of participants with similar traits and experiences. Their interaction in the discussion enables the researcher to take into account different experiences, and the

discussion enables participants to agree, disagree or argue on certain points (Bryman 2012). In a FGD setting there is usually a moderator and an observer /note taker. In this case the moderating role fell naturally on the Research Assistant, particularly when the FGDs were conducted in Chichewa. This also allowed the researcher to an extent to take a step back, and let the participants take control, and cover issues of importance to them (Barbour 2007). This method was chosen particularly to gather the views of women, men and VH, because it allowed the researcher to gain further understanding of their collective, as well as individual, perceptions of the 2007 Policy Guidelines. It also allowed the researcher to hear from more participants. However, a limit of 8 participants was placed on FGD participants numbers, because the researcher felt it may be difficult to maintain a meaningful discussions with a larger number (the smallest FGD was with 3 SBAs participants and the biggest with 8 women).

All interviews and FGDs taking place in Chichewa were undertaken by the researcher and research assistant together, as well as all other FGDs in English. Interviews taking place in English only were undertaken by the researcher alone.

This point brings the section to considering the key role played by the **Research Assistant (RA)** in a study such as this one, where participants speak a different language to that of the researcher. This is an aspect of the methodology seldom discussed in details, and yet the relationship with the RA and their role are crucial to the data collection process. In this study, selecting the right RA was considered as one of the most important tasks of field work. For reasons related to the topic under study, a female RA was selected. The RA for this study (Miss Caro Beya) was interviewed upon recommendation from the Centre for Research Studies in Zomba. She was selected for her experience and later showed excellent rapport with participants in the field. She was trained by the researcher on the aims and methods of the project for a day prior to the first interviews and FGDs, and thereafter in the field. The RA was paid at the going rate for RAs in Malawi in 2013 (as recommended by the Centre for Social Research in Zomba). As time went on the RA and researcher built mutual trust and a comfortable way of working together. This relationship was key, especially when conducting interviews in Chichewa where the main points had to be regularly summarised by the RA to the researcher so that further probing could take place. This RA had wonderful rapport with

community participants in rural areas particularly, and made them feel at ease with her warm personality and good humour. This likely also contributed to the quality of the data collected.

4.5 Recruitment and Data Collection

The below Table summarises the details and location of all the interviews and FGDs conducted in each of the three sites. In order to protect the anonymity of the participants, each interview and FGD was assigned a unique code. For instance the code TBA01 was assigned to the first TBA interview (01), whereas FTBA01, in the table below would refer to the first Focus group discussion (01) with TBAs. W01, refers to Women focus group number, thus the number 01. H01 refers to the first men’s focus group discussion (the letter H was used to refer to ‘husbands’ originally), and so on. A full list of all the codes with their descriptions is available in Appendix 2.

Table 4. Details and locations of all interviews and FGDs by Site

SITE 1- NKHOMA & NATHENJE AREA (LILONGWE DISTRICT) INTERVIEWS				
Participant type	Code (<i>unique reference</i>): Characteristics (<i>see below table</i>) ; Gender (female or male); and ~ approximate) age for TBA)	Number taking part in interview or FGD	Interview or FGD Location	Totals
Traditional birth attendant	<u>TBA01</u> : TTBA/H; Female; ~50 years old	1	Rural village, 3kms from the hospital*	6
	<u>TBA02-03</u> : TBAs; Female ~20s/50 years old	2	Rural village, 5kms from the hospital*	
	<u>TBA04</u> : TTBA; Female; 81 years old	1	Rural village in the hills, 10kms from hospital*	
	<u>TBA05</u> : TTBA/H; Female ~60s years old	1	Rural village in the hills, 10kms from hospital*	
	<u>TBA14</u> : TTBA; Female ~80 years old	1	Rural village, 25kms from hospital*	
Skilled birth attendant	<u>SBA01</u> : NMT, Female	1	Hospital (CHAM)	3
	<u>SBA02</u> : CO, Male	1	Hospital (CHAM)	

	<u>SBA03</u> : NMT, Female	1	Rural Health Centre (approx. 20kms from Hospital*)	
Village Headperson	<u>VH04</u> : TA, Female	1	At TA's house (25kms from Hospital*)	1

SITE 1- NKHOMA & NATHENJE AREA (LILONGWE DISTRICT)- FOCUS GROUP DISCUSSIONS

Skilled birth attendant	<u>FSBA01</u> : NMTs; Female	3	Hospital (CHAM)	3
Women	<u>W01</u> : Female	5	Both women FGDs took place at the hospital (CHAM), in a room adjacent to the ANC Clinic waiting area.	10
	<u>W02</u> : Female	5		
Men	<u>H01</u> : Male	4	Both men FGDs took place at the hospital (CHAM), in a room adjacent to the ANC Clinic waiting area.	8
	<u>H02</u> : Male	4		
Village Headperson	<u>FVH01</u> : 3 VH Male and 1 GVH Female	4	Both FGDs took place at the TA's compound community meeting place, 25kms from the hospital*	9
	<u>FVH02</u> : 1 VH Male and 4 GVH Male and Female	5		
Health Surveillance Assistant	<u>HSA01</u> : 3 Female; 2Male	5	Hospital	5
				45

Keys to the table abbreviations:

DR: Doctor; CO: clinical Officer; NMT: Nurse Midwife Technician; TA: Traditional Authority Chief; TBA: untrained TBA; TTBA: Trained TBA; TTBA /H: trained TBA also traditional healer; TBA/H: untrained TBA also traditional healer; VH: village Headperson

* Distances are calculated from the CHAM or District hospital contained in the site

SITE 2- MCHINJI AREA (MCHINJI DISTRICT)-INTERVIEWS

Participant	Code (unique reference):	Number	Interview or FGD	Total
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type	Characteristics (<i>see below table</i>) ; Gender (female or male); and ~ approximate age for TBA)	taking part in interview or FGD	Location	
Traditional birth attendant	<u>TBA06</u> : TBA/H; Female ~60 years old	1	Rural village 4kms from the hospital*	6
	<u>TBA07</u> : TTBA; Female ~50s years old	1	Rural village 2kms from the hospital*	
	<u>TBA08</u> : TBA/H; Female; ~50s years old	1	Rural hilly village 20kms from the hospital*	
	<u>TBA09</u> : TTBA/H; Female, ~70s years old	1	Rural hilly village 20kms from the hospital*	
	<u>TBA10</u> : TBA/H; Female; 73	1	Rural village 20kms from the hospital*	
	<u>TBA11</u> :TTBA/H; Female ~70s	1	The Rural village 20kms from hospital*	
Skilled birth attendant	<u>SBA04</u> : NMT, Female (ex TBA co-ordinator)	1	Hospital	8
	<u>SBA05</u> : NMT; Female	1	Hospital	
	<u>SBA06</u> : CO; Male	1	Hospital	
	<u>SBA07</u> : NMT; Female	1	Hospital	
	<u>SBA08</u> : NMT; Male	1	Hospital	
	<u>SBA09</u> : NMT; Male	1	Hospital	
	<u>SBA10</u> : NMT; Male	1	Rural Health Centre (35 kms from Hospital*)	
	<u>SBA11</u> : NMT; Male	1	Rural Health Centre (20 kms from Hospital*)	
Village Headperson	<u>VH01</u> : VH; Male	1	At rural community centre (30kms from Hospital*)	3
	<u>VH02-03</u> : VH; 1 Male and 1 Female	2	At rural community centre (30kms from Hospital*)	
SITE 2- MCHINJI AREA (MCHINJI DISTRICT)-FOCUS GROUP DISCUSSIONS				
Women	<u>W03</u> : Female	5	Rural village (30kms from Hospital*)	18
	<u>W04</u> : Female	5	Rural village (40kms from	

	<u>W05</u> : Female	8	Hospital*) Rural village (15kms from Hospital*)	
Men	<u>H03</u> : Male	5	Rural village (35kms from Hospital*)	11
	<u>H04</u> : Male	6	Rural village (15kms from Hospital*)	
Heath Surveillance Assistant	<u>HSA02</u> : 3 Male; 2 Female	5	Hospital	5
				51

SITE 3- MALOSA AND SURROUNDING AREA (DISTRICT OF ZOMBA)- INTERVIEWS

Participant type	Code (<i>unique reference Appendix 2</i>): Characteristics (<i>see below table</i>) ; Gender (female or male); and ~ approximate) age for TBA)	Number taking part in interview or FGD	Interview or FGD Location	Total
	<u>TBA12</u> : TTBA; Female; ~70 years old	1	Rural Health centre 25kms from hospital*	2
	<u>TBA13</u> : TTBA; Female; ~50 years old	1	Rural village 7kms from hospital*	
	<u>SBA12</u> : CO; Male	1	Hospital	5
	<u>SBA13</u> : NMT/CM; Female	1	Rural village 7kms from Hospital at HSA's house*	
	<u>SBA14</u> : NMT, Male	1	Rural Health Centre 30kms from Hospital*	
	<u>SBA15</u> : NMT; Female	1	Hospital	
	<u>SBA16</u> : DR; Female	1	Hospital	

SITE 3- MALOSA AND SURROUNDING AREA (DISTRICT OF ZOMBA)- FOCUS GROUP DISCUSSIONS

	<u>FTBA01</u> : 4 TTBA's, 2TBA/H, 1 TBA; all Female; ~30 to 70 years old	7	Both FGDs were held at a rural health centre (<u>approx. 130kms from the Hospital*</u>); some TBA's had travelled from their surrounding rural locations for up to 4 hours by foot to take part in those groups	14
	<u>FTBA02</u> : 3 TTBA's, 3TBA/H, 1 TBA; all Female; ~30 to 70 years old	7		
	<u>W06</u> : Female	7	Rural village 1 km	

	<u>W07</u> : Female	7	from Hospital* Rural village, 10 kms from Hospital*	14
	<u>H05</u> : Male <u>H06</u> : Male	4 6	Rural village 1 km from Hospital* Rural village 10 kms from Hospital*	10
	<u>FVH03</u> : 1VH Male and 4 GVH Male	5	TA's house (approx.. 10Kms from the hospital*)	5
	<u>HSA03</u> : 3 Male	3	Hospital	3
				53

4.5.1.1 Other Interviews conducted during field work

The rest of the interviews conducted are summarized in the table below. They were mainly of policymakers and others who could offer a 'view from the top' on the phenomenon under scrutiny. They were recruited by the researcher in writing (by email), and interviewed at various stages of the data collection.

Participant type	Code (<i>unique reference Appendix 2</i>); Number	Location	Total
Other main stakeholder	<u>OMS01</u> : Ministry of Health Official	1	Office in Lilongwe
	<u>OMS02</u> : Representative of Nurse/Midwives regulatory body	1	Office in Lilongwe
	<u>OMS03</u> : Maternal Health co-ordinator large Malawian NGO	1	Office in Lilongwe
	<u>OMS04</u> : Safe Motherhood co-ordinator	1	Hospital in Site 1
	<u>OMS05</u> : Lecturer at Nursing College	1	Office in Lilongwe
	<u>OMS06</u> : Ministry of Health Official	1	Office in Lilongwe
	<u>OMS07</u> : Director of Maternal Health large Malawian NGO	1	Office in Lilongwe
	<u>OMS08</u> : Maternal and Neonatal		

4.5.1.2 The use of mediators for recruitment in this study

The role of mediators in recruitment for qualitative health research, and their potential impact is not often reported on and is an important to reflect on. Here the mediator is defined, as by Kristensen and Ravn, as “a person who uses his/her formal or informal position and relationships to facilitate contact between a researcher and potential informants” (Kristensen, Ravn 2015, p.175). Various people in this study were used as mediators at different points, and in different sites, and served as points of entry to particular participants groups. For instance on entering Site 1, a note that the researcher wished to interview TBAs was sent via a very experienced and well known health surveillance assistant, who had worked in surrounding communities for a long time. In site 2, an older nurse midwife technician, who had been the TBA co-ordinator in the past at the hospital (in charge of training and supervision of TBAs), was used as point of entry. The rationale was that in the current context of the TBA ban, it is not necessarily easy to find TBAs, as some have ceased to practice and others may not necessarily want to be found as they still practice secretly (Banda 2013). Therefore, using the mediation of an ex- TBA coordinator who had had a personal relationship with local TBAs in the past, seemed appropriate.

However in order to limit the impact of the mediator on the gathered data, they were not allowed to attend the interviews (except for the first interview in the research when the ex-TBA co-ordinator was still present). It was the researcher who decided amongst all the possible locations, to select such or such TBA. In a couple of cases, the researcher and RA came to the TBA's house, but the TBA was absent (or working in her fields), and another was selected. In Site 3 the TBAs were recruited through word of mouth spread from the local rural health centre, which was very isolated rural health and serving a widespread population. To reach this location, the researcher and RA had had to travel for nearly four hours by minibus, bicycle taxi and on foot, and gained some understanding of the journey some women must undertake to go and deliver at the hospital. The TBAs who took part in the two focus group discussions at this very isolated rural health centre, were recruited by word of mouth through contacts at that health centre.

Mediators are often also referred to as ‘gatekeepers’, that is people who can facilitate or deny access to particular participants (Kristensen, Ravn 2015, p.175). In Malawi, those gatekeepers would normally be the village headpersons (VH). However for reasons explained in section

3.4 related to their ‘surveillance’ roles regarding TBAs, it is less likely that they would have been the best mediator for gaining access to TBAs in this study.

Women and men took place in FGDs separately, and were not related for the most part. The reason for conducting those FGDS separately was that, with childbirth being culturally a woman’s concern in Malawi (Kululanga, Sundby et al. 2012), it was felt that women would be less likely to speak if men were present. Women and men in Site 1 were recruited directly at the antenatal clinic at the hospital for reasons of convenience (as they came from spread our geographical areas). Once the FGDs started, it was noticed that men and women- some of whom had travelled some distance and had waited in the queue at the ANC clinic to be seen- seemed worried that if they took part in the discussion they may lose their place in the queue at the clinic. However, the researcher had agreed with the SBA in charge this would not happen, therefore, men and women would were able to leave the FGD if or when they were called for their ANC appointments. However, it is possible that in the setting of the hospital, those women and men may have been less inclined to speak less freely about the TBA ban and the problem they faced in their communities. In site 2, with regards to men and women recruitment the local mediator who was the head of a NGO which ran a number of Safe Motherhood women groups in the area. They had a lot of contacts in the communities, and sent word about the researcher’s study through their community agents. Men and women who wished to take part then met the researcher a few days later, at a place in their villages. Only some of the women in W03 actually belonged to one of the NGO’s Safe Motherhood women group. However the presence of the said NGO’s work in the area may have meant that, on the whole, these particular women and men were more aware of the importance of attending at facilities for delivery, which does not necessarily mean, as the findings demonstrate, that they did attend. In Site 3, the mediator used to recruit participants for women and men FGDs were the local village headpersons, who verbally spread the word amongst their communities about the researcher’s study. Those who wished to take part were then told they could meet the researcher a few days later, at a meeting place in their locality.

In all sites, SBAs and HSAs were recruited directly by the researcher through word of mouth at the Hospital and at Rural Health Centres.

In all sites, the VHs were recruited through the mediation of either local Traditional Authority Chiefs, or through the information of the hospital administrators.

4.5.1.3 Reflections on theoretical sampling in this study

None of the processes of constructivist grounded theory described earlier in Figure 12 are discreet phases with a beginning and an end but rather overlap and build upon one another. From the initial sampling at the start of the study, researchers move into some form of theoretical sampling, which Charmaz describes as “seeking and collecting pertinent data to your category(ies) until no new properties emerge... sampling to develop the properties of your category(ies) until no new properties emerge” (Charmaz 2006, p.96). In the case of this study, the preliminary categories starting to emerge from the coding and initial analysis of the data from Site 1 guided some initial theoretical sampling in Site 2. For instance, in order to further develop the properties of ‘*concordance/ compliance/ resistance to the ban*’, the researcher decided to include more untrained TBAs in Site 2 data collection, as in Site 1 most TBAs interviewed were with trained TBAs (TTBAs). The rationale was that this may enable the researcher to sense if there were differences between TTBAs and TBAs with regards to how they perceived the 2007 Policy Guidelines and their positions regarding its implementation. Later analysis demonstrated as Chapter 5 and Chapter 6 demonstrate that in this respect there was no difference between the perceptions of TBAs and TTBAs (save for the deviant case of TTBA-interview TBA14). Some theoretical sampling was applied too in Sites 2 and 3, with regards to developing the tentative category of ‘*breaking in linkages between TBAs and SBAs*’. The researcher recruited SBAs working in rural health centres to explore whether their perspective on the breaking in linkages between them and TBAs was different, given that they worked nearer to the communities they served. As the findings in Chapter 7 show, this appeared in fact not to be the case. However, this theoretical sampling gave the researcher empirical evidence to compare one emerging category to another, and as Charmaz expresses to decide whether she had “lumped properties under one category that might call for constructing separate, distinctive categories” (Charmaz 2006, p.106).

However, as Charmaz also states, “engaging in theoretical sampling prompts you to *predict* where and how you can find needed data to fill gaps and to saturate categories.” (Charmaz 2006, p.103). Theoretical saturation takes place when no further collection of data can add anymore to the categories identified (Charmaz 2006). It is unlikely that this study reached

complete theoretical saturation. Although theoretical sampling was used in the very early stages of the research, it was not possible to return to the field later on when the definitive categories were formed, and therefore it is possible that new properties of those categories could have still emerged, or new insights be found (for instance if the researcher had been able to return to some participants).

4.6 Limitations of the data collection

The main limitations faced in conducting data collection in this study were: working in translation, and time and financial constraints. Of the 54 interviews and focus groups discussions conducted, over half were conducted in Chichewa, which the researcher does not speak fluently. This means they were conducted in co-operation with the Research Assistant. This made the process of interviewing slower and somewhat less ‘flowing’³². Although the RA was very receptive and very well versed on the goals of the study, there is always a slight possibility that they may translate inaccurately what is being said by the participant. Although the interviews were recorded, there is equally a possibility that those who translated verbatim may translate somewhat inaccurately. In order to minimize this risk, the Chichewa interviews were first transcribed in Chichewa written, before they were translated in written English. Furthermore, the researcher applied some quality control to the translations from some of the Chichewa interviews by having a sample of those double-checked by a professional translator in Malawi (Mr Pearson Namatchosa), to increase the chance that they had been properly transcribed before they could be analysed (the sample double-checked included all TBA interviews and FGDs as well as of the women FGDs). However the process of transcription and translation was very time consuming and also very costly. Besides some of the interviews conducted in English which were translated by the researcher, 8 translators/ transcribers (including the RA) were hired and paid at the going rate to conduct the rest of the translations and transcriptions in Malawi, on which they worked tirelessly for weeks under the researcher’s supervision. These people were young University graduates, and personal contacts of the researcher in Malawi. The process of transcription and translation,

³² In an interview in another language the question is asked in the language of the interviewee, who answers. At some point which is a natural break in the answer, the RA translates the main points to the researcher, who may probe further on what the interviewee has just said, and then the RA moves to the next question, and so on and so forth.

particularly when successive waves of data collection are taking place, also somewhat delayed the analytical process.

Other limitations concerned the time some participants could give to take part in the study. For instance some of the midwives at facilities were under tremendous time pressure and overworked, and the researcher had to make every effort to accommodate their schedule for them to take part. One of the ways in which the researcher mitigated time-constraints was by working each and every day in the field whilst in Malawi, which was tiring, but also meant that the researcher was fully absorbed in the process of constant comparison and of joint data collection-coding-analysis.

4.7 Ethical considerations

Ethical approvals were granted for this project at Queen Margaret University in October 2012, and by the National Health Sciences Research Committee of the Ministry of Health in Malawi in December 2012, before data collection proceeded in February 2013 (a copy of both approval letters can be found in Appendix 5). However, ethical considerations reach further than the simple process of gaining approval from institutions. Ethical principles also relate to issues as diverse as personal beliefs & biases, professional integrity, relationship with, and responsibilities towards participants, accountability, anonymity and confidentiality (May 2001, Creswell 2009).

Much time and care was thus spent with each participant or group of participant to gather consent, maximizing the chance they understood the aims and the scope of the study. Every precaution possible was also taken to protect the confidentiality and anonymity of the participants. This started from the moment the interviews and FGDs took place. Recordings contained no names, but the unique reference code attributed to each participant or group of participants. Once they had been recorded they were downloaded into a password protected computer and a password protected NVivo software project (which also contained notes and journal), and backed up onto a password protected USB key for storage. When transcribed, the data was anonymized (with every name and place name removed from the transcripts and translations on word documents). The consent forms and the recordings and transcriptions have been placed upon return from fieldwork in the QMU Research Repository: <http://eresearch.qmu.ac.uk/> . Following submission of this thesis, this primary data will continue to be stored and retained in the Repository for a period of five years. Signed consent

forms will also be stored at Queen Margaret University, at the Institute for Global Health and Development for a year, after which they will be returned and placed thereafter in a remote secure storage for the duration of the retention of the physical data as per the Research Ethics Guidelines of the university (Section 1, paragraph 2.4.2).

Preserving the anonymity and confidentiality of participants, particularly of TBAs on whom a ban is now imposed and could be rendered more vulnerable if exposed, was seen as essential in this study. Therefore no photos of TBAs are displayed in this study to protect their identity. Any photo of participants in this thesis is reproduced only with express consent of the participants involved. In the findings, quotations are referenced by the unique code which was assigned to each transcript from each interview or focus group discussion, and the type of participant.

4.8 Data Analysis procedures

The analysis of the data collected was guided by the process indicated by (2006) as represented in Figure 12 . From the start interviews and FGDs were transcribed and translated in the field, and downloaded into the Nivo software to support the management, sorting and analysis of the data.

4.8.1 Initial Coding

The initial coding started in Site 1 with the first interviews conducted once they were transcribed and translated. This was a line-by-line coding of interviews or FGDs, which aimed to remain open, and not to apply preconceived concepts to the data. The researcher coded actively, using gerunds as to attempt to remain engaged in the actions participants expressed (Charmaz 2006). The initial coding produced a large number of codes, which were later focused and organised in subsequent waves of coding following each phase of the data collections. Some nvivo codes were created- where the participant's words are used verbatim as a code- where they seemed to fit the data perfectly (e.g. '*being stopped*', which emerged from the first TBA interviews and came to embody the way in which they seemed to perceived the 2007 Policy Guidelines).

Memo-writing started early on in the coding. Memos are notes which are written by the researcher which allow them to note ideas about the data, and the codes they chose and

gradually become more analytical as the coding becomes more focused and theoretical (Charmaz 2006).

4.8.2 Focused Coding

Charmaz described this phase of coding as a “selective phase that uses the most significant or frequent initial codes to sort, synthesize, integrate, and organize large amounts of data” (Charmaz 2006, p.46). In this study this consisted first in grouping large number of codes identified in the initial coding, organising them in trees, subsuming some earlier codes, and enabling categories to emerge. For instance, during the early initial coding, a code was formed named “*explaining differences in care received*”. After more focused coding this was split between ‘*technical care*’ and the ‘*interpersonal care*’ and properties shaped up which described both negative and positive experiences of such care. This then led to the emerging sub-category of code of “*experiences at the receiving end of delivery care*” and some of its properties “*being welcomed well or harshly*” and “*continuous support in labour vs neglect*”, which were later used in building the theory.

4.8.3 Theoretical coding, and advanced memo-writing

Theoretical coding followed on from focused coding, to “specify possible relationships between categories” (Charmaz 2006, p.63). This process was supported by the writing of more analytical memos and the building of more analytical categories. At that stage, memos help reach further abstraction in the theory building (Charmaz 2006, Strauss, Corbin 1990). Later the memos are sorted and form the first draft of the writing of the theory. An example of a more advanced memo can be found in Appendix 6.

4.9 Conclusion

In this Chapter, the methodology and methods used in this study were described at length, starting with the philosophical underpinning of the study. The choice of a CGT was justified, as well as the use of semi-structured interviews and focus group discussions as methods for data collection. The site selection and recruitment process were described in details and context was provided which will enable the reader to understand the role and position of each group of actors vis a vis the implementation of the 2007 Policy Guidelines. The procedures

for data analysis for this CGT study were also described. The following three chapters are the empirical Chapters, which describe the findings in which the theory is embedded.

5 Chapter 5: Between concordance and secret non-compliance with the 2007 Policy Guidelines

5.1 Introduction

This is the first of the findings Chapters. In this chapter and the two which follow, each of the main categories which make the grounded theory are presented. Each main category has a number of sub-categories which explain and relate to it. This chapter presents the findings supporting the first main category in the theory, of being *between concordance and secret non-compliance with the Policy*. Its subcategories are *facing new interdictions*, *yielding to the authoritative knowledge in childbirth*, *believing in the safety of skilled birth attendance*, *managing perceived risks*, and *partaking in secret-non-compliance*. This main category underlines the cognitive context in which women weigh their options for delivery care. It describes the cognitive factors which influence their positioning regarding concordance, compliance or secret non-compliance with the 2007 Policy Guidelines and TBA ban. The term ‘cognitive’ is used to mean the act or the process of knowing or perceiving of women (and other actors): what they know of the Policy, how they perceive it, what they believe about the care available at facilities and the skills of SBAs, and how they perceive other types of knowledge of childbirth (particularly TBAs’). In relation to the core category (weighing the options for delivery care), this category of *between concordance and secret non-compliance with the Policy* begins to show how, because the Policy (inc. sanctions) and the redefined the roles of TBAs, women-and to an extent TBAs- all have had to choose whether or not to comply with it. It exposes the space where the Policy enters the lived experiences of women and the “arenas in which interactions become oriented around problems of bridging, accommodating, segregating or contesting social, evaluative and cognitive standpoints” (Long 1999, p.1). This main category is extrapolated from not only women’s own perceptions, but also that of the other actors with whom they intersect: particularly VHS, TBAs and SBAs. For instance, it demonstrates how when it comes to risks, women and SBAs perceive and operationalise those differently. It shows how, even though both women and SBAs may both conceive of hospitals as safer for deliveries, this may not translate into their actions.

5.2 Facing new interdictions

The first subcategory *facing new interdictions* relates how the 2007 Policy Guidelines and TBA ban are perceived by participants, mainly as prescriptive, and as the expression of power over their decisions regarding delivery care options. As expressed earlier in section 2.3.1 the phrase ‘authoritative knowledge’ was applied to childbirth by Jordan (1997) to explain how the biomedical knowledge gained ascendance and legitimacy over other types of knowing in childbirth, often leading to their devaluation. Within the context in which women weigh their options for delivery care in rural Malawi, the data will show that authoritative knowledge is apparent not only in the content of Policy itself and what it promotes, but is also embodied in those who implement it (e.g. VH, SBAs) and hold such knowledge. By contrast the lesser knowledge, viewed as outdated and not fit for the purpose of maternal mortality reduction, is the traditional knowledge embodied by traditional birth attendants (TBAs). By exploring the workings of authoritative knowledge in childbirth in relation to a maternal health policy implementation in a LIC setting, in a manner not done before, the findings add significant nuances to the development of this concept. The below subsections show how different community actors perceive the new interdictions which came with the Guidelines for Community Initiatives for Reproductive Health (Republic of Malawi Ministry of Health 2007a)

5.2.1 Perceptions of the 2007 Policy Guidelines and TBA ban

The findings show that, first and foremost, this Policy was perceived as imposed from the top down. As expressed in section 3.4 this Policy’s authoritative power lay in the hands of those who issued it (the Government, “the stronger power base” (Jordan 1997) and of those who can ensure that it is complied with (district and other health officials, village headpersons, SBAs). This type of authority is what Sargent and Bascope call the “control of action” (Sargent, Bascope 1996, p.214). It typifies “a top-down model of implementation... by those with authority located at the upper reaches of the bureaucratic or organizational hierarchy, in pursuit of pre-determined policy objectives” (Erasmus, Gilson 2008, p.362). This control of action and exertion of power over was perceived by the community participants in this study, who routinely expressed that TBAs had been “*stopped*” by the Government or indeed by the health workers (SBAs and District Health Managers), whom they saw as an extension of the Government. The word ‘*stopped*’ expressed both the sudden and imperative nature of the new rule. The table below was drawn to shows the phrases community participants actually used

to describe the Policy. It provides a departure point in the Chapter, to understand the way the Policy is perceived to show how these perceptions may influence the actions of women, and those who support them in their delivery care seeking.

Table 5. Terms used by Participants regarding the 2007 Policy Guidelines and TBA ban

<p>A- Terms used by TBAs to describe the 2007 Policy Guidelines & TBA ban</p>	<p>B- Terms used by other Community participants to describe the 2007 Policy Guidelines & TBA ban</p>
<p><i>"we were stopped from conducting deliveries to people", "they banned us up", plus a number of participants saying "they stopped us" (TBA, in focus group FTBA01³³)</i></p> <p><i>"they stopped us not to do the deliveries in the village", "they banned us" "they told us not to deliver women at home" (TBA in focus group FTBA02³⁴)</i></p> <p><i>" they say the azamba should stop operating" (TTBA in interview TBA01)</i></p> <p><i>"there is a new policy that after giving birth you need to go to the hospital" (TBA in interview TBA02).</i></p> <p><i>" a new policy came out" (TTBA in interview TBA04)</i></p> <p><i>" we do not have the authority to do that job" (TTBA in interview TBA05)</i></p> <p><i>" we were told to stop" " it was a Government policy so you can't go against it" (TBA in interview TBA06)</i></p> <p><i>" it was stopped" (TTBA in interview TBA07)</i></p> <p><i>"they have stopped us...we should stop...it's prohibited...it has been stopped everywhere" (TBA in interview TBA08)</i></p> <p><i>"the change that has been there is the one they are saying the TBAs should stop" (TTBA in interview TBA14)</i></p>	<p><i>" because of the upcoming policy that the TBAs should stop operating" (woman in focus group W02)</i></p> <p><i>"Because of the law that we are using that someone should not deliver at home but at the hospital" (woman in focus group in W04)</i></p> <p><i>"the law that they have put in place" (woman in focus group W06)</i></p> <p><i>"(Participant1)The TBAs were stopped"; (Participant 2) " the decree came... they stopped them so that people should go to the hospital to get help" (men in focus group H03)</i></p> <p><i>"we have rules in place that those expectant woman who deliver in the village or along the way, it is an offence to the chief" (village headperson in focus group FVH01)</i></p> <p><i>"the government banned the TBAs, the nurses came in the villages to explain to the TBAs the reason why they have stopped them" (village headperson in focus group FVH02)</i></p> <p><i>"they were stopped by health workers from the hospital and us chiefs"(village headperson in interview VH01)</i></p> <p><i>"it is the health workers who gave a directive in conjunction with the government that there will no longer be azambas in this village" (village headperson in group interview VH02-03)</i></p>

³³ In order to make reading easier, quotations from participants are referenced by the interview or FGD unique codes -a key for which is provided in Appendix 2- and with a description of the type of participant (e.g. Male clinical officer, female nurse midwife technician or TTBA.) .Where several participants are quoted in the same extract from a focus group discussion, they are referenced as Participant 1 and Participant 2 and so on.

³⁴ Where quotes are cited from the focus groups FTBA01 and FTBA02, these do not mention if the TBA quoted was a TTBA or a TBA, because the nature of the discussion with 7 people in the group made it impossible to record this information at the time.

These extracts are used as a form of basic discourse analysis here, depicting how words used may show how “an object and the ways of depicting it frame the way we comprehend that object” (Bryman 2012). Namely, the way the 2007 Policy Guidelines and TBA ban are depicted show they are seen as imposed from above, as an immutable edict that should be obeyed. The participants use the pronoun “*they*” as in “*they stopped them*” (or us) in the passive form, when they described where the Policy originated from. This points to perceptions of an authority located outside of the community, unspecified, and remote, yet still powerful enough that it needs to be obeyed. Participants often conflated the authority of hospital, SBAs, and VH as being one and the same, because they saw them as an extension of the central Government. Interestingly, some of the village headperson (VH) saw themselves as part of this authority as the quote in Column B shows: “*they were stopped by health workers from the hospital and us chiefs*” (VH01). Words such as “*it’s prohibited*” (Column A), or “*the law*” or “*rules/decree*” shows the perceived strength of how Policy Guidelines were viewed as legislation, despite the fact that they were not. As explained in section 3.3, the Guidelines for Community Initiatives for Reproductive Health (2007a) were originally presented as a means to empower the community to partake in interventions to reduce maternal and neonatal mortality. However, because the policy was not the result of a consultative process with the communities, but imposed from the above, it has been perceived as a law. Specifically, it has been perceived as a law that places interdictions on community actors, such as the ban on the utilization of TBAs for routine deliveries.

One of the main reasons this Policy has been perceived as top-down and prescriptive is because it was first disseminated to the communities through meetings called by the health authorities and the chiefs, and was later backed up by the application of potential sanctions for non-compliance. As previously explained, village headpersons (VH) and group village headpersons (GVH) hold considerable power and authority in their areas. They are able to observe what is taking place in communities, directly or for instance, indirectly, by nominating volunteer ‘*amayi a chinsinsi*’ or ‘*secret women*’³⁵, who support the VH by recording the number of pregnant women in the community and report whether they delivered at health facilities. VH were given a key role in safe motherhood by the PISM. The

³⁵ Secret women are sometimes given two or three days of training; their role is to go door to door, identifying pregnant women for the VH, and educating them with regards to matters related to pregnancy and family planning.

strength of this delegated authority is made visible in the excerpt below from a key Ministry of Health Official interviewed:

the chiefs are custodians of everything, ...they must take responsibility for every death that happens in their village, they must be able to count the pregnant women, they must be able to count the children, ... the chiefs must be able to say... use their power of the culture and tradition to say no, we are going to set these rules, any death is not acceptable, every pregnant woman must be registered, they must deliver at the health centre, they must never deliver at Traditional Birth Attendants, no traditional birth attendant must be allowed to deliver in the village for whatever reason (Ministry of Health Official, interview OMS06)

One of the means which VH have enforced the rules and ensured the compliance of villagers has been to apply fines for women who deliver at home or at a TBA (and fines for TBAs too), which are imposed through local bylaws. The following extract from a village headpersons' FGD expresses this:

Participant 1: Since we have rules in place that those expectant woman who deliver in the village or along the way, it is an offence to the chief. We say they should pay a goat, but it's just a matter of encouraging them to go and deliver at the hospital because there are still other people that do not follow such rules of delivering at the hospital due to their own reasons. Participant 2: I just want to add, that we have put that rules in place because you know there are still some other people who don't follow what we are saying that's why those that deliver at the TBA or along the way are supposed to pay a goat (Village headpersons, focus group FVH01)

It was interesting to note that the VH in this extract saw the sanctions as an encouragement, rather than a punitive action. The use of fines for home and TBA delivery, used as a deterrent, is supported by evidence from other personal correspondence with B. De Kok (January 2015). A very recent article concerning the TBA ban in Malawi (Godlonton, Okeke 2016) also raised this issue. Those references suggest that bylaws are now quite commonplace in Malawi. They were certainly prevalent in this study. In over half of the women's and a third of the men's FGDs (from Site 1 and Site 2) in this study, participants stated that fines could be applied to them if they delivered at home. The cost was usually a goat, or chicken(s), or an amount of money sometimes as high as to K3,000 [approximately £3] to be paid to the VH. For most rural community members, this would be a significant price to pay. It is clear that the sanctions were seen as a deterrent also by participants, in fact women and men stated that the fear of fines was one the reasons they went to hospitals for deliveries. Therefore through this form of punitive action, village headpersons (VH) have de facto become a 'street-level bureaucrats', an extension of the authority of the Government in

charge of the implementation of the new policy (Erasmus 2014), as is expressed in the quote below by a VH:

When we received the message, knowing that hospital people are experts in health issues, we convened a meeting and announced that no pregnant woman should come to azamba for delivery. You azamba should stop welcoming pregnant women for deliveries. They should go to hospital. So they were stopped by health workers from the hospital and us chiefs. I ordered azamba to stop operating in my village...Yeah, the government issued a directive ... So when I received that directive, it filled me with awe and admiration as I noted that it is a sensible directive...So about azamba, I advised people in my village to never dare go to azamba here in my village when they fall pregnant, No (village headperson, focus group VH01).

This quotation shows how the delegated power of top-down authority (those viewed higher in the social and organizational hierarchy- SBAs, Government- with ‘awe and admiration’ by the village headperson) is used to facilitate the dissemination of the message which itself is backed by authoritative “expert” knowledge and perceived locally as a ‘sensible directive’. The impact was indeed powerful as this VH expressed: “*they were stopped by health workers from the hospital and us chiefs.*”

However, conversely the way the policy was disseminated and implemented, along with the threat of the sanctions, has left community participants feeling somewhat powerless (as exemplified in the table above with the use of passive phrases such as ‘*they have stopped them*’, ‘*we were stopped*’). The manner in which women particularly perceived the new policy did betray a lack of engagement with the process. This is tellingly expressed by the woman in the quote below:

Here we are at the receiving end, do this, we do it, don't do it, we stop. So that is how it goes, so when they just said the TBAs must stop, they stopped (woman, interview W04)

This finding resonates with Banda (2013), which stated that women felt they had not been consulted when the Policy which included the TBA ban had been put in place. This perception may have consequences on the actions/re-actions of women with regards to their compliance with the Policy. These are explored towards the end of this Chapter.

Whereas the above section has shown how the 2007 Policy Guidelines and the authorities who issued it were perceived, the next section explores how some of the intention behind this policy are perceived. It is the Government’s stated intention that all “the availability and utilization of quality Emergency Obstetric Care (EmOC) and the assistance of skilled

attendants at childbirth are critical prerequisites for the reduction of maternal and neonatal mortality” (Republic of Malawi Ministry of Health 2007a, p.1), to ensure that “all women in Malawi go through pregnancy, childbirth and the postpartum period safely and their babies are born alive” (Republic of Malawi Ministry of Health 2007b, p.6). The ‘safety’ of hospital deliveries, in the mind of policymakers, is guaranteed by the assistance of a skilled attendant at delivery, who has not only the authoritative knowledge in childbirth, but also the necessary equipment and enabling environment at their disposal to protect women against childbirth’s potential risks and complications. By contrast, they claim that this safety cannot be guaranteed by TBAs, because their knowledge and skills are considered insufficient, and their environment lacking. The next section thus shows how through the 2007 Policy Guidelines, the authoritative biomedical knowledge has established itself more deeply and led to the devaluation of TBAs’ knowledge, even at community level.

5.3 Yielding to the authoritative knowledge

This sub-section relates to the multiplicity of existing knowledge about childbirth, and their interface with the 2007 Policy Guidelines and TBA ban. As the findings in this section show, even though one type of knowledge has become the dominant one and women are *yielding to this authoritative knowledge*- other knowledge do subsist and are weighed in their decision-making. As Long stated:

knowledge is a cognitive and social construction that results from and is constantly shaped by the experiences, encounters and discontinuities that emerge at the points of intersection between different actors’ lifeworlds (Long 1999, p.3).

The main argument given by Malawi policymakers for banning TBAs through the 2007 Policy Guidelines, was that their traditional skills and knowledge were insufficient to deal with complications in childbirth which may cause deaths. In fact, the Government’s assessment of the role of TBAs conducted in 2006 which led to their banning stated that:

15% of women have serious complications during pregnancy or delivery. Reduction in MMR has to target these complications with interventions that have been proven to be effective. TBAs have little impact, if any, on these complications. Much emphasis is therefore now being placed on importance of emergency obstetric care (EmOC) and this has now become the focus of safe motherhood activities. To save lives, programmes must ensure that mothers have skilled attendants for normal deliveries and EmOC for the complicated ones. TBAs cannot provide the latter (Republic of Malawi Ministry of Health, WHO Malawi 2006, p.22)

Promoting skilled birth attendance through Policies has been seen by policymakers as a way of moving away from traditional knowledge and behaviours in childbirth and towards more

modern, and deemed as safer, knowledge and practices. As a Ministry of Health official articulated it:

we are moving with the times, we are moving with technology, we are moving with the trends , and the advice from the technical expertise is that we go skilled attendance at delivery (Ministry of Health Official, interview OMS01)

This quote denotes the modernisation agenda described in section 2.3.1. and that SBAs are seen by policymakers as holding skilled modern knowledge, unlike TBAs.

5.3.1 TBAs have experience but no knowledge: the nature of competing knowledge in childbirth

Long and Jinlong, whose insights have been used in the analysis in this study, stated in their actor interface analysis (AIA) approach that:

knowledge is present in all social situations ... it entails the interplay or confrontation of 'expert' versus 'lay' forms of knowledge, beliefs and values, and struggles over their legitimation, segregation and communication (Long 1999, p.3)

With the exception of the TBAs themselves, most of the participants in my study expressed this interplay. They reported that TBAs have experience but not knowledge. This suggested that they perceived a clear segregation between TBA and SBA knowledge in childbirth. In those participants' views, TBAs' experience in childbirth was traditionally gained, intuitive, but remained somehow limited. On the other hand SBAs' knowledge was perceived as schooled, rational, in-depth. Those who perceived the difference most keenly were SBAs unsurprisingly. As holders of the authoritative biomedical knowledge in childbirth, SBAs claimed that TBAs experience albeit in some cases of having carried out hundreds of deliveries in their career was not 'knowing'. The quote below shows this:

I don't think they have the knowledge, to me I think they are just doing that because of the experience of what has happened through the other deliveries and they wait for the other delivery to take place; but I don't they really follow the mechanism of what, how the pregnancy really works, maybe the contractions, how the baby descends down to the vagina they don't know anything about that. What they know is that at the end of the day the baby will come from this way (Male Clinical Officer, interview SBA12)

The above quote paints the portrait of a rather passive TBA just waiting for a baby to be born in the same fashion every time, as they have always experienced. It describes a TBA with little understanding of the physiology, which, as will be demonstrated later is not the way some TBAs view their own knowledge. Yet for SBAs, this kind of experiential knowledge contrasted with their own biomedical knowledge, which they described first and foremost as

schooled. This is because SBAs had attended nursing training college to learn their trade, whereas TBAs had not, as is expressed in the following:

here I can say we are more trained than them. Some of them did not go to school they are ignorant, yes they were trained but they cannot manage to do everything (Female Nurse Midwife Technician, interview SBA01)

maybe when the woman is in labour, here at hospital, we know that the cervix has to go from 1cm to 10cm, we learn in class at least for 3 years, but for them they just like, they just doing it, they just look out for signs for second stage of labour...but of course they, but the, most of them didn't go to school so it is difficult to say this 2 or 3 cm so that's why they mostly use the signs for, what they see from the woman (Female Nurse Midwife Technician, interview SBA15)

For the SBAs in the quote above, even TBAs who had received Government training, did not have enough knowledge. Yet, in counterpoint, it can be said that the TBAs interviewed in this study seemed confident in their own experiential knowledge in childbirth, even though they recognized also that it was not schooled. The quote below shows this:

(Participant 1) we have a lot of knowledge because we have delivered a lot of babies but without problem even if we are not educated; ... (Participant 2) we are the ones who have a lot of knowledge even though we did not go to school because we just use wisdom from God ; (Participant 3) we have a lot of knowledge as TBAs because we use our head, while the nurses they assess the patient, do a lot of check-ups...we just use our own knowledge and deliver the woman properly (TBAs, focus group discussion FTBA02)

This quote expresses that TBAs have confidence in their abilities, in the skills they have gained in conducting a number of successful deliveries. It shows that for TBAs, even though experience may not be equal to biomedical knowledge, it does count. This kind of cognitive self-perception by TBAs is rare, but is reported in a couple of studies conducted in Kenya (Dietsch, Mulimbalimba-Masururu 2011b, Dietsch, Mulimbalimba-Masururu 2011a). It highlights the importance of being able to hear the voice of TBAs themselves in studies concerning them and their utilisation in maternal health care strategies.

In this study, for instance, those TBAs who had received training in the past from the Government, described their knowledge as more blended, a mix of their own experiential knowledge and what they had learned in formal training in the past (more akin to the biomedical knowledge). Some TBAs had integrated into their practice procedures more akin to those of SBAs. For instance they talked in their interviews about carrying out 'assessments' on women who presented to them, as SBAS do, such as in the following:

because when I observed them, I assessed them and concluded that she would not deliver, immediately I would refer them...They told us to be counting minutes[between contractions] two, three, then take her here. You want to wait and observe her and if time is going up to three and you have seen that...we take her to the hospital (TTBA , interview TBA04).

The word ‘assessment’ is often also used by SBAs describing how they deal with women in labour. This betrays, as Long expressed, an “interplay” of different knowledge in childbirth (Long 1999, p.3). It works both ways and in fact there has been some debate around whether midwives use their intuition, as much as their schooled knowledge and expertise when they deliver babies, an intuition is depicted as a mix of experiential knowledge and expertise (Davis-Floyd, Sargent 1997, Cheyne 2008, Hunter 2008)

However, for the SBAs in this study, the experience and self-confidence of the TBAs, could not compare to what they described as their own scientific knowledge. The SBAs considered their knowledge as superior because it gave them the ability not only to measure, and read ‘scientific’ or technical instruments, but also to make rational decisions. Those rational decisions were needed for instance, when deciding on how and when to best intervene in deliveries, particularly where complications occurred, as the SBA expresses below:

their [TBAs] knowledge is limited somehow, because you know I would say my knowledge is sort of scientific I do certain things because there is a reason why I have to do that...while the TBAs they do that out of experience, like ‘Last time I did this I was successful so it means this is the best way of doing’...Me, I know may be in the third stage, I have to give Pitocin, because I want to shorten it so that the woman doesn't develop the post-partum haemorrhage. I am doing interventions with a rationale, to say “I have to do this, because of that!” the TBA doesn't have that kind of understanding, right? at the same time I am using a labour graph I am monitoring this labour, I know this labour's maybe now has crossed the action line, there is something else we have to do, a different intervention otherwise we are heading on the wrong bend. The TBA just waits until, they just follow the progress of labour awaiting when the baby is going to pop out... The TBA doesn't have that kind of ..., you know, scientific reasoning. (Male Nurse Midwife Technician, interview SBA09)

The type of analytical knowledge and rational decision-making described in this quote is typical of the biomedical management of childbirth (Tew 1998, Rhodes 1995). When the biomedical management of childbirth is pitted against the traditional, experiential knowledge of TBAs, decisions taken in the context of the latter framework seemed to be made more on the basis of instinct, and can appear haphazard. This is because, as Cheyne explains, “analytical thinking is characterised as slow, reasoned and deliberate thinking which may be logically explained, while intuitive thought is fast, automatic, experiential and may not be logically described or explained” (2008, p.43). In this “*scientific reasoning*” described above,

SBAAs are aided by their grasp of physiology and anatomy, which they claimed allow them to assess complications and thus take appropriate action, as expressed below:

You know a midwife is trained in a lot of things, you know the anatomy, the structure of a human being and we, even when pre-partum you know if I can touch here, I'm touching either a liver or whatever and even the presentation, so most of the azamba just see, they depend on the shape...I mean the shape of the pregnancy, they may say if it is round it might be a breech or it might be...you know while we the midwives we can say 'ah this is transverse', this is a breech this is shoulder presentation of whatever because we have got the skills (Male Nurse Midwife Technician, interview SBA14)

However the above quote begs the question as to whether indeed SBAAs always know with certainty what is happening 'inside' the body of the pregnant woman and whether they are necessarily as skilled as they claim. This issue has been raised by a number of studies (Bell, Hussein et al. 2003, Harvey, Blandón et al. 2007, Graham, Bell et al. 2001), including in Malawi. In Malawi, a study of knowledge and perceptions of quality of obstetric and newborn care involving 52 SBAAs in three districts of the central region, found, for instance, a significant percentage were lacking in their "knowledge regarding monitoring during routine labour and management of emergency new-born care" (Bayley, Colbourn et al. 2013, p.1). Another recent Malawian study which retrospectively investigated 14 maternal deaths in the central district of Lilongwe cited some deficiencies in SBAAs knowledge and skills including "inadequate clinical workups and monitoring, missed and incorrect diagnoses, delayed or incorrect treatment" (Thorsen, Meguid et al. 2014,p.16). Interestingly, the TBAAs interviewed in the study presented here did express that they felt it was not enough to focus on what is happening inside the pregnant woman -applying the 'clinical gaze' (Foucault 1973)-, and on mechanistic tasks, as the excerpt below expresses:

Azamba [TBA] she has more knowledge because if she finds a pregnant woman she gives chances to the woman to explain everything, how she feels, when she started labour, whilst the doctors they say, this is your time, you have to deliver, or this is not your time to deliver, you have to wait such and such a time to deliver whilst they are writing on their hospital pads. (TTBA, interview TBA13)

Indeed, the reliance on scientific, standardized knowledge at the expense of basic communication with the woman, has been leading to deficits in interpersonal care which are problematic and explored at length in sections 6.2.4.1 and 6.2.4.2.

Figure 22, presented below is the model of the hierarchy of knowledge in childbirth built from the analysis of the data in this study. In the figure, the two main forms of knowledge –

SBA's and TBA's -are labelled 'skilled-biomedical-scientific-analytical knowledge', and 'traditional-intuitive-experiential knowledge'. As the pyramid shows, '**SBA skilled knowledge**' has gained value and is placed at the top. It is the knowledge prioritised by the 2007 Policy Guidelines and other Government Policies for maternal mortality reduction. It is seen as the knowledge which is deemed scientific and which can deal with complications in childbirth, and is therefore the authoritative knowledge. By contrast the '**TBA Traditional knowledge**' is placed lower the hierarchy. It is devalued because it is based on intuition and because it is deemed insufficient to deal with obstetric complications. At the very bottom of the figure is another layer in the hierarchy of knowledge, other knowledge in childbirth, such as the woman's own embodied knowledge. Embodied knowledge in health refers to knowledge which is not necessarily made explicit but is felt and known through the body and comes from experience (Blaxter 2004). The concept has been applied in childbirth, to refer to what women know intuitively 'in their own body', rather than rationally or intellectually (Cheyney 2008, Fahy, Parratt 2006, Davis-Floyd, Sargent 1997). It may be particularly present where multiparous women are concerned.

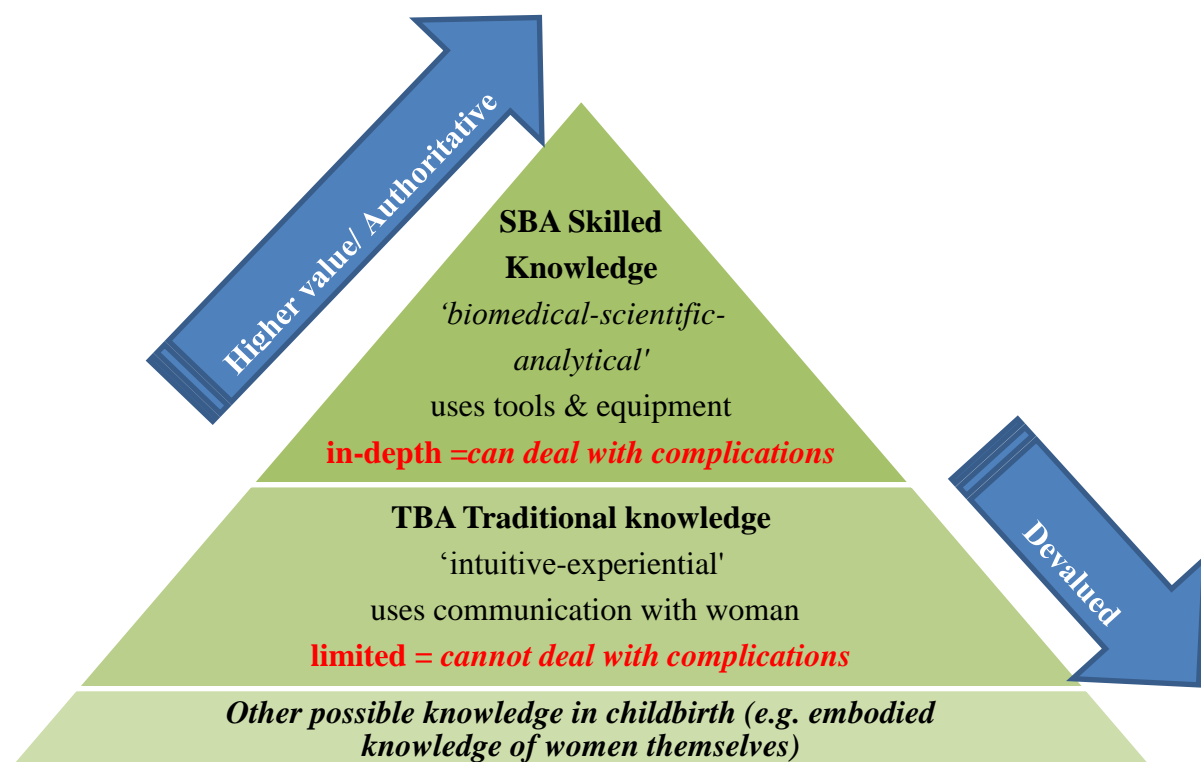


Figure 22. Model of the hierarchy of knowledge in childbirth in this study

As the pyramid above shows, both traditional and embodied knowledge have been devalued at the same time as the authoritative knowledge (AK)- SBA's skilled knowledge- has gained dominance (this is indicated on the Figure by the two large blue arrows going in opposite directions). The dominant position of the authoritative knowledge in childbirth, however, does not mean that other types of knowledge have ceased to exist altogether. Rather, it means that other forms of knowledge may conflict with the accepted dominant one, which in turn may lead to different modes of action or reaction on the part of women or TBAs particularly. One instance of this is when the women expressed in FGD that when SBAs attended to them at facilities, they seemed to do their work 'by the clock', telling them to wait for 'their time' to deliver. This expression- 'your time'- was used in a majority of women FGDs, to refer to what SBAs believe is the time when the woman's cervix is dilated enough and they have moved into the 2nd stage of labour, therefore are ready to push. This time was determined on the part of SBAs by their authoritative and scientific knowledge. In fact, a significant number of women reported that if the SBA judged from their assessment that their time to deliver had not yet come, they sometimes turned the women away from the labour ward asking them to return only when their time was due. However, this biomedical management of childbirth, by time and clock and standardized symptoms, sometimes ran contrary to the woman's embodied knowledge (e.g. their own sense of when the time to deliver was near). The quote below exemplifies this:

at the hospital...with one baby, when I went in, when my time was due, they chased me and sent me out saying that it was not yet time. When I went back in, they did the same thing, they said 'go outside', it was hard for me. Then I forced my way in [feeling delivery was near] and immediately, the baby was born (Woman, focus group W06)

The above quote shows this woman's persistence to try and establish the authority of her own embodied knowledge, and on the other hand the resistance of the SBA to accept it, their desire to impose their authoritative knowledge by telling the woman to "go outside" each time.

As will be shown later in this Chapter, the different knowledge about birth also translates into different notions of risks between women and SBAs, and also into different perceptions on the part of SBAs and TBAs about what complications are. All of these differences are crucial to grasp if we are to understand what motivates different actors' responses. Figure 22 above highlights in red what qualifies the SBA's knowledge as superior, compared to traditional

knowledge: namely its capacity to deal with complications which may occur in childbirth. Because it is one of the main reasons which has led to the TBA ban in the first instance, it is explored in details in the section below.

5.3.2 TBAs' knowledge is insufficient to deal with complications in childbirth

The data from this study shows that most participants were *yielding to the authoritative knowledge* in childbirth, because they perceived TBAs' knowledge as either insufficient or inadequate to deal with complications arising in childbirth. It was not only the SBAs who perceived it such but also women and men.

Indeed women in all but one focus group discussion (FGD) stated that they felt TBAs did not have enough knowledge to detect malpositions, or lacked the skills to help when operations were needed. They also stressed that TBAs could not help with loss of blood or transfusions, or with water drips, and that this lack of equipment placed women at risk. The quotes following clearly express this:

(Participant 1)TBAs help but here [at hospital] they can increase the birth canal and then suture. Can TBAs suture? (Participant 2) here if there is need for an operation, caesarean section, they take you for that, while at the TBAs they will just be looking at you. You keep waiting until you're dying (Women, focus group W01)

On the part of TBAs, they help women but it is not enough, because when you have complications like bleeding or you have remains in the womb the TBAs will not know what to do, while at the hospital they know how to treat a woman with complications (Woman, focus group W07)

The women above clearly stated that they believed that the hospital had both the skills and the equipment to manage complications. Men's FGDs echoed women's perceptions. Men described SBAs, unlike TBAS, as "*well trained*", "*professional*", "*specialists*", those who "*can quickly say what is wrong*" (H03), and who know "*all the ways of delivering*" (focus groups H03, H04 and H06). In contrast men saw TBAs' knowledge as only able to deal with uncomplicated ('normal') birth, as the following extract points out:

TBAs know their job but not to the fullest because they were not trained. They just rely on their experience that during delivery, they do this and that therefore let me assist her this way, and finished! You see that? They use their experience this far only, no more than that. Where they do not know it is where problems rise for the woman. (Man, interview H04)

The words used in both the men and women's extracts above ("*not enough*" "*not to the*

fullest” “*this far only*”) really express that something is lacking in the knowledge and training of TBAs, specifically, the skills that may enable them to address complications. It is worth remembering here that in the short training TBAs received in the past In Malawi, they were indeed instructed on the recognition of danger signs in labour, and instructed to refer women with complications, or who displayed such signs (Wendland 2015, Banda 2013). They would not have then, as now, necessarily dealt with the complications themselves.

Interestingly, few men and women made a distinction between trained TBAs (TTBA) and untrained ones, in terms of how able they were to deal with complications. This may be explained by the fact that the data collection for this study was conducted in 2013, a number of years after the training of TBAs had ceased. At that point, and with all TBAs banned from conducting deliveries, participants may no longer have perceived much difference between those two kinds of TBAs, if they ever did. To the women participating, it seems that the label of the TBA mattered less than the support they may be able to offer, or what they may be able to do when emergencies occurred. Women in one FGD communicated this well:

(Participant 1) Sometimes you can be helped by family TBAs but in cases of emergency you can call other people to help you, if maybe your relatives are not around; (Participant 2) For example if this lady comes to my home and all of a sudden the labour pains start, I can help her; (Participant 3) Some women are experts, eeh they know how to deliver woman at home, while some women can be old enough but they don't know what to do to deliver a woman ...They [TBAs]are there and they help women in cases of emergencies (Women, focus group W07)

As these women reported, if labour happened suddenly and quickly, a family TBA or a relative could help with delivery, because they were seen to have the expertise (possibly from having delivered other babies before). This shows that although the SBAs skilled knowledge in childbirth has become the dominant knowledge, there are more variations in the types of knowledge which co-exist on the ground, in the lower parts of the hierarchy of knowledge pyramid (Figure 22). Yet by singling particularly the TTBA as those whose roles were redefined, the Government, in the 2007 Policy Guidelines content itself signalled that they were the only TBAs they recognised, de facto further devaluating the other forms of knowing held by other types of TBAs- e.g. family TBAs or TBA healers.- (Republic of Malawi Ministry of Health 2007a, p.11, emphasised).

By contrast, most TBAs in this study expressed that they perceived themselves as having some knowledge of complications, albeit variable. Table 6 below lays out what TBAs in this study recognised as complications.

Table 6. TBAs knowledge of complications in this study

TBA Ref.	TTBA (trained) or TBA (untrained)	Complications TBAs said they stated they could recognise ³⁶	Expressed whether they knew at which stage to refer
FTBA 01	4 TTBA, 3 TBA	Loss of blood (haemorrhage); malposition of baby	Yes (some)
FTBA 02	3 TTBA, 4 TBA	Loss of blood (haemorrhage);	Yes (some)
TBA 01	TTBA	Baby in bad position; twin pregnancies; prolonged labour	Yes
TBA02-03	2 TBA	Woman looking weak; loss of blood (haemorrhage); retained placenta	Yes
TBA 04	TTBA	Mal-positions (breech baby)	Yes
TBA 05	TTBA	<i>“passage for the baby is too small”</i> (obstructed labour or woman need an episiotomy)	Yes
TBA 06	TBA	Breech baby position	Yes
TBA 07	TTBA	Not dilated enough; needs a C-section	Yes
TBA 08	TBA	Shortage of blood (anaemia); retained placenta;	Yes
TBA 09	TTBA	Failure to deliver (obstructed labour?)	Yes
TBA 10	TBA	Shortage of blood (anaemia); Breech baby position	Yes
TBA 11	TTBA	<i>“the passage is not opening”</i> (obstructed labour)	Yes
TBA 12	TTBA	[no mention]	?
TBA 13	TTBA	Waters mixed with blood; <i>“baby is stuck in the mother’s womb and failing to come out”</i> (obstructed labour)	Yes
TBA 14	TTBA	Mal-positions (baby is feet first, or has chord around them)	Yes

³⁶ The TBAs words used to talk about the complication are mentioned, and in parenthesis is the researcher’s interpretation of what some of the phrases meant (an understanding which was gained from discussing those with the Research Assistant and other Chichewa speakers).

The above information suggests that some TBAs- whether trained or untrained- perceived that they were able to take their 'limited' traditional knowledge beyond that of normal labour, and to assess complications. This contrasts somewhat with the views expressed by SBAs that TBAs have no knowledge of the pregnant woman's physiology. It is supported by another study from Tanzania which showed TBAs as able to recognise high-risk pregnancies and complications (Hussein, Mpembeni 2005). This is perhaps because, within their own knowledge of birthing, some TBAs can differentiate between what they see as a 'normal' birth and other more complicated ones. A TBA articulated this in the extract below:

maybe the woman sometimes may need operation due to other complications, or that the baby is not in a better position, on such cases, we don't have the knowledge that, we can't do any operation, no. Such complication will need the hospital people, but if it's a normal delivery, we help the women without problems (TBA, focus group FTBA02).

What this TBA expresses contradicts also the previous SBA depiction of a TBA passively awaiting for similar outcomes of labour. Instead it shows some TBAs' confidence in the normal process of birthing, which has been raised elsewhere (Davis-Floyd, Sargent 1997, Dietsch, Mulimbalimba-Masururu 2011b), and also their confidence in their ability to facilitate it. This must not be confused necessarily with the limitation of their knowledge, since they may be able to recognise a complication but unable to address it. Conversely, SBAs in this study stated they did not believe in the concept of a 'normal' birth. The concept of normal birth is controversial, and context specific, and there is no global agreement on its definition, although here it could be broadly framed as a birth "without intervention in an environment that enables choice and empowerment for the woman" (Clews 2013, p.4) , which portrayed how TBAs may have viewed it. However, within the context of the authoritative biomedical knowledge in childbirth, where birth has been medicalised and pathologised, one can understand why SBAs did not conceive of normal births. As one put it quite rightly: "*the normal delivery is being called a normal delivery after everything has gone well, but when you are pregnant you don't know how you are going to deliver*" (Nurse Midwife Technician, FSBA01). This SBA, and most others interviewed, believed that childbirth carries omnipresent risks and thus is inherently safer in a health facilities, assisted by themselves, which is what the section below demonstrates.

5.4 Believing in the safety of skilled birth attendance

Believing in the safety of skilled birth attendance is the second subcategory identified in the analysis of the data, and relates to the category of *between concordance and secret non-compliance*. It intersects with the previous sub-categories *facing new interdictions* and *yielding to authoritative knowledge* presented above, in the sense that the cognitive context in which women will make decisions on compliance with the Policy Guidelines depends not only on how they perceive the interdictions it places on them, but also on the fact that they perceive the SBA's knowledge as superior and the hospital as the safer place. Here the word "Believing" is used because it refers to what women (and others around them) believe skilled birth attendance represents, rather than what they may actually encounter at facilities.

As defined in section 2.2.3 the term 'skilled birth attendance' refers to the conjunction of a skilled birth attendant (SBA) with an enabling environment which includes the facility, services, drugs, transport for referrals, and accessible emergency obstetric care (Hussein, Clapham 2005, Adegoke, Van den Broek 2009). As the data below demonstrates, the safety of skilled birth attendance is perceived to reside in both the biomedical authoritative knowledge of SBAs and in its locus: the health facility or hospital. For women in this study the health facility itself – with its equipment, theatres, drugs- is what enables the SBA to perform 'safer' births than TBAs. Indeed, women spoke of the safety of health facility in the terms exemplified in the following extracts:

(Participant 1) In the past expectant women were delivering at the TBAs, although their safety is not guaranteed at the TBA especially these days when there is this disease [HIV-AIDS]. TBAs normally do not have gloves; (Participant 2) Sometimes you lose a lot of blood ...when you lose a lot of blood doctors know how to help you, so instead of dying you do not die it is like they have saved your life. (Women, focus group W01)

At the hospital they know many things like if you don't have enough water in the body they give you a drip, and if you need operation you go to the theatre for operation, and they can also help a woman if other things have remained in the womb during delivery, quickly (Woman, focus group W07)

The above express the belief women have in both SBAs knowledge and their use of life-saving equipment. Women placed a high value in the capacity of SBAs to save lives. The extracts also show that the capabilities (skills) of SBAs, and the availability of equipment to bring safety, were often conflated. For instance the word hospital was 'personified' in the

phrases used: e.g. “*at the hospital they know many things*”, or “*the hospital is helpful...They save our lives*” (woman, focus group W01). This emphasises that both place and person symbolise safety as has been expressed in other studies on AK (Davis-Floyd, Sargent 1997, Sargent, Bascope 1997). It also stresses the importance of an enabling environment for safety, as men did when they spoke of the “*necessary equipment*”, the “*right equipment*” or “*tools to assess*” complications (focus groups H01, H02, H04 and H03). Of course men’s focus on the tools of safe birth may be explained by their low involvement in the actual event of delivery in Malawi, where birth are culturally and traditionally the domain of women (Kululanga, Sundby et al. 2012, Kalembo, Zgambo et al. 2013), and men mostly do not enter labour wards.

The perceived safety achieved by skilled birth attendance was highlighted by the SBAs in this study, as in the following quote:

the best place for, for them [women], to give birth is probably at the health facility, ...not necessarily at the TBA or at home, for reasons that are obvious: complications! obstetrics complications! ... Now, when you look at those obstetric complications, you need to have equipment ready, to support that. So at a hospital you’re much safer because, even if the complication doesn’t happen, okay fine, so much the better. But in case somebody goes into complications you know obviously that people are there, they will attend to you, skilled people for that matter. They have got equipments, cannulas, IV lines, you have got BP machines, you know, you monitor everything going on, you look for the cause of bleeding. If you find the cause of the bleeding you try you know to rectify it, you know, by doing whatever you are supposed to do, in as far protocols are concerned, taking the woman to the theatre if there is need be, if there is need for referral you do everything quick, quick, the ambulance is there, you take the woman to the next level of the care you know. But at the TBA they have got probably nothing, absolutely nothing. In case of those emergencies it’s gonna be a catastrophe anyway (Male Clinical officer, SBA02)

As reassuring as the above may sound to any pregnant woman, it also depicts an ideal situation, where the SBA is both knowledgeable and present, where equipment and resources are at hand, and where referral system are functioning. This is not always the reality. In this case, this clinical officer was functioning within a hospital, which may have had more resources than some isolated health centres. In other locations, the situation may have been far from ideal. In fact, recent studies conducted in Malawi show that the lack of resources and equipment is a major obstacle for the delivery of quality maternal health care (Bradley, Kamwendo et al. 2015, Chimwaza, Chipeta et al. 2014). Although the availability of EmOc is improving (Republic of Malawi Ministry of Health 2011), in rural areas, the reality is still

often that SBAs, drugs and equipment and referral transport are in short supply.

Yet despite this situation, for women in this study, the health facility continued to represent a symbolic safety, as defined in section 2.3.1. This is because messages of safety have been reinforced by media campaigns, by the Presidential Initiative for Safe Motherhood, and in local safe motherhood meetings called by VH, and in safe motherhood groups (which were in existence in 2 of the 3 sites in this study). Often this message about safety has been contrasted by the authorities themselves with depictions of unsafe and risky TBAs, operating in unhygienic environments. For instance, the below pictures, which were used by Safe Motherhood Women's Groups in an area of site 2 to teach illiterate rural women about safe behaviours in delivery care, tell a telling story about these messages of safety.

Table 7. Safe Motherhood Groups picture cards-(Site 2)- © Maimwana.



The picture above shows on the right a TBA cutting the umbilical cord with a non-sterile instrument, whilst the woman is lying bleeding on the dirty ground; this is placed in contrast on the left with that of a woman making her way in advance of her labour to a clean orderly clinic. This paints a clear picture of the options on offer: safe environment versus risky environment. Safe SBA practices versus unsafe TBA practices.

The discourse of risk in childbirth has been reported in a number of studies as what reinforces the authoritative biomedical knowledge (Pigg 1995, Davis-Floyd, Sargent 1997, Parry 2008). It pervaded SBAs' interviews in this study. They talked about risk factors and high-risk pregnancies, about the risks of utilizing TBAs and the pervasive risks of complications in labour. The below quote illustrates this:

every woman should be attended by skilled health personnel because pregnant is a pregnant, because we don't know what will happen later on, because a woman can have a complication in due course when she is maybe in labour or what, so she can start bleeding, that's a complication...we say every pregnant woman is at risk nowadays (Male Nurse Midwife, interview SBA10)

This belief in an ever-present risk of complication in pregnancy may be born out of the experiences of SBAs, particularly clinical officers and doctors who are called upon when severe complications happen, to perform surgery. These situations sometimes have great outcomes, but this perception of risks is also embedded in “differing views of both nature and technology in relation to birth” (Coxon, Sandal et al. 2014, p.52). Some SBAs showed how risks could be mitigated through their own interventions:

we work hand in hand with the nurse and midwife technicians so they do their part, but I, my part I will concentrate much more on the risk women, those who have risk factors; and when it comes to labour or delivering mothers we do our part when there is like a complicated delivery or when we anticipate a difficult delivery it's when we come in to intervene (Male Clinical Officer, interview SBA12)

Of course the perception of risks of a clinical officer versus that of a nurse midwife technician may be heightened, as the above quote suggests, since they are the cadre who deal with more severe obstetric complications. Although, interestingly, when SBAs, such as the one above, were asked if a large number of women presented with major complications, they replied that those were in fact rare. Still they maintained that the risk of complications was there, for every woman, at any point. They also stated that if complications did not occur more often, it was because SBAs could spot risks early, for instance during in antenatal clinics, and avert them. This confidence of SBAs in their own power as mitigators of risks reinforces the power of their authoritative biomedical knowledge in the eyes of women and community members. The fact that TBAs could not pre-empt or manage complications by contrast made them appear even more unsafe, as an option for delivery care. This could be sensed in the perceived reasons given by each group of participant in this study regarding the rationale for banning TBAs which are laid out in the table below.

Table 8. Perceived rationale for banning TBAs, by participant type

Participant type		Perceived reasons for banning TBAs
Skilled	birth	<ul style="list-style-type: none"> Because delivering is dangerous, and complications may occur which TBAs cannot handle because they do not have the tools or equipment to

Attendants; Health Surveillance Assistants; Village Headpersons; Other Main Stakeholders	deal with complications, which adds risks for women <ul style="list-style-type: none"> • Because of HIV-AIDs and other diseases and risk of transmission (both to women, babies and TBAs) • Because of TBAs traditional beliefs (e.g. they persevere when things get hard but lack proper knowledge and use traditional remedies and practices and create more complications) • TBAs overstepped their boundaries therefore caused further complications
Women Men	<ul style="list-style-type: none"> • Because TBAs do not have the tools or equipment to deal with complications and can cause more complications • Because of HIV-AIDs and other diseases and risk of infections (both to women, babies and TBAs)
Traditional Birth Attendants own perception of why they were banned (including in their own words)	<ul style="list-style-type: none"> • <i>Because of the risk presented by the disease (meaning HIV-AIDs)-mentioned in FTBA01, FTBA02, TBA01, TBA05, TBA09, TBA14)</i> • <i>“we were banned because they were many accidents happening frequently so they banned, saying that, don’t deliver at home “ (TBA in FTBA01)</i> • <i>Because TBAs did not have the necessary equipment (mentioned TBA08, FTBA01, TBA11)</i> • <i>“because some of the azambas were killing a lot of women” (mentioned in TBA02-03, TBA14); “they are saying we might be killing people, the TBAs might kill people, that’s the main reason they have stopped us” (mentioned in TBA09, TBA10)</i>

The above table shows that TBA practice was viewed by SBAs at least as dangerous, because of their lack of knowledge, their tendency to overstep their limitations, and because of their traditional beliefs and practices. As Sarelin states:

The traditional birth culture in Malawi, embodied in TBAs, is portrayed as conservative, non-changeable, primitive and impossible to control and monitor, due to the oral tradition it is based on and the low literacy rate. In short, TBAs are a representation of “the Other”. They are seen as unable to deal with the complications that sometimes cause maternal deaths (Sarelin 2014)

Some SBAs in the study mentioned that TBAs were using some cruel traditional means to deliver women, such as applying fundal pressure with a large wooden spoon (*mtondo*) to force the baby to come out, or giving women herbal pitocines to hasten labour, both of which could lead to ruptured uteri. Others also blamed the TBAs for their belief in witchcraft, as one SBA did when saying: *“every complication of pregnancy they associate it with witchcraft”* (Nurse Midwife Technician, interview SBA09). Beliefs in witchcraft are fairly common in rural areas in Malawi, as other studies have reported (Simwaka, de Kok et al. 2014), and it is quite possible that some TBAs shared them. It is important to state here that this study’s aim is not to ascertain whether women did indeed get injured in the care of in

TBAs, even though this sometimes possibly happened. None of the TBAs in this study admitted to occurrences of deaths or serious injuries taking place in their care. This is understandable, given that they were banned, and also that the researcher could have looked to some as a *mzungu* (white) doctor who could possibly be linked to the authorities, and able to report to them any malpractice.

Despite this dominant discourse of the risks posed by TBA deliveries which was perpetuated by SBAs, women had different perceptions of risk, which therefore potentially led to different actions. The analysis of these yielded the subcategory of *managing perceived risks*. At the onset, it is useful to differentiate between perceiving complications as risks or as dangers. Giddens offers a framework for this in his seminal article on risks (1999), presented earlier in section 2.3.1. The concept of risk betrays a preoccupation with controlling future events and their outcomes, which fits with the SBAs' perceptions laid out above. On the other hand, the notion of danger represents the belief that certain events are unpredictable, and thus requiring to be managed as and when they arise. Seminal publications in safe motherhood in the 1980s and 1990s helped define the notion of risk and complications in childbirth (Rosenfield, Maine 1985, Berer, Sundari Ravindran 2000) when they differentiated clearly between risk (as a prior poor obstetric or other relevant medical history) and complication (as suddenly arising and unpredictable events). They contributed to the pervading notion that complications may arise at any time of the pregnancy, labour or delivery and that pregnancy as such was dangerous.

Women in this study perceived childbirth complications rather as dangers, that is as part and parcel of the hazards of being pregnant, usually in the manner quoted below:

It's just the way things happen when the birth canal is narrow, or someone fails to walk [to facilities]. So it is incumbent upon those who carried the patient to find a means of transport to take her up to the hospital to be assessed for possible complications. That is what happens (Woman, focus group W05)

Women referred to complications as 'problems' (in Chichewa "zovuta", "vuto/ mavuto"[s; pl], "zikavuta"). Those are words commonly used in Chichewa to refer to all kinds of obstacles and difficulties, not exclusively in childbirth. It is worth noting that in Chichewa, which is a highly contextually language, there is no word for 'risk'. Women in this study talked about the problems that they had experienced in labour or birth as occurrences which had disrupted the course of what may have been otherwise expected to be a normal birth, and

which needed to be overcome at the time it arose. Some of the descriptions used by women were “*I had a problem because I was losing a lot of blood*”, “*I had labour pains maybe for 2 days without delivering, so this was a problem*”, or “*I had a problem of bleeding*” (quotes from Women in focus group W07). Although there was a widespread belief amongst women that when those unpredictable events happened, they would be safer at the hospital rather than at the home of TBA, it did not necessarily mean that women managed those risks in the way the 2007 Policy guidelines and the authorities recommended (e.g. by coming to wait at waiting homes ahead of deliveries to be monitored, or by having birth-preparedness plans in place). Understanding how women perceive and manage childbirth risks in different cultures and contexts, particularly in rural areas, is key to ensure the success of strategies and interventions focusing on birth preparedness and complication readiness to tackle maternal mortality (Soubeiga, Gauvin et al. 2014). These findings make a start here, and this topic deserves further investigation.

The final section of this first Chapter of findings builds upon the subcategories presented thus far of *facing new interdictions, yielding to the authoritative knowledge in childbirth, believing in the safety of skilled birth attendance, managing perceived risks*-and introduces a further sub-category of *secret-non-compliance*- to bear on the main category of being ***between concordance and secret non-compliance with the Policy*** .

5.5 Being between concordance and secret non-compliance with the 2007 Policy Guidelines

The Chapter up to this point has shown that despite the new interdictions which the 2007 Policy Guidelines and TBA ban bring, women are in concordance with its intent and strategies, at least in so much as they believe in the safety of skilled birth attendance. The data showed that if complications do arise in the course of labour and delivery, women perceive that SBAs, with their knowledge and the support of resources they believe available at facilities, can address those, and thus save their lives. In doing so, women are *yielding to the authoritative knowledge*, which is viewed as superior and safer than the traditional knowledge of the TBAs. This Chapter has highlighted also the discourse of prevalent risks which surrounds women’s decision-making. All these factors, - including the application of fines if they are to be seen as deterrents- should potentially lead women to act in compliance with the course of action laid out in the 2007 Policy Guidelines. However, the

data shows that women's positions regarding compliance – and indeed TBAs - are more complicated.

First, the coexistence of competing forms of knowledge (traditional or embodied) may make compliance a reluctant compliance, particularly where women and other community actors do not feel they were consulted in the Policy making. For instance, it could be argued that these rural women come to facilities for their deliveries not simply because they believe it is the better, safer place, but in the words of a woman from FGD W01, “*because they fear fines which they cannot afford*”. The data also showed that most of the TBAs display the same reluctant compliance with the Policy, but for slightly different reasons, as illustrated below:

with that job [being TBA], now there are too many parties, the rules, ... that this should not be handled traditionally, so, as long as the law is working, a person has to adhere to the law that has been put in place. That is why every TBA here has stopped and demolished their hospital, so that we should heed the Government (TBA, interview TBA10)

For both the women and TBAs there was the sense of an obligation to comply and a feeling of resignation, rather than one of voluntarily or enthusiastic concordance with the Policy. For TBAs this reluctance may have also been founded in the fact that they perceived that SBAs, with their superior knowledge, had taken over the ‘job’ of birthing women. As a TBA keenly expressed:

They said that the health worker are the ones doing that job, where there are health workers, us, us, we are useless (TBA, focus group FTBA01)

It is possible that this unhappiness at their new situation may have led some TBAs towards *non-compliance* with the Policy and the ban. Although those in positions of authority – policymakers, SBA, VH- stated that some TBAs defied the ban because they still needed the money or in-kind donations they used to receive for deliveries, as evidenced elsewhere (Banda 2013). There is little doubt indeed that owing to the ban, some TBAs have become worse off financially, as the quote below attests:

at first this skill [of TBA] was better, because we were not lacking in anything but nowadays they have stopped us, we have become poor³⁷ (TBA, interview TBA08)

³⁷ Only a couple of TBAs mentioned that they still received occasional payments from the families of women whom they helped them in emergencies. Those were in the form of small amounts of money [K300 to K200: equivalent to 20 or 30p] or maize flour.

Although this may have motivated some to defy or resist the ban, this study argues that for TBAs, the monetary incentive was only secondary to their desire to help. This argument was in fact backed up by the perceptions of women in this study:

(Participant 1) some of the TBAs were just helping, so that as long as our friend gets what? gets well. Not the money, they were not receiving money; (Participant 2): these TBAs were just helping, helping those people who wanted to deliver they don't receive money, just helping (Women, focus group W06)

In the TBAs' own minds, their work of delivering women had been important job, which not only deserved payment, but also first and foremost, recognition. They referred to their work as '*ntchito*' (the Chichewa word for 'work', or job), as the quote below makes clear:

we worked hard...but some people they do not consider what we are doing, they don't see it as a job but we are trying our best working hard, and we will continue (TBA, focus group FTBA02)

This has been stressed in a few other studies of TBAs in Africa (Dietsch, Mulimbalimba-Masururu 2011b, Chamberlain 2013, Tomedi, Stroud et al. 2015), particularly in Chamberlain's in Sierra Leone, where he found that TBAs "prioritized recognition over incentives [and] often discussed their loss of recognition and their threatened standing in the community first" (2013, p.4). In Malawi, the difficulty is that the 2007 policy Guidelines banned TBA utilisation abruptly and irrevocably, which led to a complete devaluation of their knowledge and of their contribution to maternal health care, therefore to a loss in their status. Nonetheless, TBAs remain part of the network of social relationships in their community, they are still known, still present, and thus are still called upon by women who are partaking with them in a *secret non-compliance* with the Policy.

This subcategory of *secret non-compliance* developed from data revealing that despite the ban, women still went for TBAs for delivery in secret, or called them to their home to be helped in secret. This action, as described by the SBA below betrayed a complicity with women:

it's dependent upon the individual who has approached them [TBAs]. If they see that that individual may be able to report to us, they do refer that one, but if they think that individual is able to keep a secret for them, they can do it and maybe say "go to the hospital although you have already delivered, tell them you have just delivered on your way" (Male Nurse Midwife Technician, interview SBA11)

The above quote suggests that it is TBAs who initiate those secret transactions, but a couple of TBAs (TBA08, TBA13) themselves stated that it was women who had come to them, asking them to be delivered in secret, as the excerpt below indicates:

we have been stopped and we are now referring them to the hospital...but they always come to us, pleading us “sorry, sorry, sorry, we don’t have a bicycle, we don’t have anything [meaning money], just do it in a secret, such that other people don’t know that we do deliver here” (TBA, interview TBA08)

The aim of this constructivist GT study is not to ascertain whether SBAs or TBAs were indeed telling the truth about who initiated those secret non-compliant deliveries. Rather it aims to show that the situation on the ground is complex and multi-faceted. Secret non-compliance may simply be for TBAs a strategy of adaptation to their new redefined roles. Or it may be the product of a position of outright defiance with regards to the Policy. However data showed that the latter was rarely the case, for the TBAs interviewed. Only one particular TTBA (TBA14) -a deviant case- practiced an open defiance to the ban contained in the 2007 Policy Guidelines. She continued to perform routine deliveries daily and was well-known by the authorities and indeed by the Government. She described the reasons for her non-compliance as follows:

I refused, they came to stop me so I said: “you should stop me after someone dies, or when there is a still birth, Then you can stop me! ...how do I stop?, there are a lot of people delivering here”...but most of the time it’s the Government who help me, they themselves come to give me, and say ‘here are the gloves, here are the aprons, put them on while you are working’... when they came here they found 7 babies and a woman here in labour and another one there, so I said how are you going to close? they said ‘no we will not close you up, go and do your work ‘ (TTBA, interview TBA14).

This TBA was a unique case, had a tremendous reputation-even as far as the country’s capital- and women came to her in significant numbers. According to the written records one of her assistant showed the researcher, she still delivered on average 200 women a month, some from as far as 40 miles away. In the quote above, this TTBA defended her record of good practice, against some of the reasons given to justify the ban as laid out in Table 8. Policymakers and other stakeholders interviewed (OMS05, OMS06), who knew of her, justified her non-compliance by the fact that she was too old to change her practice, and abide by the new redefined roles. However the researcher wondered if the reason was not also pragmatic. After all, the 2000 or so deliveries she and her helpers carried out yearly must have been relieving pressure from the nearby overcrowded health centres and hospital (

which was 30kms away). For her part, she continued to charge for deliveries, and it is doubtful that those who came to her to deliver, thus colluding in her non-compliance with the Policy- were being fined by their local VH.

This Chapter has presented the “modes of rationality” (Long 1999, p.1) with which women weigh their options for delivery care in some rural areas of Malawi. It has presented how they perceive the 2007 Policy Guidelines and the interdictions associated with it. It has laid out the types of knowledge about childbirth which surround them, as well as of their own belief in the safety offered by skilled birth attendance, and their own concordance with it. This Chapter has showed how community actors may find themselves between that concordance and *a secret non-compliance* with the Policy. The next Chapter of findings builds on what has been presented thus far, and show the relationships between this cognitive context and the second and third main categories, *encountering barriers*, and *considering proximal help*. These categories further account for some of the barriers women face, and for the strategies women devise in their daily lives to deal with the 2007 Policy Guidelines and TBA ban, and weigh their options for delivery care.

6 Chapter 6: Encountering barriers and considering proximal help

6.1 Introduction

This Chapter presents the findings which support the second and the third main categories in the theory: *encountering barriers* and *considering proximal help*. *Encountering barriers* has two sub-categories are *facing geographical, economic, and socio-cultural barriers*, and *experiencing disrespectful and abusive (D&A) care at facilities*. Together they give an account of what stands in the way of rural women- and those who may support them- when weighing their options for delivery care. It starts to unveil why women may be choosing compliance or non-compliance with the 2007 Policy Guidelines and TBA ban (Republic of Malawi Ministry of Health 2007a, p.3). Thus *Considering proximal help* builds on the first and second categories to show how women's cognitive context and encountering barriers may lead to considering proximal help, rather than to attend at facilities for their deliveries. It shows how one set of actions may lead to another, and may end up placing TBAs also in a difficult situation. Therefore this Chapter uses the findings to show how the implementation of the 2007 Policy Guidelines leads to a complex web of actions and reactions which all come into play in the weighing of delivery care options.

6.2 Facing geographical, economic, and socio-cultural barriers

As in a number of other studies (Bohren, Hunter et al. 2014, Thaddeus, Maine 1994, Gabrysch, Campbell 2009, Brighton, D'Arcy et al. 2013, Ensor, Cooper 2004), the data shows that transport, distances and costs are significant barriers, as are some socio-cultural practices and experiences of poor quality of care at facilities. The 2007 Guidelines for Community Initiatives for Reproductive Health stated aim was: “empowering women, their partners, families and the community to make appropriate decisions and take timely actions especially when there are complications in pregnancy and childbirth” (Republic of Malawi Ministry of Health 2007a, p.3, emphasised) by urging them to deliver at health facilities with SBAs. Yet there are barriers and delays in doing so, which go beyond the ‘three delays’ described in Thaddeus and Maine’s seminal article (1994), which were described in section 2.4.1. Bohren et al, in their synthesis of ‘Facilitators and barriers to facility-based delivery in low-and middle-income countries’, identified evidence of over 39 different barriers at play in women being unable to access skilled birth attendance. They grouped those barriers under the

four themes of: “perceptions of pregnancy and delivery, influence of sociocultural context and care experiences, resource availability and access, and perceptions of quality of care” (Bohren, Hunter et al. 2014, p.4). The analysis below focuses on aspects of the geographical, economic, and socio-cultural barriers least explored in the literature, and on the inter-connections between those barriers. By doing so, it reveals how some barriers, even though they may not be the most significant, can ‘*tip the scale*’ for rural Malawian women, with regards to their compliance with the 2007 Policy Guidelines and TBA ban.

6.2.1 “When the legs get tired”: geographical barriers to facility deliveries

The 42 women who took part in focus groups in this study were of all ages (from their 20s to their 60s) and ranged from having had 1 to as many as 11 deliveries. They were a mixed sample in terms of their places of their delivery. Most had had experiences of home, institutional and TBA deliveries. Some had given birth in the past on their way to hospitals, owing to large distances between their communities and facilities. Some lived within a few kilometres of facilities, whilst others lived as far as 20 or 30 kilometres from facilities (those in sites 2 and 3 in this study lived the furthest). The subcategory ‘*when the legs get tired*’ is taken verbatim from the data because it embodies more than simply the issue of distance, and represents the efforts women make to comply with the Policy and attempt to reach the facility (e.g. by walking from their homes). The issue of large distances to facilities is well reported in Malawi as elsewhere (Edmonds, Paul et al. 2012, Palamuleni 2011, Titaley, Hunter et al. 2010, Seljeskog, Sundby et al. 2006, Lohela, Campbell et al. 2012, Nesbitt, Lohela et al. 2016).

In this study, all seven women’s focus groups expressed that distance and transport were significant barriers to achieving institutional deliveries. The quotes below express this and the fact that the Policy has made matters worse by cutting out the proximal help of TBAs, although some still go to them in emergencies:

Help is found at the hospital, but our hospital is far away so it’s like in the past... we were being assisted by the TBAs but then they stopped the TBAs. The hospital is good but when your time has come [when you are in labour], for you to go to the hospital [pause] some are delivering on the way, because the hospital is far and we do not have a reliable bicycle for us to use and rush to the hospital so I think somehow our help is limited (Woman, focus group W04)

Others when they go to the TBAs they go there because the hospital is far from them so when the hospital is far, and you get tired, you go to the TBA (Woman, focus group W06)

This echoes other literature regarding distance barriers and the fact that women may be turning to TBAs (Izugbara, Ezeh et al. 2009, Izugbara, Ukwayi 2003, Prata, Passano et al. 2011). However, the lack of transport and the inability to bridge the distance to hospital were not the only barriers for women. Those were related to- and made worse- by associated economic barriers, which are expanded upon below.

6.2.2 “It is just because some people are poor”: economic barriers to facility deliveries

Economic barriers to institutional deliveries are well reported in Africa (Pfeiffer, Mwaipopo 2013, Seljeskog, Sundby et al. 2006). Although poverty is often cited as a major economic factor (Oyerinde, Harding et al. 2012, Pfeiffer, Mwaipopo 2013, Sipsma, Thompson et al. 2013, Nesbitt, Lohela et al. 2016), this is often done without elucidation from the lived experience of those affected. Yet this is important to understand from the perspective of women in rural areas, who survive on subsistence farming. This section unpacks what, in the rural Malawian context, comprises economic barriers, to see how this impacts on the actions and decisions made by women in this study.

The perceived effect of applying monetary sanctions for non-compliance with the 2007 Policy Guidelines is a relatively recent phenomenon and has been little researched, which is why this study wishes to explore it. Although section 5.2.1 stated that the bylaws and fines were intended as a deterrent, rather than as a punitive action, it showed that women’s were fearful of those and this pushed them to deliver at facility. This is expressed in the following quotes from women’s focus group discussions:

Everybody comes here [at the health facility], because they fear fines which they cannot afford (woman, focus group W01)

Nowadays everyone is going to the hospital, because if you deliver here you are supposed to pay a goat, so everyone is afraid to pay the goat, and then they rush to the hospital (woman, focus group W03)

Although in this study, women mentioned the threat of fines more than the fact that they had paid them in the past, it is obvious from the above that it affected their actions regarding their compliance with the Policy. A very recent study from Zambia has also expressed fears that

instead of acting as an incentive to convince women that they must deliver at facilities, fines may place further burdens on the poorest women (Greeson, Sacks et al. 2016).

Women in this study also mentioned facing charges when attending at facilities. Although, as section 1.2.2.1 explained, there is currently an agreement between the Government and private facilities to ensure that all maternal and child services are free at the point of delivery, some of the participants in this study did speak of paying some charges at facilities. This may point to the fact that the service level agreement was not working in all areas, or was not fully understood by women (which may be because they were unaware that they needed to pay if coming from outside the catchment area of the said facility). This is an issue that requires further investigation, because it also impacts on women's care seeking behaviours. Women in focus group W06 explained that in their areas some people chose to travel further away from their nearest private health centre to reach Government facilities, where they would not be charged.

However the data also showed that economic barriers, relate to more than lack of funds to pay for transport. They often operate at other basic levels, which are poorly reported on. The findings demonstrated for instance that poverty in rural areas may mean also being so destitute that a woman is unable to afford the items she has been asked to carry with her to the facility. Part of the message promoted by the 2007 Policy Guidelines and reinforced by the PISM since, is that women must be ready and prepared for childbirth. Recent studies, including some conducted in Malawi, have indeed stressed the potential of birth preparedness and complication readiness education programmes to increase skilled birth attendance (Soubeiga, Gauvin et al. 2014, Kupatsa Botha, Maluwa et al. 2013, Solnes Miltenburg, Roggeveen et al. 2015). In Malawi, women's groups for safe motherhood are used to educate women about the danger signs of pregnancy and teach them to prepare for their births at facilities (Prost, Colbourn et al. 2013). Those groups advise, amongst other things, that financial arrangements be made ahead of the delivery, and that women carry a number of items with them when coming to health facilities for delivery. Those comprise a clean razor blade and a thread (should someone need to cut and tie the umbilical cord along the way), a number of clean cloths or *chitenje*³⁸ to wrap herself and the baby in, a basin and soap to

³⁸A Chitenje(*pl. Zitenje*) is a colourful, usually 2m x 1m piece of cloth that most women use in Malawi on their head, for decoration, or to hide shabby clothes, as protection against the cold or when farming the fields and as baby sling, and in childbirth to wrap around the new born.

wash after birth, as well as a plastic sheet to place on the labour bed at the facility to avoid soiling (since those are not always available). The picture below is from a card used by a local safe motherhood women's group in one of the sites in this study, to reinforce this message to rural women (pictures are normally used because a large number of rural women are illiterate):

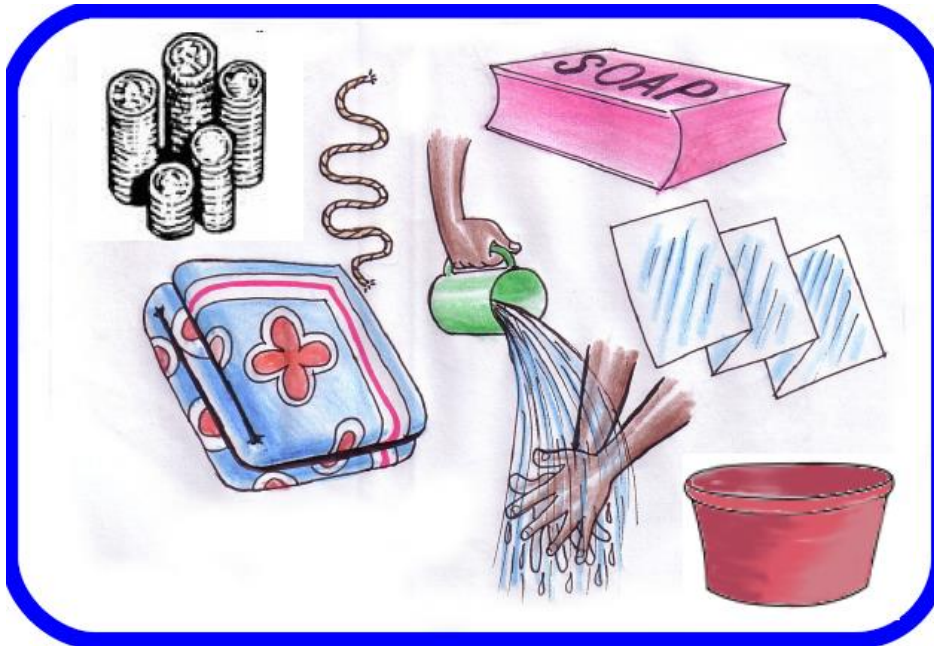


Figure 23. Picture card from Safe Motherhood Women's group teaching about birth preparedness- © Maimwana

However for a number of women in this study, buying the items pictured above was often beyond their financial means. Some reported avoiding going to facilities altogether because they felt ashamed at the idea of arriving at facilities without the prescribed items (or in ragged clothes rather than clean new ones). The quote below expresses this:

It is just because some people are poor, because if you want to go to the hospital you need to have food, soup, cloths, yet the husband is not working, and you don't have anything to take to the hospital. So the woman thinks that she could not be comfortable at the hospital seeing other women having such things and not her, so she says 'it's better I could just stay at home when it is my time'[to deliver] (Woman, focus group W07)

The same has been noted in another recent study in Malawi (Ryan, Hamela et al. 2015). However, what this data adds is that women expressed that at times, the pressure to have all that is required to be prepared for birth, came from the health staff themselves:

At the hospital they say when you go to the antenatal clinic, they tell you in the first place that “mum, you are now pregnant, are you ready?”... if you do not have six cloths [meaning chitenje to wrap baby in] , and I tried to buy these cloths, some I already had, but if you do not have those, they tell you that you will not get discharged until you do what? bring the six cloths. And by the time you are being discharged you should have a basin, the basin is for washing ...The plastic, it helps you not to mess up the bed on which you lay; that is why there is the rule that each and every one should be ready (Woman, focus group W06)

The above may represent an isolated occurrence where SBAs asked women to bring more items than is usually insisted on, but it clearly placed women under added financial pressure. It must be noted here as a counterpoint, that in a different area, a nurse midwife from a fairly isolated rural health centre (interview SBA11), stated that he told women by way of encouragement not to compare themselves with others who had more means and to bring only what they could for their deliveries. Regardless , those economic barriers sometimes did push some women to use the proximal help of the TBAs (even though those were banned) just because TBAs did not require them to buy and bring all these items they could not afford, and accepted them as they were. What the data suggests here, is that economic barrier issues go beyond simple matters of money and may touch at the dignity of mothers. This deserves further research, particularly with regards to birth-preparedness interventions in rural areas, as it has may have a bigger impact than anticipated on women’s delivery care-seeking behaviours.

From here, one of the least researched economic barrier to skilled birth attendance, is that of the cost associated with coming to wait for delivery at waiting homes (WH). This policy was a main prong of the PISM, and the rationale for building waiting homes adjacent to facilities was twofold. First it was meant to was to address the distance barriers and increase facility attendance. Secondly, it was meant to allow high-risk women with pre-existing conditions (e.g. pre-eclampsia, anaemia) to come and await their deliveries at the facility, where they could be monitored to avoid complications (Sialubanje, Massar et al. 2015, Gaym, Pearson et al. 2012, Lori, Wadsworth et al. 2013, Wild, Barclay et al. 2012). There is still relatively little literature on the effectiveness of building such waiting homes (Wild, Barclay et al. 2012, Lori, Wadsworth et al. 2013, Sialubanje, Massar et al. 2015). However data from this study

shows that, in some cases, being asked to wait at WHs added further hardship for women in rural areas, rather than helped them. This was because women reported they had to bring their own food to consume at WHs whilst they waited. Some were waiting for much as two months at the WH (e.g. if their pre-existing conditions were serious and required constant monitoring), and finding food to consume for the whole duration of their stay was sometimes difficult during the ‘hungry season’³⁹. Similar issues have been reported by participants in another recent study in Zambia (Cheelo, Nzala et al. 2016).

Another problem with the cost of waiting at WHs was that when a woman stays there, a family member has to travel back and forth to re-stock her food supplies, and bring her other items. Women themselves perceived that, whilst waiting at WHs, they were losing income by not working on the farm. Sometimes, those added costs were just too much to bear, and as a result women opted for non-compliance with the 2007 Policy Guidelines, and waited at home as the extract below exemplifies:

to deliver at the hospital is good ...but now, the exercise of going there to wait is the restraining factor because, as they have already said , maybe your income is low for you to divide the little food that you find is not easy, so you just say it's better for me to wait for the labour to start and just get there in time for delivery and then because of the long distance to the hospital, you find that you deliver on the way (Woman, focus group W04)

The above extract also shows a new type of ‘delay’ which can be added to the ‘three delays’ model and others: delaying by waiting at home rather than at WH, which can create complications for pregnant women such as the one cited above. WHs, rather than offer a solution to bridge gaps in the continuum of care, may in fact in certain ways make the gap wider, for the reasons explained here.

This section has described the relationship between economic and distance barriers, and how they may weigh in women’s decision-making regarding where to seek delivery care. Added to those are also a number of socio-cultural barriers which merit some attention, and are described in the section following.

6.2.3 Socio-cultural barriers to institutional deliveries

³⁹ The ‘hungry season’ is what people in rural areas described as the time towards the end of the dry season, and before the wet season starts and before the new crop is harvested is when food gets increasingly scarcer and harder to share between members of large families.

Socio-cultural barriers are conceived here as the barriers linked to women's own cultural beliefs or social context. Literature demonstrates that those are often compounded by women's low level of education- particularly in rural areas- and their limited powers of decision-making within the household, all of which may prevent them from accessing adequate care (Palamuleni 2011, Treacy, Sagbakken 2015, Edmonds, Paul et al. 2012, Mbweza, Norr et al. 2008, Barber 2004). With regards to this particular barrier, women in this study talked mainly of intra-household relationships. Those concerned, for instance, the attitude of husbands regarding women's deliveries. Women expressed that some husbands refused to escort them to health facilities, or failed to provide them with the money or means to go there, causing them in some cases to have to deliver at home. This partner's lack of interest in their wives birth-preparedness has been noted in another recent study in Malawi (Ryan, Hamela et al. 2015). The current study however adds to this a socio-cultural point seldom made, which is that some women are concerned about what husbands may do whilst they are away at facilities or at waiting homes. Those are mentioned in the extract following:

For a woman to start off on her own for the hospital is very hard, because for some, even their own husbands refuse to escort them. For them to go to the hospital and wait there, the husband says 'you want to run away from household chores here at home', so the women are afraid of such things and say 'oh let me just stay'. Maybe if I go I'll find that my husband has taken in another wife [other participants nodding and expressing agreement] because he thought I was competing with him, so these things are very hard for us here! (Woman, focus group W04)

The above reveals that socio-cultural barriers are linked to issues of social networks, gender inequality and vulnerability. For instance, De Kok, Hussein et al state that:

Women are often socially and economically more vulnerable than men, and securing their relatives' and spouses' support, through bearing children, is crucial. Thus, economic vulnerability heightens women's social vulnerability and dependency on (for instance) their husbands, and vice versa (de Kok, Hussein et al. 2010, p.1706).

Social relationships with members of the family other than their husbands were mentioned by women in this study, as well as how they weighed in their decisions to seek particular types of delivery care. Once such instance was when parents urged their daughters to deliver at TBAs in keeping with family traditions that the firstborn child should be delivered by a traditional birth attendant. To go against such recommendations, for some women, could have been seen as disrespectful to elders. Such social relationships and power differentials are relevant to delivery care-seeking behaviours, and signal that the single focus on promoting biomedically managed births, which focus only on women's physical bodies, rather on their

cultural context may be misguided. This is a point which will be addressed further in the Discussion in Chapter 9.

In this study, some participants gave insight as to how decisions regarding delivery care are made within rural households. They explained that in their areas it was customary to seek either the husband (or failing this, the brother's or uncle's) permission to travel to the health facility for delivery. Some participants stated that delays occurred sometimes, when the family needed to find the right guardians to accompany the woman to the facility: that is one from the husband's family and one from the wife's. A guardian in this case is the person who comes with the woman to the health facility for delivery, usually women. They are usually one, sometimes more, who will stay with her at the facility until she returns home, although they do not necessarily accompany the woman in the labour ward. They are usually found outside on hospital grounds, doing laundry, cooking or resting, awaiting for the woman to have delivered or be discharged. Men were not usually guardians. Sometimes husbands happened to be away for work, or had failed to make the proper arrangements for their wife's deliveries. It is important to remember here, that, culturally-speaking, pregnancy and birth are a woman's domain in Malawi, and husbands on the whole in rural areas do not accompany their wives into the hospital for delivery (though some may transport them there on bicycles or with oxcarts). The lack of men's involvement in maternal health has been raised by other recent research in Malawi (Aarnio, Chipeta et al. 2013, Ryan, Hamela et al. 2015), and some innovative projects are now attempting to increase male involvement and husband's engagement in deliveries and pregnancy matters (Kululanga, Sundby et al. 2012, Kalembo, Zgambo et al. 2013). In Site 1, in this study, young men were being encouraged to accompany their wives to their ante-natal clinic appointments, and indeed a number of them took part in the FGD.

Undoubtedly, the mechanics of decision-making within a household with regards to childbirth are complex. Barber described those in detail in a number of case studies in her thesis situated within a matrilineal community in the Zomba district of Malawi (Barber 2004). In the case studies, she described how some women attended at a TBA because their matrikin's permission could not be obtained in time to go attend at facilities, or because their parents refused hospital care, or refused to acknowledge the gravity of their situation in time. Social relationships and networks can affect women's care-seeking behaviours positively or negatively. As a recent study on the use of institutional maternity care in remote rural

Cameroon showed, women who had networks supporting them with their health needs in their communities (e.g. church groups, women's groups or family members), where their health needs were discussed, and addressed, were more likely to use facility services (McTavish, Moore 2015). One can argue also that women's needs may be best served by members of their communities- such as TBAs-, who know them and partake in their culture and beliefs about birth, as is expressed below:

because there are even other mothers who are just convinced to go to two antenatal places, to azamba and here. Because they think here we are just concerned with just physical but at home they are concerned with spiritual beliefs (Male Nurse Midwife Technician, interview SBA11)

This points to another key aspect of proximity, which is not purely geographical, and is explored in details in the next section, it has to do with cultural and social proximity, and with empathy. When women are *considering proximal help* rather than institutional help for their delivery care, they are not simply doing so out of circumstances, but because they wish to be helped by people who respect their traditions and treat them in the manner they wish to be treated (Nyanzi, Manneh et al. 2007, Byrne, Caulfield et al. 2016).

6.2.4 Barriers related to negative experiences of interpersonal care at health facilities.

Besides the subcategory of *geographical, economic and socio-cultural barriers* described above, there are other significant barriers posed by facilities themselves, which need exploration because they emerged clearly in the findings from this study. Those barriers do not relate to external factors, but to the behaviour of some SBAs themselves at facilities and to the sub-optimal care some women receive from them (Seljeskog, Sundby et al. 2006, Chodzaza, Bultemeier 2010). In this respect, one body of literature has explored issues of cultural safety and cultural acceptability of maternity care (Phiri, Dietsch et al. 2010, Kaphle, Hancock et al. 2013, Chalanda 1995). Cultural safety in health care can be described as health staff displaying:

a broad understanding of respect, support, empowerment, identity and upholding human rights...Cultural safety has been identified as a framework that when used in nursing, midwifery and other health professions gives recognition to power imbalances, which are often inherent in relationships between health care providers and recipients... Cultural safety involves protecting beliefs, practices and values of all cultures (Phiri, Dietsch et al. 2010, p.106).

Another body of literature, more pertinent still to this study, has emerged in the last few years, concerning issues of disrespectful and abusive care (D&A) in childbirth, which some women receive at facilities. Section 2.4.1 described the relevant literature on D&A care in childbirth. Bohren et al's typology is used here as a point of reference, which defines D&A care as "physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, health system conditions and constraints" (Bohren, Vogel et al. 2015, p.7). A number of studies have reported on instances of D&A care in childbirth in Malawi also (Seljeskog, Sundby et al. 2006, Chanza, Chirwa et al. 2012, Simwaka, de Kok et al. 2014, Kumbani, Chirwa et al. 2012, Banda 2013, O'Donnell, Utz et al. 2014). Some of those studied suggest that women's negative experiences of childbirth care may have consequences on their subsequent care-seeking behaviours and decisions. Although there is so far little hard evidence of experiences of D&A care alone preventing women from attending facilities for their deliveries, it may be logical to assume that it is a factor. In fact the findings presented below go some way in demonstrating this. Importantly, what these findings contribute to the debate on D&A care in childbirth in Malawi is how the implementation of the 2007 Policy Guidelines and TBA ban appear to have aggravated the situation for some women in remote rural areas, and lead to '*tipping the scale*' towards non-compliance with the Policy.

6.2.4.1 Experiences at the receiving end of delivery care: being welcomed well or harshly

What was striking from the analysis of the women's focus groups discussion data is the distinct way in which they described TBA and SBA care. Data indicated that besides expecting to receive medical treatment and have safe births at facilities, women also valued being supported through labour and welcomed kindly. This caring, welcoming attitude has been described as a characteristic of TBA care both in Malawi and elsewhere (Dietsch, Mulimbalimba-Masururu 2010, Dietsch 2005, Anderson, Anderson et al. 2004, Sargent, Bascope 1997) and is now crucially lacking since the ban. This kind and caring attitude has also been cited as a reason for women seeking their particular delivery care (Ryan, Hamela et al. 2015). TBA care was described in those terms by women in the majority of FGDs in this study. TBAs were portrayed as able to make women feel at ease, reassuring them through kind words and physical contact, giving them food to keep their energy up to deliver, and providing them with warm water to bathe after delivery, as the following extracts express:

(Participant 1) at the TBAs, they do welcome a person very well, because if a person has come, they give her accommodation... if they don't have enough food, they were giving them; (Participant 2) they were helping her to find energy until she delivers and then cleanse her, separating the baby from the umbilical cord, yeah and then they were putting the baby aside and then taking the mother to take a bath so that she can put on clothes. (Women, focus group W03)

(Participant 1) The ones who used to welcome women better in the past were the azambas [TBA] because when a woman went to azamba's places, she was not disparaged; (Participant 2) At the azamba, they used to welcome you well and you would also be given a good place to sleep. Over and above that, they would help you deliver the baby. After delivery they would give you porridge. (Women, focus group W05)

The second extract above particularly highlights how much the welcoming and interpersonal care matters to women beyond the technical delivery care (as was alluded to in section 2.4.2). In over half of the focus group discussions with women, having been “welcomed well” or “received nicely” at the TBA was stressed as being important. This interpersonal care contributes not only to a positive emotional experience of labour, it may also have real impacts on physical outcomes. As Dietsch and Mulimbalimba-Masururu suggest: “the strategies the traditional midwives used as caring and compassionate, intuitive responses to labouring women are favoured by women, will not cause harm, and may help facilitate normal birth” (Dietsch, Mulimbalimba-Masururu 2011a, p.164).

In this study, this welcoming and caring attitude was contrasted by women with the way they had been welcomed at health facilities. Some spoke of a ‘harsh’ welcome at facilities, where some SBAs shouted at them or addressed them in a rude manner. It must be stressed here that the data from this study brought up mostly instances of verbal rather than physical abuse (only two instances of what were perceived as physical abuse were reported by participants, one of being slapped and one beaten in H06 and W07 respectively). The D&A care displayed by some SBAs is expressed in the below quotes:

you complain, because of the way you are, what you are feeling [with the pains of labour]. Sometimes doctors don't talk with respect, they despise us. I experienced that with my first born child, if you ask “I want to go to the toilet”, instead of telling you nicely they just say “you just go” then if you go you just discover that the baby has fallen into a pit latrine [toilet] ...that's when they call us and begin to shout at us saying “you say we kill your babies, yet you are killing the babies yourselves” [by going to the toilet] (Woman, focus group W01)

it is a policy that everyone has to deliver here at the hospital, the doctors shout that “why didn't you go straight to hospital by the time the labour pains started ? why

were you going to the TBA's? look, you are not ok, inside your womb, you need D & C, you have to go to a big hospital at X, you have done a wrong thing!" (Woman, focus group W02)

The second quote above reports an incident which could be construed as the SBA simply expressing genuine concern for the woman's safety, but it also shows some disrespect and a lack of understanding of the reasons why this woman may have gone to the TBA in the first place, which the previous sections revealed. Shouting at the woman and telling her what she has done was wrong would not have reassured her, and may have had some adverse effects on the delivery (e.g. stress and fear). Most of the growing literature of the effects of D&A care in childbirth focuses on women's negative perceptions of the quality of the care received at facilities, and on their unmet expectations in that regard (McMahon, George et al. 2014, Kruk, Kujawski et al. 2014, Bohren, Hunter et al. 2014, Rosen, Lynam et al. 2015, Okafor, Ugwu et al. 2015, Kujawski, Mbaruku et al. 2015, Bohren, Vogel et al. 2015, Abuya, Warren et al. 2015, Ratcliffe, Sando et al. 2016, Bradley, McCourt et al. 2016).

However, it would be short-sighted to view instances of disrespectful and abusive care strictly- as is often done- from a Western point of view, or to assume that some SBAs behave in the way they do- including shouting or being rude- simply because they are cruel and do not care about their patients. Notwithstanding those who clearly do show malpractice, it is possible that for some SBAs, acting in the way they do is actually meant to show their care for the woman. As Brown (Brown 2010) explains in her study of SBAs disrespectful behaviour in Kenya, SBAs expect women to behave in a certain way to receive the care they need. Brown gave instances of SBAs slapping women on the leg during labour or addressing them in abrupt manner to avoid them "being relaxed", which they perceived as "a potential inhibitor in the successful provision and receipt of care" (p.125). In the current study, women did express a similar sentiment and ventured that some SBAs shouted at them because they had been found to have delivered at home or with TBAs, that is behaved in the wrong way, against the advice of the Policy Guidelines. Because those women may arrive too late at the facility with severe complications to be addressed, it is quite possible SBAs were genuinely concerned, although expressing this in ways which are arguably problematic. One woman, cited below, gave real insight into how crucially different perceptions of what is labelled D&A care can be:

When doctors tell you to calm down it is like they are insulting you because of the pains. But that is not insulting you but assisting you so that the baby should be

coming out properly. When they say lie down, they want the baby to come out properly, as they know their job. When they do that we think they are ill-treating us but that is not ill-treatment but they want to do their job well. Of course there some who ill-treat patients, we should say the truth there are some who ill-treat patients here at the clinic... you just need to be patient because you want assistance. You should not cry because even if you cry, tears don't come out, there is time when tears come out. When doctors instruct you to turn, just do what they are telling you, and you see that within a short time you are saved (Woman, focus group W01)

This quote reveals the woman's sophisticated analysis of an experience of disrespectful care: first it acknowledges how the Sab's desire to do their job properly and swiftly can be misconstrued for D&A care; secondly it points to the fact that women do differentiate this from what they perceive as actual ill-treatment; thirdly however, it suggests that some women may be tolerating some "ill-treatment"- or poor interpersonal care- in order to get the technical care that they need. This has also been reported by Kumbani, Chirwa et al in their qualitative study assessing whether women at a district hospital in the Southern region of Malawi critically assessed the delivery care they receive. They stated:

A participant in labour who was told to put a plastic paper and cloth on the bed by herself before lying down was satisfied with the way she was received. This was unacceptable, as beds are made by health workers...Another participant even justified being shouted at by health workers. Possibly the participants felt they should tolerate the health workers' behaviour in order to be assisted (Kumbani, Chirwa et al. 2012, p.10)

6.2.4.2 Experiences at the receiving end of delivery care: continuous support in labour versus neglect

The second main perceived difference between TBA and SBA care was that of continuous labour support. According to Barrett and Stark, labour support encompasses "emotional support, physical comfort, and advocacy" (2010, p.13). Emotional support signifies "a continuous presence, positive reassurance, and praise", physical comfort refers to actions such as "therapeutic touch, massage, warm baths or showers, and encouraging fluid intake and output", and advocacy "consists of communicating the woman's wishes and offering information about the progress of labour, coping methods, or relaxation techniques" (Barrett, Stark 2010, p.13). Labour support should ideally be continuous – that is provided throughout by one attendant- which means that the care provider would stay close to the woman, attentive to her needs, and communicative. Even though Barrett and Stark's developed their

work in the context of HICs, their definition fits with the manner in which participants described the interpersonal care and labour support provided by TBAs.

In this study, the TBAs were portrayed by participants as providing better continuous labour support for women, as in the following extract:

At the TBAs when we went there for delivery, the TBA stayed there, waiting until we delivered and received the baby when it is born and took it and washed it within, what, a short time, because she was there unlike someone who is far, the baby is born, the cold beats on it, by the time the doctor comes, the baby is cold, yeah, so the TBAs were very helpful (Woman, focus group W04)

Interestingly, this continuous labour support – staying with the woman in labour, chatting with her, listening to her and reassuring her through kind words and physical contact-, was also described by TBAs themselves as the way they did their work. To them, it was their way of ensuring women's safety, as expressed in the quote below:

(Participant1) how can we run away from her? (Participant 2) We wait for her because maybe if you go away she can deliver while you are not there, and it is not helpful, so we wait there until we have seen that things are okay. (TBAs, FTBA01)

The above suggests that the safety of mothers may not be guaranteed exclusively by having the right skills, knowledge and equipment- as was expressed earlier in 5.4- but also by being there, offering continuous support. Indeed research shows that labour support leads to positive delivery outcomes. Hodnett and al's comprehensive review (2013) of 23 different trials, assessed the impact of continuous interpersonal support during labour on over 15,000 women from 16 different countries (including some LMICs). Their review demonstrated that women who received continuous labour support were less likely to require interventions or C-sections, were better able and more confident to have spontaneous vaginal deliveries, and also reported a more positive experience of childbirth. Moreover, their new-borns were more likely to have better Apgar scores. The tangible benefits of labour support are also well documented in a number of other studies (Dahlberg, Aune 2013, Ross-Davie 2012, Yuenyong, O'Brien et al. 2012). Continuous labour support has been described as a characteristic of TBA care in other African countries (Dietsch, Mulimbalimba-Masururu 2011a, Mahiti, Kiwara et al. 2015), characterized by offering kind words throughout, allowing women to adopt their preferred birth positions and offering a continuous reassuring presence throughout labour. The quote below aptly describes this:

At azamba's [TBA] when you are about to give birth, you sit up like this. At that time the azamba will hold your back [sitting behind the pregnant woman] as a way of helping you to give birth. In that way you feel good, you don't face any problem because they help you. But when you go to hospital, they tell to lie on a bed. So when you lie on the bed, the nurse will just sit and only urge you, "Push! Push!" That makes you regret coming to hospital and wish you had gone to azamba's (Woman, focus group W05)

This quote stresses both the importance of physical contact in labour support (both to support the woman, but also to make her 'feel good'), and the lack of cultural safety mentioned earlier (when women are asked by SBAs to adopt the standardised supine position in labour rather than the sitting position they prefer).

In the findings, the continuous labour support of TBAs was contrasted with the absenteeism and neglect of some SBAs at health facilities. This has been raised also in other studies in Malawi (Banda 2013, Hamela, Kabondo et al. 2014, Kumbani, Chirwa et al. 2012). Some women, in this study, described SBAs "knocking off" (meaning coming off-shift; FGD W03), when women presented to them at facilities in labour, or "going to their friends to chat", rather than attending to them (FGD W07):

When you, as a patient, arrive, for them to pay attention to you! they just say sit here 'it's not yet time', when in fact the time has already, what? Is already due! but then he [the SBA] goes away. And here the labour progresses, you do not know what to do, and then the baby is what? is born. He [the midwife] comes back from there and says 'how did you deliver'? (Woman, focus group W04)

This woman above expressed perceptions shared by others, that some SBAs' preoccupation is with the time of delivery- as expressed earlier in section 5.3.1-, and that they tend to be there for the last active stage only, rather than to support the whole process of labour. Of course this perceived neglect may have also resulted from midwives being extremely busy supporting several women at once in short-staffed facilities, as was found to be the case in some of the health centres where SBAs were interviewed. In practice it meant that a number of women reported delivering by themselves in facility corridors or outside. The fact that these women felt neglected, may well have eroded their trust in their SBAs. As Gilson expresses, trust in health care providers depends on their displaying "technical competence, openness, concern, and reliability" (Gilson 2003, p.1454). Here SBAs failed to show reliability by simply not being there. Because being there, to the women in this study, meant being close, rather than absent or occupied elsewhere (as a woman expressed "they don't get close to us the doctors, everyone goes out, they sit on a chair and write their stuff" (Woman,

focus group W06). Similar issues were reported by Banda in her recent study, where she stated that her:

Participants in all phases reported that mothers at the health facilities met providers who were bullies, unfriendly, harsh, rude and abusive towards them... When the mothers reported to the health facility at night, the nurse-midwife was not readily available to assist. (Banda 2013, p.155).

By contrast, of all the SBAs in this study, only one acknowledged this apparent deficit in continuous labour support:

We're not doing enough about the psychological care, when a woman comes in a labour ward, what comes in our mind? it's the labour! Is she in labour? How progressed is she? When is she going to deliver? What can we do about it? But about maybe their concerns, maybe welcoming them, giving them a smile, I think we are not doing much as midwives, we are focused on the.. you know.. the physical care, and the labour and its process, not actually what the woman feels about it. No! (Male Nurse Midwife Technician, interview SBA09)

This quote highlights SBAs' focus on technical care, on standardized symptoms typical of the biomedical management of childbirth, which may be putting women off and leading them back to the care of TBAs. Although an investigation of the drivers of D&A care in Malawi is beyond the scope of the present study, some possible causes can be advanced here. First, undoubtedly, some SBAS are tired and overworked. Thorsen et al, in their cross-sectional study of the rates of burnout among staff working in obstetrics at a district referral hospital in Malawi have also indicated that this may be a driver of D&A care (Thorsen, Tharp et al. 2011). Some of the SBAs interviewed in rural health centres in this study had done several shifts in a row because they were the only midwife available at the facility, and seemed very tired. A second potential driver of D&A care may be depersonalization, which Thorsen et al defined as "the experience of becoming cold and indifferent to other's needs" (2011, p.2), which may be the result of a sort of defence mechanism on the part of SBAs, particularly those who have witnessed a number of very serious complications and possibly maternal deaths (de Kok 2015). More research is certainly needed in Malawi in this area to support interventions to redress the problem⁴⁰.

⁴⁰ One such project is called "*Improving Respectful Care in Rural Malawi: A Human Rights Approach*" which is a partnership between The Association of Malawian Midwives (AMAMI) and the White Ribbon Alliance (WRA), Edinburgh Napier University, Robert Gordon University Aberdeen, and the University of Aberdeen.

Notwithstanding, it is important here to highlight that D&A care does not necessarily happen everywhere in Malawi. Although it was an important issue in this study, a number of women in FGD also portrayed the interpersonal care received at hospital in a positive manner (W03). Sadly, however, this kind care was described as inconsistent. Those SBAs perceived to be most caring and kind, were the male nurse midwife technicians, whom women sometimes requested when coming to deliver at facilities. They advanced the reasons below:

(Participant 1) we even found that some male nurses do their work well (Participant 2) yah, more than the female nurses)- they are the ones who help to deliver women! those men yah, deliver the women; and the men, when the woman is in labour they caress her, “ah don’t worry eeh, don’t worry” caressing her and reassuring her until the baby is what? is born (Women, focus group W06)

Female participants talked about those male nurse midwives as “*feeling pity*” for them, “*staying by [their] side*”, stressing that continuous support again. Women argued that the main reason for their kindness was that they “*don’t know the labour pains and they just imagine how a woman is feeling*” (Woman, focus group W07). Thus One driver of ‘good delivery care’ could be perceived as empathy, namely the ability to understand and share in the feelings of the patient, and familiarity knowing the patient.

Empathy and familiarity were traits perceived to be displayed by TBAs. A number of participants in this study for instance, explained that TBAs treated women as if they were relatives. Of course this could have simply meant that some of the TBAs were indeed related to their patients, as they came from the same village or community. More likely it referred to the TBA’s familiarity- and respect- for the women they helped. For participants, this familiarity was a driver of good interpersonal care, as is expressed below:

(Participant 1) the TBA knows good customer care. May be because TBAs know that they are treating their own relatives. They can’t afford to lose the life of their own relatives. But because hospital staff they take it as employment, they don’t give the needed care to the patient; (Participant 2) She [the TBA] knows how to respect the patient, because the hospital staff capitalize on the fact that they do not know the patient. The possibility to insult is very high, while the TBA knows the patient, therefore, they treat her with dignity (Men, focus group H04)

This quote expresses the perception that familiarity breeds respect, and as such minimizes the chance of D&A behaviour taking place. Unfortunately, in Malawi, the SBAs at facilities are often deployed from other districts, and tend not to be locals. This means they have no familiarity with the women they serve, and are at times unaware of their cultural needs in

childbirth (Chary, Diaz et al. 2013, Saravanan, Turrell et al. 2012, Leedam 1985, WHO 1992, Dorwie, Pacquiao 2014). By contrast, for women in this study, being treated like a relative in the TBA's place, or in their own home, meant that they felt more comfortable in their own environment, able to explain how they felt and what they wanted, and able to have the emotional support of their own guardians or relatives. Conversely, the lack of privacy and familiarity at health facilities was aggravated by the fact that women usually delivered alone due to the lack of space in labour wards (especially in some small rural health centres). The picture below of a crowded space with a few beds and only the privacy of a curtain shows this, with and has been reported elsewhere as problematic (Sarelin 2014, Kululanga, Sundby et al. 2012).



Figure 24. Labour ward in a rural health centre (Site 3)

In this section all the key properties of the subcategory *experiencing disrespectful and abusive (D&A) care at facilities* have been presented. This ultimate barrier, when added to the other geographical, economic and socio-cultural barriers women encounter, forms what can be called a 'the tipping point' towards non-compliance with the 2007 Policy Guidelines and TBA ban. This means that although a prior negative experience of delivery care at facility may not be the barrier that weighs the heaviest in the way women weigh their options for delivery care on a case by case basis, it may also become the tipping point, yet another reason why women decide not to go to facility and why they may be *considering proximal help* instead.

The literature describing factors which influence delivery care-seeking behaviours is extensive, and aims to explain what motivates women to opt for home or TBA deliveries rather than institutional deliveries even where services are available (Pfeiffer, Mwaipopo 2013, Titaley, Hunter et al. 2010, Phiri, Kiserud et al. 2014, Morrison, Thapa et al. 2014, Jamas, Hoga et al. 2011). One of the most comprehensive reviews (Gabrysch, Campbell 2009) shows that previous experiences of care, especially if negative, also come to bear into delivery care-seeking behaviours. This seemed to be confirmed also here by some community actors besides women; particularly VH and HSAs who witness and monitor what takes place in their communities. The first quote which follows is from a HSA focus group where participants conveyed what women had expressed to them in their communities:

(Participant 1) Some were saying that “aaah, no, the nurses will shout at us” so I will not go to the hospital; (Participant 2) “many, many, they fear Nurses”; *(Participant 3) I can say some [nurses] are good but some they are not good, so ... the community, that’s why some they shy to come to the hospital, they prefer to deliver at home (HSAs, focus group HSA02)*

The next quote is from village headpersons (VH), whose role, as expressed earlier, is to urge women to deliver at facilities, and to monitor that they do so. It clearly illustrates the issue of women’s unmet expectations of good interpersonal care at facilities:

(Participant 1) the nurses become tired with their job due to a large number of patients to attend to, and in some cases instead of treating people they just shout at them, ... words that discourage women to go to the hospital again; (Participant 2) the doctors sometimes shout a lot, when it is time for a woman to give birth they say “stay there and deliver yourself” ... then women say “why did I come here at the hospital? I would rather stay at home”. (Village Headperson, focus group FVH02)

The quote above also makes a larger point about the barriers women face, which is one related to choice and autonomy. It is often assumed in studies relating to women’s delivery care seeking behaviour in LICs that they have little choice in the matter, and that geographical, economic or socio-cultural barriers decide their options for them. It is also often assumed that if women had a choice, they would certainly decide to deliver at a health facility with a SBA. In this Chapter I show that within what are real obstacles and constraints, and new interdictions, it is possible that some women make a choice. They may indeed be using what Veneklasen and Miller call their “power to” and “power within” to make decisions with regards to their own delivery care (Veneklasen, Miller 2002); decisions sometimes based on what women perceive to be good versus unsatisfactory care (Kumbani, Chirwa et al. 2012). The theory, in Chapter 8, will return to this argument. It highlights a

disconnect between the way policymakers, such as the one below, view the choices available to women, and the actual decisions women may make on the ground. As this MoH official saw it:

Given a choice no woman would have a choice to die. If I knew that I am pregnant and am going to deliver, if I knew that I am going to deliver at a TBA ... my chances of dying are much higher than if I went to the health centre, I definitely wouldn't choose to go there... but if they also knew, if I they went to the district hospital to deliver, then the chances of this 'pakati' [being between life and death] would be reduced, then, you would be talking of choice! (Key Ministry of Health official, interview OMS06)

For the policymaker above, the choice seemed more binary (either die at a TBA or have a safe birth at a facility). However for women, for the reasons presented in this Chapter and the previous one, there were a number of factors that came into play in their decision-making, a number of options to consider. One such option was that of *considering turning to proximal help*, the third main category in the grounded theory.

6.3 Considering turning to proximal help

“*Considering proximal help*” describes the strategy deployed by some women in rural areas when the barriers mentioned above are tipping the scales on the side of non-compliance with the 2007 Policy Guidelines and TBA ban. Proximal help may come from relatives, or from TBAs. This main category has two subcategories: *placing TBAs between a rock and a hard place*, and *doing it in a secret*. This section shows that when women consider this proximal help they are placing TBAs under immense pressure; pressure to support women whom they know, and for whom they feel empathy; pressure also because even if TBAs stick to their new redefined roles, in practice, referring women who turn to them to the facilities is nearly impossible.

6.3.1 “Conducting deliveries only in unavoidable circumstances”: leaving TBAs between a rock and a hard place

As was mentioned in section 3.4, the 2007 Guidelines for Community Initiatives for Reproductive Health redefined the roles of TTBA as follows:

- Advising women on health matters (IEC)
- Providing information to communities on danger signs of pregnancy, childbirth and the postpartum period
- Educating couples on birth preparedness

- Referring women with problems during pregnancy, childbirth and after delivery
- Referring any woman who presents to her for delivery to the nearest health centre and report the case to the Village Health Committee/Village Head Man
- Referring new-born babies with problems soon after delivery and during the postnatal period
- Encouraging mothers to go to the health facility for antenatal, delivery and postnatal care.
- conducting deliveries only in unavoidable circumstances and should accompany the mother to the nearest health centre as soon as possible
- keeping records and producing reports
- Acting as link between health facility and community
- Family Planning motivation (Republic of Malawi Ministry of Health 2007a, p.11, emphasised)

In practice, however, the findings showed that this had left TBAs stuck between what was labelled ‘*a rock and a hard place*’, a subcategory which best described the situation TBAs currently found themselves in. First, on the one hand they are not allowed to help with routine deliveries, yet on the other hand they are still called upon by women who either need their help, or come to them because they prefer the care they provide. This dilemma was also reported in Banda’s study (2013), and is exemplified in the following extract:

They [women] still come...they don’t accept, they refuse [the Policy]. It is when the labour pains have already started, they say that the labour pains have already started and they cannot go back [to facilities] (TBA, group interview TBA02-03)

In the TBA focus groups, several participants expressed that despite the new Policy, they had recently helped women who were about to deliver on their way to health centres. Those focus groups were made of TBAs from a very remote rural area in Site 3, and it was obvious that the pressure was higher for them to help in those remote areas, where facilities were far.

For TBAs, the pressure to assist women despite the ban was not exerted simply by women’s demands. There were also internal struggles apparent within the TBAs themselves, which were possibly leading to them partaking in the secret non-compliance. Most TBAs had delivered women for decades, and had learnt their trade in mentorship to others TBAs, or had come to this ‘calling’ through revelations (Wendland 2015, Banda 2013). Therefore there is little doubt that this work of *mzimba* has deep resonance within who they were. This kind of calling is unlikely to be something that can be turned on or off, just because a Policy redefines people’s role. For the TBAs who took part in this study, being a TBA was clearly

difficult to stop, and they expressed an urge –born out of their empathy-to help women who presented to them at times of need, as the quotes below demonstrate:

We are helping lives of others, we can't leave people suffering or facing problem because we need to get something no...we cannot leave people facing problems, that's why we are still working hard (TBA, focus group FTBA02)

it just happens, we just see a person who is in need of help coming, not that we really desire that we should be doing this job, but someone comes and they need your help, how do you deny them? That is why we do it (TTBA, interview TBA05)

These quotes relates to the *secret-non-compliance* with the Policy described in section 5.5. Whilst some women were considering turning to TBAS, TBAS were almost certainly considering helping women.

It must be noted that the 2007 Policy Guidelines had not discounted the TBA entirely, but rather had given them new roles as sign post to facilities and referral agents. Specifically the Policy tasked them with:

- Referring women with problems during pregnancy, childbirth and after delivery
- Referring any woman who presents to her for delivery to the nearest health centre and report the case to the Village Health Committee⁴¹/ Village Head Man
- Referring new-born babies with problems soon after delivery and during the postnatal period. (Republic of Malawi Ministry of Health 2007a, p.11, emphasised)

However here there appears to be a disconnect between a policy which, on the one hand, '*stopped*' TBAs from conducting routine deliveries and on the other hand expects them to refer and escort women to facilities when they come to them, with no allocated resources to do so. Because TBAs perceived the Policy in the way expressed in Chapter 5 and exerted varying degrees of compliance with it, they operationalised their roles as referral agents and escorts in different ways. Some viewed referring as simply telling pregnant women to go to facilities for delivery, whilst others sent them with a note to the health centre⁴², when they seemed to have a complications. For very few TBAs it meant perhaps actively calling for an ambulance to transport the woman to a hospital. Only 4 of the TBAs in this study actually reported escorting women to health facilities, at their own cost. For most TBAs, who faced

⁴¹ As far as the data indicated, TBAs were not often elected into VHC in the sites where this study took place. VHCs also did not seem to be in place in all areas, but they did exist in some of the areas in this study.

⁴² Though the researcher never saw such letter, it is assumed this would have been a simple note from literate TBAs, sent alongside the woman when she is referred to the facility to explain to SBAs what had taken place.

most of the same barriers as women in their communities, the means to escort (transport or money to procure transport or mobile phones to call facilities for ambulances) were simply not there (Banda 2013, Bisika 2008). Therefore, sometimes, rather than bring women who called upon them to deliver their babies to the facility, they, and the women were *doing it in a secret*, sometimes with grave consequences.

6.3.2 Consequences of “*doing it in a secret*”

The subcategory *doing it in a secret* relates to that of *secret non-compliance* described in section 5.5. However, it goes beyond considering whether women and TBAs may be accomplices in the act of secret non-compliance and starts to consider what consequences this action of *doing in a secret* may have.

The findings thus far have demonstrated that the act of secret non-compliance is resulting from some women attempting to circumvent both the interdictions they face and the barriers which are preventing them from attending at facilities for deliveries, be them geographical, economic, socio-cultural, or of previous negative experiences of institutional delivery care. However there are potential consequences from deliveries taking place with TBAs at home in a secret, not least, as a SBA expressed below, that they may delay the arrival of a woman with complications to the health facility, and endanger their lives:

they [TBAs] are really delivering, because these women after complications they come here, it's when they tell us that “oh I have been delayed at the azamba”. So we know that some are delivering although this is really secret to azambas; they tell the mothers “don't tell the people that you were here”... they are afraid because their role has been redefined, they were stopped to deliver now (Male Clinical Officer, interview SBA12)

The figure below represents in simple terms what may be consequences of doing deliveries in secret. Figure 25 attempts to show what may happen in remote rural areas when a woman calls on a TBA to help her to deliver in secret. Perhaps the woman is attempting to avoid a fine by keeping this delivery secret, or perhaps she keeps it secret to avoid the potential reprimand SBAs when she may later arrive at the facility with a complication. One possible outcome is that the woman delivers ‘normally’ and the secret stays with her, her family and the TBA who gave her help. Another outcome is that a complication occurs, and that the TBA perhaps perseveres, or is unable to find means for referral, and the women ends up reaching the health facility too late, potentially with disastrous consequences for her and her baby.

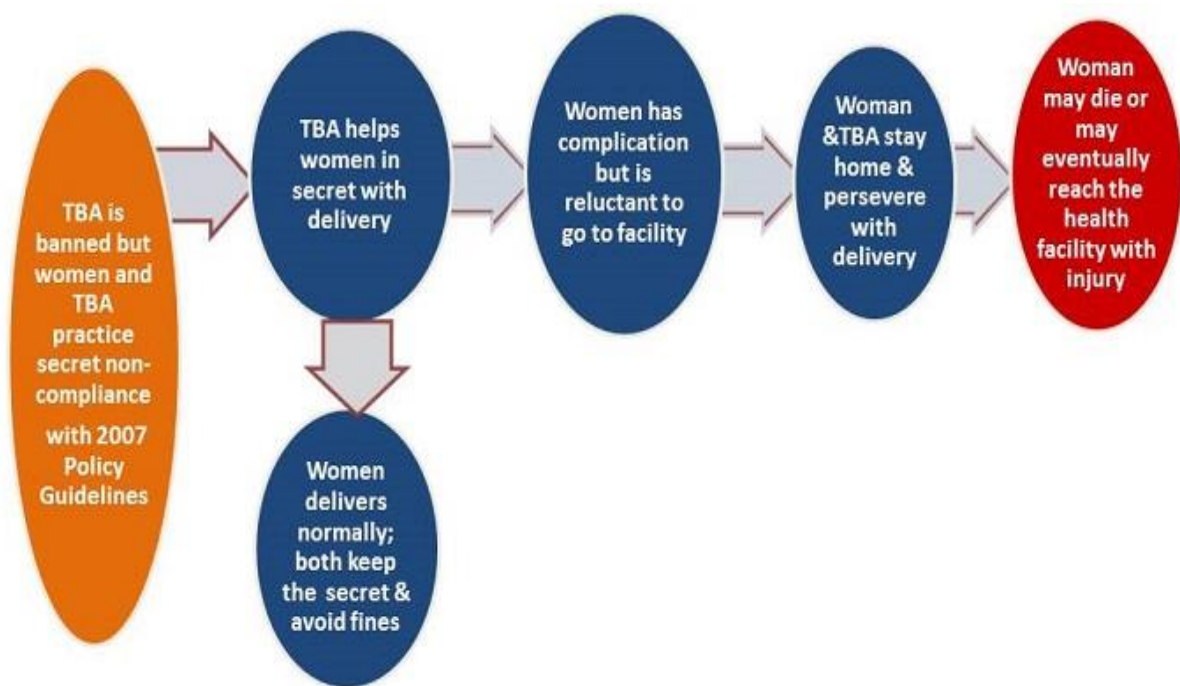


Figure 25. Possible consequences of 'doing it in a secret'

Chapter 6 has demonstrated the interplay between the implementation of the 2007 Policy Guidelines and its new interdictions, and the barriers women face in their attempts to comply. The findings did not argue that the Policy created such barriers, but rather that in some cases, it aggravated them. Although it cannot be argued that it is because of this Policy that women have no transport to cover the distance to facilities, it can be argued that because they are prohibited from routinely accessing the proximal help of TBAs, some are left with no option to feel the gap but to deliver at home or *doing it in a secret*. Although it cannot be argued either that it is because of this Policy that women are poor and do not have the economic means to procure the items they need to deliver at facilities, it can be argued on the other hand that the threat of fines for non-compliance or the potential added costs of waiting home attendance, may inadvertently create more hardship for women. Finally, even though it cannot be argued that 2007 Policy Guidelines gave rise to some of the sub-par standards of interpersonal care displayed at some facilities, it can be argued that having banned the TBAs' - who displayed quality interpersonal care- has led to an increased deficit in that area.

An effective continuum of care is defined as a continuum that fosters strong links between home, community and facility care (Kerber, de Graft-Johnson et al. 2007, Kikuchi, Ansah et al. 2015, Yeji, Shibanuma et al. 2015). It is contingent on facilities being available, accessible, fully equipped and free of charge- as indeed the Malawi Government has been striving to do. But at its core, it also depends on the building of effective relationships and trust between the different care providers, as well as on their collaboration. The final Chapter of findings explores the nature of the relationships between TBAs and SBAs, as well as with other community actors, since the advent of the 2007 Policy Guidelines. It assesses the Policy's impact on the linkages for maternity and delivery care available to women weighing their options for delivery care in rural communities of Malawi.

7 Chapter 7: Facing the breaking of linkages in the continuum of care

7.1 Introduction

The previous Chapter revealed some of the barriers faced by women in their attempts to comply with the 2007 Policy Guidelines Policy, and the resultant strategies they may deploy, some of which in contradiction with the Policy and TBA ban. Chapter 7 offers a detailed description of the fourth main category in this theory, labelled the *breaking of linkages in the continuum of care*. It presents the context of the broken continuum of care in which women now have to operationalize their choices regarding their deliveries, a context where the vital links between community and health facility are lacking. The subcategories for this main category were *ineffective links through HSAs and VHs*, and *broken linkages in the continuum of care between TBAs and SBAs*. Most barriers which have been revealed in Chapter 6 of the findings have related to the space dimension of the continuum of care (CoC). The literature regarding the CoC (Kerber, de Graft-Johnson et al. 2007, The Partnership for Maternal, Newborn and Child Health 2010) stresses the importance of linking space and time dimensions, but not the necessary links between the various providers of care at the different levels in the time/space dimensions. Those linkages are essential to an effective CoC and to reducing maternal mortality, as Pasha et al express:

A successful model for reduction of intrapartum mortality must span care across time and place, including families, communities and providers of delivery and related services, with an emphasis on coverage and quality of care as well as functional linkages between the various levels of care (2010, p.2)

A recent systematic review showed that strengthened linkages between community and facility care providers can make the CoC more effective in some countries to reduce maternal mortality (Kikuchi, Ansah et al. 2015). This Chapter shows how the implementation of the new Policy has, by contrast, led to a rupture in linkages between traditional birth attendants and skilled birth attendants and resulting in a rupture in the continuum of care (CoC) for women.

The chapter starts with a shorter contextual section which shows the linkages which existed prior to the 2007 Policy Guidelines and TBA ban coming into place 7.2. It then presents what linkages the new Policy intended between community and health care system to support

maternal mortality reduction strategies 7.3. Thereafter section 7.4 shows that not only those intended linkages have not really materialised, others have also been broken (particularly between TBAs and SBAs). Section 7.5 shows how this situation weighs in the decisions women have to make in rural areas today. Throughout the chapter the interface between this context of broken linkages and the other main categories presented in the two previous chapters are made salient. The Chapter concludes in section 7.6 with the recommendations made by some of the participants themselves with regards to restoring CoC linkages that can better serve their needs and aspirations.

7.2 TBAs as a key link in the chain of continuum of care: the situation prior to 2007

Labelling this fourth main category the *Breaking of Linkages in CoC* implies that those linkages did exist in some form in the past, prior to the advent of the 2007 Policy Guidelines and TBA ban. Indeed participants in this study expressed that prior to the new Policy coming into place, there were better contacts between TBAs and SBAs. As explained in Chapter 2 and 3, TBAs were trained in Malawi by the Government and supervised until the early 2000s (Wendland 2015). That training covered basic hygiene, normal delivery, the usage of delivery kits and recognition of complications, and normally took place at hospitals over 2-4 weeks (Banda 2013). It was delivered at times by nurse midwives technicians, and in some cases by HSAs (Wendland 2015, Banda 2013). Through it, a contact was created, between TBAs and health personnel. Of course, as was suggested earlier, this was not a meeting of equals, and often fell short of being a real hands-on collaboration (Pigg 1997b, Pigg 1995). Nonetheless, since it is estimated that close to 40% of the estimated 5000 TBAs in Malawi did receive this training (Bisika 2008), it can be argued that the programme did foster some basic contact between the two providers, and possibly an understanding of each other's knowledge in childbirth. Another more personal contact was afforded by the supervisory visits which some SBAs conducted at TBAs' homes. During those visits they used to check whether TBAs had assimilated the training they had received, were putting it into practice adequately, and discussed concerns. Of course such visits did not take place everywhere, and eventually stopped due to lack of funds (Wendland 2015), however some participants in this study expressed that those visits did enable some form of exchange:

Back then, the traditional birth attendants used to have quarterly meetings with matrons from the hospital to discuss various issues but this used to happen before the government banned them (Health surveillance assistant, focus group HSA01)

Other HSAs articulated that before 2007, they could talk more freely to TBAs, and some SBAs confirmed also that there were better communications which also helped create a better CoC in some places, as the extract below articulates:

it was good because we were working with them - there was good coordination. TBAs, village headmen, the community and the health personnel, yeah, we were meeting every quarterly...during that time we had committees on maternal health from that catchment area, so we were meeting them. In that committee we had the TBAs, some village headmen, the village health committees members, as well, as well as HSAs... we would meet and raise our concerns - let's say for the facilities, the challenges we were facing, and even the TBAs as well and the community so that they may, after that, we could see the way forward and at least we had an improvement. They were open. (Male Nurse Midwife Technician, SBA14)

The quote above indicates the signs of an effective continuum of care, such as 'good coordination' between TBAs, VH, HSAs, and crucially SBAs. The quote seems to suggest that SBAs used the meetings in the past to discuss issues with community members including TBAs (e.g. maybe maternal deaths in villages). There was however a power differential in those interactions, and visit may have served also as a way of asserting or re-asserting the authoritative knowledge, as is hinted at in the following:

I have met them[TBAs]...we used to train them ...when they were operating, so we could update them with the knowledge and the skills on how to do it and when to refer (Male Clinical Officer, SBA12)

Since this section is about the former linkages between TBAs and SBAs, it is important here to show in counterpoint how TBAs viewed these contacts in the past. Nearly all confirmed that they had attended community meetings, or trainings and refresher courses at hospitals in the past. They expressed their satisfaction at this contact, which had made them feel linked into the system, somewhat insiders to the maternal health strategies. Some stated they felt 'encouraged' by those meetings, and saw themselves as allies to the SBAs. The quote below exemplifies this:

I was very happy in the past because when they have come, they were giving me encouragement that if you are doing this work, and there is no complications, that means it is well, because at the hospital they don't want people to die. They want people to get well and they should hold something [a live baby] when going back home. So they were encouraging us, they were calling us to be together like a child who is doing some project development, because what we are doing is Development. The hospital is doing the development of healing people and we are also doing the same development of healing people. So we have been like children from the same parent, we understand each other (TTBA, interview TBA01)

This TBA's words express that they felt part of the solution to help save lives in the past, and that they had a sense of working hand in hand with SBAs towards the same goal "healing people". Tellingly this TBA states "*So we have been like children from the same parent, we understand each other*", which suggests that the TBA saw herself as part of the Government plan (the parent) in unison with the other sibling, the SBA. The phrases that other TBAs used to describe those former relationships were "*linked*", "*equals*", working "*hand-in-hand*", having a "*real relationship*". Some called SBAs "*friends*" or "*relations*"⁴³, which pointed to somewhat good natured and equal relationships. Admittedly this was more the perception of TBAs than that of SBAs, who did not call TBAs friends or equals. Nonetheless, one particular TBA even mentioned a rare and very hands-on, type of former collaboration:

Now at the hospital, I would go and you know they know me there that I deliver, there would be patients there and the nurse would be helping one and she would tell me to deliver the other one so I would deliver. Yes, that was way back in the 70s...you know it was my job too and the doctor would record that he did the delivery when he had actually given the job to me, that's what we used to do with the doctors who were here (TBA, interview TBA10)

It is worth noting also that even in the unusual case quoted above, the credit for delivery did eventually go to the 'doctors', showing that from the SBA's point of view, the TBA remained a helper, rather than as an equal.

However, the key point from the above is that some direct, face-to-face relationships were formed between TBAs and SBAs in the past. As Gilson expresses "face work commitments, that is, the trust relations built through inter-personal interactions, are critical in sustaining system-level trust" (Gilson 2003, p.1458). It has been cited in recent studies as a factor for the successful collaborations between TBAs and SBAs, which can foster more effective CoC (Yeboah-Antwi, Hamer et al. 2014, Pyone, Adaji et al. 2014, Higgins-Steele A., Waller K. et al. 2015). This has been reported in other recent studies regarding TBAs in Malawi (Wendland 2015, Banda 2013). Wendland stated for instance that TBA training "created social relationships between trainers and trained" (2015, p.6); and Banda claims that before the ban "the communities considered TBAs part of the formal health system because of the working relationship between them and the healthcare providers" (2013, p.140). The importance of such social relationships - and the respect they afforded to TBAs in their

⁴³ The words friend ('mnzanga/azanga') and relatives ('abale') are very commonly used words in Chichewa, to describe relationships to people and refer to relatives.

community, when they were seen to work ‘with’ SBAs, cannot be underestimated. It gave purchase to the TBA, it gave them entry into the health facilities, as recognised TBAs, which is in sharp contrast with the current circumstances.

By contrast TBAs describe their current situation as " *just staying*" ("*timangokhala*", a Chichewa phrase used a lot by Malawians to express that they are not doing any paid work but maybe just farming their land). In fact one of the adverse effects of taking away this important work from TBAs is that they have lost status in their community. As a Ministry of Health representative put it below:

now that they [TBAs]are no longer delivering, some of the community people are actually laughing at them, they are like a laughing stock, “ eh, you now don’t have anything to do” (Ministry of Health Official, interview OMS01)

This loss of status has been raised also in the findings of a very recent study from rural Zambia concerning the impact of the TBA ban in that particular country (Cheelo, Nzala et al. 2016). By contrast, in the past, TBAs had been important enough to work with and be respected by SBAs. The two quotes which conclude this section express this past working relationship from the juxtaposed perspectives of a TBA and of a SBA from the same geographical area in Site 3:

At first we were working together because when we went to the hospital we said “yes you are finding us with a pregnant woman and we want you the nurses to help us”, so the nurses allowed us to enter the hospital and explain everything (TTBA, interview TBA13)

We had a very good relationship with them yes, because they could comfortably come to you and tell you what is really going on with the woman in labour, they were comfortable coming to the hospital, escorting the women and explaining what they have done, the part they have done, and what they wanted you at least to assist with (Female Midwife, interview SBA15)

These may not show side-by-side collaboration in facility, but they point to a willingness to listen to each other, to ask each other in trust, for help when needed. In this extracts, the TBA expressed feeling comfortable to escort a woman with complications to the health facility, able to explain what they had done within their own limitations, and able to seek the help of the SBA to secure the best care for the woman, safe in the knowledge that the SBA would welcome them and treat them respectfully, despite their shortcomings. This had gone a long way in building trust between the different care providers, which is key to an effective CoC. Those instances of good communication and co-operation in the past are a far cry from

today's situation in Malawi, which, as Chapter 5 demonstrated, is one where TBAs are blamed for causing deaths and complications, and seen as untrustworthy. However, when the 2007 Policy Guidelines were designed, they did not anticipate such breakages, instead they had envisioned potential new linkages for the CoC from community to health system. In order to understand how sharp the change has been it is crucial explore what linkages were conceived by the Policy Guidelines in the first place.

7.3 How did the 2007 Policy Guidelines envision CoC linkages?

As expressed early in the thesis, the primary aim of the 2007 Policy Guidelines was to further reduce maternal mortality through community mobilisation and involvement. This Policy conceived of the links between health system staff and community actors as follows:

The Health Centre staff and a representative of District level staff should enter the community through the community leaders... Following this the TA will now organize a meeting between the health workers with the Area Development Committee (ADC), comprising, Group Village Headmen (GVH), representatives of Religious leaders, youth, politicians, and other influential leaders in the community to explain the intended purpose, and seek their approval and support... Village Headman (VH) and VHC in collaboration with Health workers (Nurse, HSAs), meet the community to explain and obtain consensus on the way forward. The Health worker will be required to explain again the issues for which they seek community involvement. Where the problem originates from the community, the community should be encouraged to report the matter to the Health Surveillance Assistant (HSA) who will report to the Health Centre staff. The Health Centre staff should go back to the community to verify the problem and later report to the Zonal Health Office through the DHMT. The Zonal Health Office, DHMT and the Health Centre staff should act together to assist the community solve the problem. The DHMT should commend the community for reporting the matter to the Health Centre staff and encourage them to continue the collaboration (Republic of Malawi Ministry of Health 2007a, p.6).

This was translated, for ease of use, in the figure below. It shows the intended linkages between health system representatives located in the top blue bubble, and various actors within the community contained below in the large, purple bubble. This figure helps understand why the Policy was perceived in the manner it was at community level, as discussed at length in Chapter 5, because it shows a clear top-down vision, from health authority through to HSAs, VHs, and at the bottom community members.

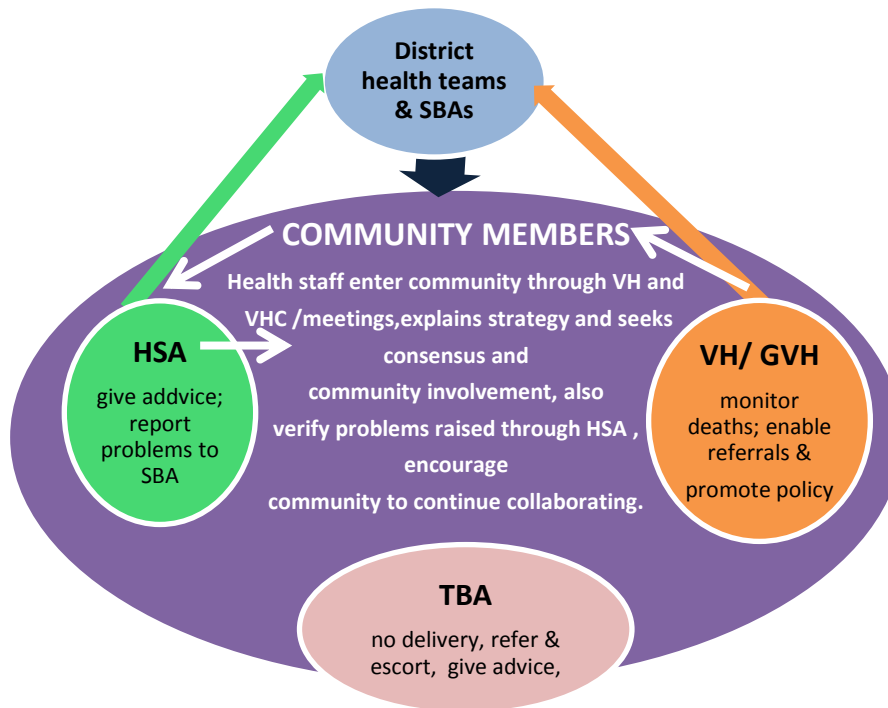


Figure 26. Community linkages envisioned in 2007 Policy Guidelines

In the figure above, the TBA is still placed within the community circle where she belongs but with no direct arrow to the HSA, VH and other health staff at the top. This is because the TBA is now per her redefined roles simply a referral and escorting agent, but an outsider to the health system. As this was envisioned, feedback and linkages from community members after the policy implementation were intended to take place through the HSAs who would report any reproductive health problem to SBAs at the top, thus ensuring an “information flow between the health delivery system and the community” (2007a, p.6). Clearly, the two most important links in the CoC from community to health system were seen as the HSAs, and the VH. However the findings below show that those linkages have not, on the whole, either materialised or been effective.

7.4 The Breaking of Linkages in the CoC

7.4.1 Ineffective links through Health Surveillance Assistants (HSAs)

As the community guidelines expressed “where the problem originates from the community, the community should be encouraged to report the matter to the Health Surveillance Assistant

(HSA) who will report to the Health Centre staff” (Republic of Malawi Ministry of Health 2007a, emphasised, p.6). However, this language talked more to problem identification than to the linkages needed for a functioning continuum of care. This is partly because the guidelines were designed for fostering community involvement in reproductive health matters, rather than as a ‘how-to’ guide for linking women in communities to their health system.

Potential linkages were shifted onto the HSAs because they were the health worker already based in, or close to, communities (and not to SBAs who, since 2007 have had no resources or time allocated to visit communities). Yet in this study women and men made few mentions of any direct linkages between themselves and the HSAs. Some men in one focus group (H04) acknowledged that they had seen HSAs conducting clinics in the communities, as did some women in a couple of the focus groups as is quoted below:

We have never seen a nurse or doctor coming here [in the village] for antenatal clinics. We only see Health Surveillance Assistants conducting antenatal and even postnatal clinics in some areas (Woman, focus group W05)

HSAs did confirm that their contacts with community members around maternity care consisted mostly in giving advice, as the extract below attests:

the pregnant women are helped by being told that once a woman is pregnant she must immediately begin with her antenatal care. When they come here at the clinic they will be vaccinated and get lessons about the pregnancy and issues concerning their health while pregnant, like healthy eating (HSA, focus group HSA01)

As a result, concerns were expressed by community members with regards to devolving the linkages to HSAs, since they are not trained to conduct deliveries, as expressed below:

the problem is that HSAs cannot perform the duties of deliveries. This is a very big problem to us. The TBA is an important person because first aid [for delivery] comes from her, because she is in a position to observe if there is a danger and be able to refer you to the hospital...This is so because some TBAs were trained and they know what to do, and not to do (Man in H04)

Within the hierarchy of knowledge, which was presented at length Chapter 5, this shows that in the mind of some community members, a TTBA- whose training was short but whose experiential knowledge of delivery may be extensive- was seen to have more specialist knowledge than HSAs when it came to childbirth. And rightfully so, since HSAs, are only trained for 8-10 weeks, and not in maternity care (Banda 2013). And even if HSAs could

assist in ‘*unavoidable circumstances*’, they do not necessarily live in the communities they serve. Besides they have now been task-shifted many other tasks, such as under-5 health and immunization, ART administration, and other health surveillance (TB, Malaria), that it is unlikely they would have enough time deal with maternal health issues. A key Ministry of Health official and policymaker recognized in the extract following that HSAs were not the ideal link for CoC with the community:

there should be somebody who is highly trained on the ground just like in other countries... you don't have the people the likes of Surveillance Assistants taking very heavy responsibilities that they shouldn't and then they cause accidents or make major mistakes, people die, children die ...it's not their fault but its lack of knowledge, lack of skills...how much can you learn in 10 weeks? ... so now you find that the community health nurses have been absorbed in the practice area because we have too few community nurses and instead that role has been given to surveillance assistants. And so because of that you find the surveillance assistant is the one who is in contact with the TBAs and the community; but what skills does he have? Of, you know, what level of training does he have? very little and so it would be unfair to expect him to do a lot more, but I would think that there is still some communication [between HSAs and community members] but it's really very small (Key MoH official, interview OMS06)

As far as a linkage between TBAs and HSAs which the above alludes to, it seemed to be limited to sporadic surveillance on the part of the HSAs

What this ineffective linkage in the CoC meant for women weighing their options for delivery care in rural areas, is that it leaved them with a gap in terms of proximal help for delivery coming from the health system. The below thus investigates if a linkage was fostered instead through the Chiefs and Village headpersons (VH) who were given a key role in the dissemination of the 2007 Community Guidelines, and the PISM.

7.4.2 Lack of linkages with village headpersons (VHs)

The 2007 Policy Guidelines recognised the position of authority held by VH in their communities, and thus assigned local leaders a number of significant tasks related to its dissemination and potential linkages for the CoC:

- Calling and Presiding over different community meetings
- Developing bye-laws to consider providing rewards for Traditional Birth Attendants promoting delivery at health facility⁴⁴

⁴⁴ Interestingly, the Policy Guidelines recommended the use of bylaws with regards to TBAs, for rewards for promoting facility delivery, rather than as punitive fines for failing to comply with the ban, which is what

- Facilitating Community maternal and neonatal death review (verbal autopsy)
- **Coordinating transport for referrals, including acquisition of bicycle ambulances**
- **Supervising management of bicycle ambulances in readiness for referral of patients to health facility**
- Promoting risk free practices and behaviours by identifying alternatives risky cultural practices
- Monitoring maternal and neonatal health outcomes in the community
- Monitoring activities of Traditional Birth Attendants
- **Initiating community birth preparedness initiatives** (Republic of Malawi Ministry of Health 2007a, emphasised, p.13)

Firstly, VH were tasked with calling meetings with community members to orient them on the new roles attributed to them. Secondly, VH were also meant to be there in an enabling capacity for communities, e.g. procuring direct transport for referral to hospital. However women and other community members in this study described the supposed ‘link’ with VH as being mostly reduced to their calling orientation meetings, and in some cases allocating fines for home or TBA deliveries, as the quote below shows:

Participant 1: Because of the law that we are using that someone should not deliver at home but at the hospital. So that was spread throughout all the villages, and the chief has also instilled that if a person is pregnant she has to go to the hospital and wait where. The one who delivers at home he [VH] will make her pay a fine of a goat ...if I only deliver at home, the chief will call for me and I will pay the fine of a goat or a chicken... because we are scared of that, we go to the hospital and deliver there. (Women, focus group W04)

The above quote clearly highlights community perceptions of the VHs’ roles as Policy implementers and enforcers. The relationship described by the woman above is that of someone deferring to a superior authority (“*the chief will call for me*”), and fearful of the consequences of non-compliance, rather than that of someone willing to call upon the VH to procure transport in emergency. None of the 71 men and women who took part in the focus groups discussions mentioned instances of VH helping them with transport for timely referral to hospital. This is not to say it never happened, and could also be explained by the fact that in lot of villages there were simply no communal bicycle ambulances to be used, which could well have inhibited their linkage in the CoC.

happened in the policy implementation. Some key officials in this study suggested that the idea of giving rewards to the TBAs (e.g. for referring or escorting) was later abandoned because the funds were simply not there

The VHs themselves also viewed their current roles, within the context of the Policy Guidelines, as promoting skilled birth attendance, by giving advice, rather than as direct ‘enablers’, as the excerpt below shows:

Most of the time, our role mainly is to encourage pregnant women and those who want to deliver to go to the hospital to receive advice... We do this to reduce the death of babies. (Village Headperson, focus group FVH02)

It could be argued that the apparent lack of direct engagement with women is due to the fact that most VHs are men and are not supposed to be directly involved in matters of childbirth. As a male VH expressed in a FGD, in keeping with customs, talking to pregnant women had to be done through husbands:

for us to know that the woman is expectant, that it reaches a certain point where you can see that the woman is pregnant... Not that we go to each and every house finding out who is pregnant. No! So when we see changes showing that the woman is pregnant, that's when we talk to the husband whether they have already gone to the hospital or not (Village Headman, focus group FVH02)

In fact, one of the ways in which some VH have been addressing this is by nominating ‘*amayi a chinsinsi*’ or ‘*secret women*’ as volunteer intermediaries in their villages. The role of secret women was mentioned earlier. They are called secret women because they counsel women in secret thus preserving their confidentiality. They do not reveal how far along in the pregnancy women may be, since some believe that doing so could put them at a danger of witchcraft. The job of the secret woman is to give advice to women and to report to the VH how many women are pregnant, and whether they delivered at a health facility as recommended⁴⁵. The role of secret women is an area which requires further research (for instance, some participants in this study hinted that they were not usually TBAs, but in other areas people expressed they could be). Notwithstanding their roles as policy implementers, the data showed that most of the VH interviewed in this study were concerned about the health of mothers and babies in their villages and keen to address the issue⁴⁶.

45 To the researcher’s knowledge, nothing has been written on the role of secret women in Malawi as of yet, but they were mentioned in several interviews. They were not usually TBAs, though they could be, as this blog attested : <http://www.jhr.ca/blog/2012/06/secret-women/> [accessed 28 January 2016]

46 In another district in Malawi (Ntcheu), regional Chief, Chief Kwataine, has gained notoriety for eliminating maternal deaths in the 89 villages he is responsible for, and in most of the region through his influence over

However it can be argued that a contact with women which consists mostly of surveillance and of applying punitive measures for home deliveries is not conducive to building trust and the two-way communications that an effective CoC requires (Gilson 2003, Ackatia-Armah, Addy et al. 2016). As for as VHs' contacts with TBAs, the findings show it consisted mostly of VH calling meetings to orient them on their new roles, or in fining them also for conducting unauthorized deliveries. TBAs in this study were not part of their local Village Health Committees, and most VH stressed that it was not necessary for them to have contact with TBAs since they had been banned. This also pointed to a lack of direct contact or communications. This section has therefore demonstrated that since 2007, VH have had little direct enabling contacts with their Community members. In practice this meant that women weighing their options for delivery care, particularly in emergencies, not only face interdictions with regards to using TBAs, but cannot necessarily not count on either HSAs or VHs for practical help.

7.4.3 Broken linkages in the CoC between TBAs and SBAs

Given that, for reasons laid out in Chapters 5 and 6, some rural women still call upon TBAs as well as SBAs, it is important to assess the state of current the linkages between them, since the advent of the 2007 Policy Guidelines. The 2007 Community Guidelines had assigned to the TBAs the role of “acting as link between health facility and community” (Republic of Malawi Ministry of Health 2007a, p.11). In the same way as for the “unavoidable circumstances” in which they may be permitted to support delivery (2007a, p.11), the way in which they were expected to act as links with facilities was not specified. The previous Chapter has demonstrated how difficult in practice it has been for TBAs to refer and escort women since the ban, so much so that very few have been doing anything more than giving advice (or indeed helping women occasionally *‘in a secret’*). Their new roles means that they have lost any face-to-face contact or link with SBAs at facilities, and have become very much an outsider in the health system strategies. Today's relationship between TBAs and SBAs is

other VHs. He was asked by the Presidential Safe Motherhood Initiative in 2012 to form a country council of chiefs for Safe Motherhood (<http://www.passblue.com/2013/04/18/a-traditional-chief-slashes-maternal-deaths-in-malawi/>)

best summarized in the words of a SBA himself: *“now it’s like cut, we don’t know the other side, they don’t know the other side (Male Clinical Officer, interview SBA12)”*.

Most SBAs stated they had either stopped seeing TBAs since 2007, or had never met them at all (particularly the younger SBAs who had started practicing around that time). They added that TBAs no longer attended community area health meetings, because they were not given monetary incentives to do so. Though this was possibly true, it is likely that it was not simply the income that TBAs were missing from being able to do their work. TBA’s lack of involvement may also have come from the fact that they no longer felt as insiders in the Government’s strategies. They also possibly partly refrained from escorting women from the community to avoid being blamed by SBAs if things went wrong and complications occurred along the way.

Most of the TBAs themselves confirmed that they no longer had any contacts with SBAs, since the ban, which was expressed in another recent study (Banda 2013). The TBA quoted below expresses this and highlights the contrast with the past:

At first we were working together because when we went to the hospital we said, yes you are finding us with a pregnant woman and we want you the nurses to help us, so the nurses allowed us to enter the hospital and explain everything... So now we don’t even see them. Where can we meet with them? We, Azamba, are just staying home. (TTBA, interview TBA01)

There were only two deviant cases in the data of two TBAs who had regular contacts with SBAs. The first was an openly non-compliant TTBA (TBA14) who was still daily conducting routine deliveries. Her situation was quite unique as expressed earlier, in that she had an extensive ‘clinic’ in her locality (built with overseas donor money). The local health centres and hospital staff held ANC and other health clinics at her place of work, and she met them routinely. Details of what made her a deviant case were provided in section 5.5 The second exception was another TTBA (TBA07), a TBA well-known of the hospital who routinely escorted pregnant women to the facility on her own time and dime. This TTBA viewed herself as a link between other TBAs- even a leader showing others the way to comply with their redefined roles- and SBAs as she articulated below:

I also am a leader who is overseeing all the people, all the Traditional Birth Attendants, that we should stick to the rule of law that has been put in place to take all the people to the hospital...as for me, I am in between them and the Government (TTBA, interview TBA07)

Her contacts with SBAs were not only more frequent, but also more positive. She offered a blueprint for what shared care between TBAs and SBAs could look like:

when I go there [at the hospital] ...they welcome me very nicely but also they'll help that woman to deliver in my presence. I do not leave, they want me to see that all has gone on well. So I observe all the delivery process, how the labour ward is being handled. And I also learn some more things that I didn't know (TTBA, interview TBA07)

The above TBA described what is today a very unique relationship between her and SBAs: a relationship based on trust. However this highlights the potential for a more active role for TBAs within facilities. That is to say not simply as guardians who are confined outside the doors of the labour wards, but potentially as advocates for women. Sadly, even this most engaged of TBAs (TBA07) still lamented the fact that she and her peers were seen as 'outsiders' in the CoC by SBAs, as the quote below shows:

Maybe if there could be an awareness campaign for the health workers, so that when they see us they should not consider us as outsiders, they should consider us as a part of them. So our request is that the health authorities should consider the TBAs, who would be able to assist them (TTBA, interview TBA07)

What this TBA suggested instead was the need for a re-orienting of SBAs, a campaign or meetings to sensitize them the value of TBAs' work. This would certainly help, as indeed, all of the other TBAs in this study also saw themselves as 'outsiders':

(Participant 1) we just come to give them the sickness [pregnancy] and it ends there and azamba sit outside...because when they have entered in there[labour ward] and you have entered too, they [SBAs]chase you out saying "no, go out it is now my job". And when the baby has come they just say mother there is a baby inside the house, but what happens there we don't know; (Participant 2) What happens is that when we have gone there with the woman...those are the ones who takes them and when they have entered we don't go there, no! The azamba, we don't get inside but the owners are the doctors, so they delivered her whilst we are outside (TBAs in FTBA01)

The word 'owners' used above to refer to SBAs reveals the notion of ownership of the patient. This relates to their power in relation to the authoritative knowledge. Because SBAs have the right knowledge, the knowledge that counts, they alone are allowed in the labour ward, and they can tell TBAs to stay outside. They own the knowledge in childbirth (because they can deal with complications), the hospital, and therefore the patient who enters. By contrast, the TBA who escorts (if she does) only owns the patient until they reach the facility, that is when the woman is still within the community realm (with its practices, beliefs and culture, as a relative). But TBAs then lose that any ownership of the woman at the facility,

they are not allowed 'inside', because they no longer do the 'job' of delivering. This runs contrary to the idea of a continuum of care where one provider would ideally follow their patients through to the end to the delivery of care, and collaborate with whoever is needed along the way (Kerber, de Graft-Johnson et al. 2007, Pasha, Goldenberg et al. 2010, Kikuchi, Ansah et al. 2015, The Partnership for Maternal, Newborn and Child Health 2010).

All other participants similarly perceived the linkages between TBAs in their villages and SBAs at facilities to be broken. Women and other community members believed that the difference in the two providers' knowledge – traditional and biomedical- was the reason they no longer had contacts, as expressed in the below extract:

There cannot be any contacts, that cannot happen because they [TBAs] are used to take a hoe to dig the herbs and the doctors are used in taking the bottles, giving vaccinations, so these are different things, yeah, because this one [TBA] doesn't know the hospital peoples' job, and they also don't know about the herbs, so there cannot be any contact (Woman, focus group W02)

The above suggests that to have contact, you need to know each other's job, just like when in the past TBAs learnt about SBAs jobs in training (and about their practices). The only problem now is that, as SBAs saw it, with the redefined roles of all, there was no need to have any contacts:

No I think the only contact is at times we give them feedback, you usually give feedback where things went wrong and when the woman...we always send the feedback through the HSAs...There is not any formal link between technicians and TBAs, and usually we don't mind them much (Male Clinical Officer, interview SBA06)

The only contact left was one of surveillance (ensuring people comply with the Policy), which was devolved to the lesser skilled health worker, the HSA, the 'non-technicians' who were supposed perhaps to relate better to the TBAs because of this. Some SBAs even stated that encouraging any linkages or relationship with TBAs today could blur their redefined roles, and encourage confusion. They argued that it would send a message to women that their practice was still legitimate and may signal to communities that TBAs were still 'insiders' in the maternal health strategies. They feared that this could lead women to considering TBAs again as a routine option, and lead to further non-compliance. For SBAs, a clear separation between them and TBAs was seen as a good thing, as expressed in the extract below:

If we continue to have contacts with them it's like we are telling them to continue doing the deliveries... [it means to TBAs]” We are still important we are working hand in hand with the nurses”. It will seem like there is still a relationship (FSBA01)

The above suggests that some SBAs were weary of re-establishing a relationship with TBAs because it would perhaps legitimize their knowledge. However TBAs perceived this attitude as more than indifference, they perceived it as contempt, as in the below:

When I am there [at the facility] they don't know where to start from, they say “this is their relative” [relative of the woman] they are ashamed with our presence, therefore, they don't insult us, but I know deep down in their hearts they are insulting us (TBA, interview TBA06)

This quote relates to the earlier one, it suggests that for the SBAs, the traditional birth attendant has been relegated to the rank of relative to the woman, a simple community member not a trained birth attendant.

These perceptions, it can be argued, have built resentment between TBAs and SBAs, and led to a sense of enmity between the two providers, rather than one of collaboration. Some participants in this study expressed this clearly:

it seems we are working as enemies which is not good ...Yeah, because they are not coming much, much closer to us, and if we tell those mothers about a certain thing, they sometimes discourage them (Male Nurse Midwife Technician, interview SBA11)

there is no contact between the TBAs, the nurses or doctors, because of some hatred between them. So people who are enemies cannot contact each other (Village headperson, focus group FVH01)

In the first extract, a SBA lamented that the TBAs no longer came to them at facilities unlike before the Ban, but they also suggests that the TBA may be working against them, encouraging non-compliance. This points to the feeling of mistrust that some SBAs feel towards TBAs. In the VH quote following, the language is strong (“*hatred*”, “*enemies*”), which is telling, since VHS are based in the community, but are also street level bureaucrats in some ways, and able to understand the situation from both sides.

In conclusion it can be argued that the lack of communication and relationships between providers described in this section does not promote trust or co-operation, which are essential to an effective CoC from community to facility (Okello, Gilson 2015, Pasha, Goldenberg et al. 2010). This may be especially problematic in rural areas where social relationships are so important, as was explained in Chapter 6. As Gilson states “the

production of health and health care requires coproduction between patient and provider and co-operation among health system agents” (Gilson 2003, p.1459), or indeed here, between health system and community agents. For the CoC to function effectively, women would need to be able to turn to TBAs, who could themselves turn-without fear of blame- to either VH or SBAs to organize referral transport, and ensure continuity of care for women, and hopefully safer deliveries. Instead, for women in this study, as indeed in other rural areas of Malawi (Banda 2013, Godlonton, Okeke 2016), the 2007 Policy Guidelines and TBA ban, have resulted in a breaking of linkages between community and SBAs. They have also resulted in broken links between community and healthsystem, through ineffective support from HSAs, TBAs or VHs, which have left rural women stranded. This breaking of linkages can have serious consequences, because once women have weighed their options for delivery care within this particular context, and there is nowhere to turn, they may opt for a home birth, or decide to make their way to the facilities too late, and eventually birth ‘on the way’. Birthing on the way, by the side of the road, in dangerous, unsanitary conditions (Banda 2013) is a reality in rural Malawi today, and the following section explore the findings around this issue.

7.5 Perceived negative consequences of the breakages in linkages for CoC: birthing “on the way”

The subcategory of *birthing on the way* emerged from participants’ accounts that, since the 2007 Policy Guidelines, some women had been delivering their babies by the side of the road on their way to health facilities. Those babies were labelled at the facility as BBAs or ‘births before arrival’. From this study’s qualitative data alone, it would be difficult to say how big of an incidence BBAs were in the areas concerned. But the estimated percentage of births with no one present (NOP) in Malawi, placed at between 1.4% and 2.7% (equivalent to 18,482 women) (National Statistical Office of Malawi 2015), gives an indication. Evidence also shows that births with NOP take place mostly in rural areas, and mostly in households with the lowest wealth (Orobaton, Austin et al. 2016).

From the data in this study, there was little doubt that NOPs and BBAs did happen, as the poster from one of the rural health centre below shows. In this poster one can see that BBAs – and home deliveries- were represented as a category on the chart at the health centre. Those

were higher in the months of January to March, when the rainy season is still ongoing which makes the roads more impassable, and when it is the ‘hungry season’, and there is less food to share before harvest and women are less likely to want to leave home.

	J	F	M	A	M	J	J	A	S	O	N	D
ANC - NEW	259	202	187	274	287	257	282	167	238			
- REVISITS	321	350	330	320	232	466	231	506	398			
TOTAL	580	552	517	594	519	723	713	673	636			
NO. OF FOCUSED ANC	16	61	45	44	31	30	37	55	62			
NO. OF COUPLES COUNSELLED/TESTED	23	40	55	79	0	68	72					
NO. OF PMTCT	7	1	3	3	0	0	6					
NO. OF HOME DELIVERIES	3	7	13	2	1	2	4	5	3			
NO. OF MDs	0	0	0	0	0	0	0	0	0			
NO. OF MNDs	1	2	0	0	0	0	0	1	0			
NO. OF BREACH DELIVERIES	1	0	1	0	1	0	1	2	2			
NO. OF BBAs	8	4	4	2	3	3	3	4	2			
NO. OF FSB	1	2	3	0	2	0	2	1	0			
NO. OF MSB	0	2	1	0	0	0	1	1	2			
NO. OF TWIN DELIVERIES	2	1	2	0	3	1	1	4	1			
NO. OF ECLAMPSIA	3	0	0	0	1	2	5	8				
NO. OF APH	2	1	0	0	2	3	0	3	2			
NO. OF PPH	5	4	6	5	7	1	1	5	7			
NO. OF OBSTETRIC LIAISON	2	2	2	0	6	10	14	12				

Figure 27. Poster recording 2012 deliveries including BBAs at a rural health centre

The incidence of BBAs shows that, owing to interdictions, barriers and lacks of linkages in the CoC, women were left with few options other than receiving delivery help at home from a relative, or giving birth along the way to the facility, if labour started early. This situation is related by two kinds of participants below, firstly a VH and secondly a HSA, both from the same Site area, both of whom partly blame the ban on TBAs:

When we had azamba [TBAS] – the trained ones – things were better because such cases [early onset labours] were taken to azamba or the azamba would be called in to help. Instead of now, as they have to travel the long distance to hospital, they end up giving birth on the way. Things are not good... the azamba were alleviating the problems. As things stand now deaths are no longer minimal (Village headperson, group interview VH02-03)

they [TBA] are important just because, others they were helping those that were delivering on their way, those that they are coming from far, they were helped without any problem, but as of now, they are helped with someone who is not trained, just because the Trained one [TTBA] is afraid to pay the fine and refuses to help that person, so I think this is a problem (Health surveillance assistant, focus group HSA02)

All categories and sub-categories in this study can be linked and it is easy to imagine that a BBA or NOP may take place where a woman is reluctant to call on a banned TBA, or where she is calling on them but is rejected by a compliant TBA fearful of being sanctioned. In this situation, a woman may start off travelling to the facility on foot, already in labour. Perhaps this woman, from a poor and remote rural locations we described, could not afford to attend at the waiting home, perhaps her husband was unprepared; perhaps she also hesitated to return to a facility where she had been badly treated before. Whatever the interface of decisions made, a theory of how and what weighs into women's decisions regarding their delivery care is now starting to emerge from the findings. Banda, in her study alluded also to a range of reasons for births with no-one present and BBAs:

*while trying to reach care, having delayed in making a decision to access care on time, mothers often delivered on the way to the facility in an undignified, unhygienic and traumatic manner. TBA participants were concerned with the loss of dignity that childbearing used to demand; *She lays there, struggles by herself with no one to cover her nakedness – we have thrown away childbirth!* Mothers could be delivered by their own mothers, husbands or even strangers who had no knowledge of how to conduct a delivery. Sometimes they delivered alone on the way to the facility. Children on their way to or from school witnessed mothers struggling to deliver alone and jeered at them... (Banda 2013, pp.184-185)*

This somewhat graphic depiction adds to the findings from the current study and highlights the added hardships that the implementation of the 2007 Policy Guidelines and TBA ban have brought to some women in rural areas. It also stresses the lack of dignity in childbirth and the helplessness of women who have no continuity of delivery care, in fact no proximal delivery care at all. It stresses the potential lack of safety of such situation, both for the exposed and vulnerable mother, and for the baby. Similar vulnerability- and the danger of post-delivery complications- has been described in other recent studies regarding BBAs and NOP (Orobaton, Austin et al. 2016, McMahon, Chase et al. 2016). A recent study from Ghana also showed the links between occurrences of BBAs and a TBA ban has (Rishworth, Dixon et al. 2016). The situation portrayed above shows therefore a clear disjunction between the intention of the Policy to provide safety and expert care to all women in Malawi, and the

reality of the adverse consequences of its implementation on the ground, which will be discussed further in Chapters 8 and 9. A birth with NOP or a BBA is probably not the option women would prefer, or aspire to. What they aspire to, in order to ensure their safety, is to collaboration and communication between the different providers of delivery care, as the findings in the next section shows.

7.6 Saving lives requires collaboration

This subcategory of *saving lives require collaboration* came out of the analysis of what Freedman calls the “implementation and aspirations gaps” (Freedman 2016). It is the space where participants proposed solutions to restore linkages necessary to an effective CoC, in order to save lives, which is the intended goal of the 2007 Policy Guidelines. Participants mainly saw this collaboration taking place between TBAs and SBAs, as the two main providers of delivery care (since neither VH nor HSAs can deliver).

The potential benefits of linking TBA to SBA care by playing to their respective strengths (e.g. interpersonal or technical care), has been stressed in other studies. For example, a study in Mexico showed that an interactive training introducing TBAs as doulas in the health facilities meant that TBAs retained an active role, and offered emotional support women in delivery, which improved outcomes and in turn encouraged women’s return to facilities (Smid, Campero et al. 2010, Lori, Wadsworth et al. 2013). Two recent studies in Sierra Leone reported on a collaboration between TBAs, CHWs and SBAs, built through ‘quality circles’(Chamberlain 2013, Higgins-Steele A., Waller K. et al. 2015). Quality circles are problem solving peer discussion-groups where there are supposed to be no hierarchies, where all attendees have a voice as peers, and where ideas for change can be worked out in collaboration ⁴⁷. Those two projects aimed to improve the quality of the care received by women, and to address the poor relationships between health workers and TBAS. The findings from those studies showed improved relationships between health workers and TBAs, improved interpersonal care for women, and resulted in some non-clinical tasks in labour wards being actually task-shifted to TBAs. the overall outcome was one of a better

⁴⁷ Chamberlain explains the method: “Using collaborative improvement and learning methods, field agents support circles in designing “change ideas” or actions that can be taken to address the problems. Members of circles implement their change ideas and create a measurement system to gauge success. Members adopt change ideas that meet their goals, and either further refine others for continued testing or abandon them in favour of a new potential solution” (Chamberlain 2013, p.3).

integrated CoC (Chamberlain 2013, Higgins-Steele A., Waller K. et al. 2015). In other countries such as Ethiopia, some important tasks meant to improve the CoC have also been task-shifted onto TBA, including “counselling, child care, immunisation, postnatal care, detection of complication and other social services” (Temesgen, Umer et al. 2012, p.1). A review by Byrne and Morgan (2011) of the various ways in which TBAs have been linked into the health system worldwide, showed that their contribution could range from simple advice giving and signposting- as is the case in Malawi- to actual direct communications with SBAs, the provision of further training for TBAs, and even their practical involvement in the provision of maternal health care within facilities. Byrne and Morgan’s findings showed that, depending on the countries context, the integration of TBAs in the health system could have significant impacts on the CoC and lead to further gains in skilled birth attendance (2011).

This study adds to the above literature by interpreting the participants’ stated aspirations and perceptions of what makes better linkages between providers in an effective CoC. This analysis is represented in Figure 28 below. This figure reads from left to right, from the current situation of where Malawi is at today (either with ‘no linkages’ or ‘uni-directional linkages’) to an ideal situation for the future (one of more ‘bi-directional linkages’ between birth attendants).

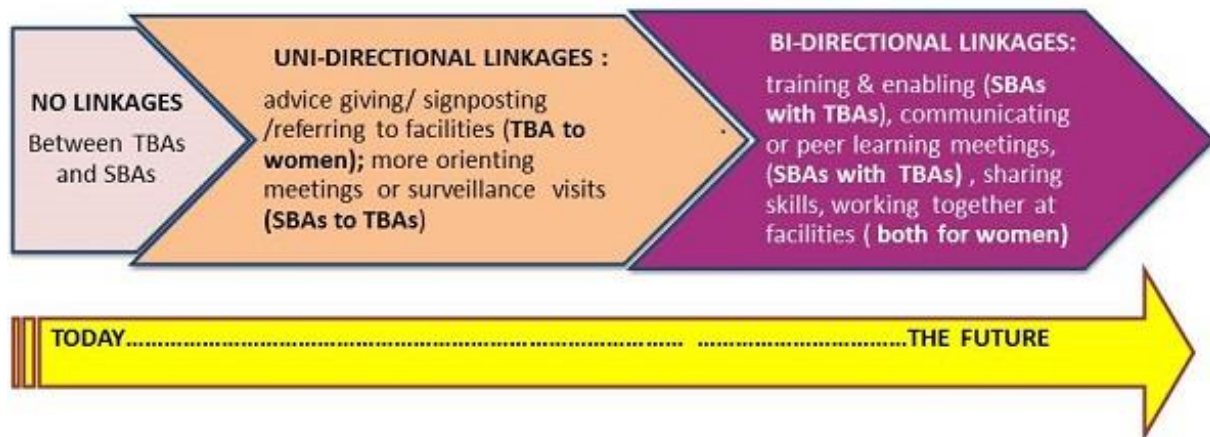


Figure 28. Spectrum of possible linkages of TBAs to the Malawi health system

In the above figure, the label ‘No linkages’ requires no further explanation as it has been hitherto defined in details in this Chapter. The phrase ‘uni-directional linkages’ was selected to refer to one-way relationships, for instance between TBAs and women, or between TBAs and SBAs, contacts where one actor is in effect telling the other what to do (e.g. the

signposting of women by TBAs, or surveillance visits of TBAs by SBAs). The phrase ‘*bi-directional linkages*’ represents the aspirations of some of the participants for more two-ways communications between TBAs and SBAs. Bi-directional linkages, as participants expressed, could take the form of further face-to-face training for TBAs at facilities, or simple referral communications (e.g. phone calls). However, although some participants envisioned an actual sharing of skills and between TBAs and SBAs (Temesgen, Umer et al. 2012, Byrne, Morgan 2011) they did not really envision them working side by side in the hospital.

7.6.1 Uni-directional linkages are better than no linkages at all

Perhaps not surprisingly given their position and their perceptions of TBAs expressed throughout this thesis, most SBAs in this study continued to advocate for ‘*uni-directional linkages*’. Mostly, they suggested calling further meetings with TBAs -perhaps monthly or quarterly if resources could be found- to continue to orient them on their redefined roles:

There should be more contact with them [TBAs] more especially supervision and force them not to deliver but they should continue with their counselling, helping telling those mothers where to go, not coming to them, because they are part... part of the community. (Female Nurse Midwife Technician and ex-TBA Co-ordinator, interview SBA04)

it's better to interact with them to emphasize to them what they should be doing because if there will not be such meetings then we will be at distance with them so it's very possible that they can be doing other things which are very wrong for our pregnant women which they are not supposed to (Male Nurse Midwife Technician, interview SBA10)

Interestingly, here the word ‘*interact*’ does not necessarily refer to two-way communications, but rather to telling TBAs what to do, re-orienting them on their new roles as defined by the 2007 Policy Guidelines. Although a small number of SBAs did express that more of an exchange could take place One particular SBA went as far as suggesting reciprocal visits to each other’s workplace to foster better understanding, as he described below:

I think... by working with them, let them come here [at hospital] and appreciate, and then we go to them, we'll appreciate how they do their own work. I think that way we can, but by fighting them we can't (Male Clinical Officer, interview SBA06)

It can be argued that what this clinical officer suggested could go some way to address the feelings of enmity and distrust evoked earlier. As Okello and Gilson state, in their study of relationships between health system staff, “workplace trust relationships involve fair

treatment and respectful interactions between individuals. Such relationships enable cooperation” (Okello, Gilson 2015, p.1).

7.6.2 Bi-directional linkages can save lives

Women, men and TBAs in this study all advocated for *bi-directional linkages* between TBAs and SBAs. They did so because they believed better communication and collaboration could save women’s lives in rural areas, because women need both providers.

Firstly, women advocated for the training of TBAs to be resumed. Two focus groups particularly (W04 , W05), where the participants lived in more remote areas, as far as 15kms on foot from their nearest health centres (and as far as 40kms from a district hospital), expressed this desire very strongly. The quote below expresses this, and places a particular emphasis on the role of communication and co-operation between care providers for an effective CoC:

The contact should be like this, if they will say that the TBAs should go back in the villages, they should make them be in contact with the hospital in trainings. What the doctors are doing and what the TBAs are doing should be similar; if there is a complication that is beyond the TBAs capability they should take it to the doctors the doctors should receive the case and confirm that it was indeed beyond your capability but we will do it (woman, focus group W04)

For the above woman, the differences in the level of skills between TBAs and SBAs ought not to stop them co-operating. In this ideal scenario, the TBA would be able to freely express to the SBAs that a complication was beyond their ‘capability’ and the SBA would therefore listen, and take over, in order to help the woman appropriately. This type of collaboration seemed to be advocated by women in cases of emergencies, when options for delivery care have to be weighed quickly, as expressed in the following extract:

(Participant 1)the TBAs and the hospital people should have contacts, because sometimes you find that labour pains just start all of a sudden so the TBA can call the hospital, so that the hospital can send an ambulance to take the person to the hospital; (Participant 2) it can be good if there can be contacts, as my friends have already said, the labour pains sometimes starts during the night and then you find that you don’t have any means of transport, if you can just tell the people like the TBAs to contact the hospital people, maybe that way you can be helped quickly (women, focus group W03)

The contacts these women advocated for were not the same as those envisioned by SBAs, but instead a more active engagement of the TBA in the referral process, at least more than mere

signposting. Here, the TBA could be linked into the health system (at least with a phone to call the facility to request ambulances).

Secondly, men also expressed, in nearly all focus groups, the need for TBAs and SBAs to be “*working together...as partners*” (man in focus group H02). The bi-directional linkages they aspired to was similar to that of women: for the TBAs’ training to restart, for them to be equipped by SBAs with the means to deliver and the means to enact referrals. The words men used in focus groups to describe ideal relationships between provider were “*contacts*”, “*consultations*”, “*discussions*”. One man expressed in the following excerpt:

[TBAs] they work on somebody’s body using hands. Therefore, if they can work together, the TBA although she does not use medical equipment, they can train her in the alternative way. By the end of the day, both sides will be singing the same song. They can even communicate on other issues through the phone, like when an emergency occurs before going to the hospital. If a TBA has this technical know-how, she can prevent both infant and maternal deaths (man, focus group H04).

Again, here, the differential in skills between SBAs and TBAs (‘using hands’ versus using medical equipment) was not seen as an obstacle. To this man, both types of knowledge could be made complementary, and the TBA could be upskilled. The wonderful phrase used by this man ‘*singing the same song*’ stresses that with bi-directional linkage, an exchange may take place whereby both providers could start working together to the same goals. This would address feelings of enmity, foster collaboration.

The notion expressed by women and men above that lives may be saved by an improved linkage between both attendants, which could feature again an active involvement of TBAs, is really important here. It is important because it is in direct contradiction with the perception of policymakers that the best strategy to ensure maternal mortality reduction is to reject TBAs wholesale and to ensure that women make their way to deliver at the facility instead. The discussion in Chapter 9 will return to this very point grounded in the findings

Finally, not surprisingly, TBAs confirmed similar aspirations to more ‘*bi-directional linkages*’ between them and SBAs. They envisaged more meetings, training, face-to face interactions, as the below quote indicates:

We would like to have meetings between the nurses and TBAs to teach each other, we need to learn from them what they know and they can also learn from us, in so doing, everyone will have more knowledge (TBA in focus group FTBA02)

The above quote portrays a two way exchange, and points once again to the fact that traditional and biomedical knowledge should not be segregated, but that, if exchanged or blended, they may be more beneficial to providers, and potentially to women. As the TBA below expressed, bi-directional linkages are key to saving lives:

we need to have more contacts, yes, because we are related, they save lives and I also save lives, we should teach each other ...So what we need is cooperation so that we can work together with the hospital (TBA, interview TTBA01)

The TBA above expressed that they would serve better as an ‘insider’ to the strategy to reduce maternal mortality, working hand-in-hand with SBAs, rather than separate. She and other TBAs intimated that policymakers needed to consider them as allies, rather than ban them and reject their knowledge altogether. The excerpt following articulates this:

they should consider us, what we may agree on. We cooperate with them, but what we need to do, is that the Government should be able to acknowledge ‘we have people here and there with the same vision as ours’ (TTBA, interview TBA07).

The above shows a TBA who still wishes to be involved, who has the same interest in safe motherhood as SBAs (“*the same vision*”). It suggests that a consensus could be found, and a collaboration built.

This subcategory of *saving lives require collaboration* has been presented as a counterpoint to *the breaking of linkages in the CoC*, in order to reveal the disjunction between the reality of the implementation of the 2007 Policy Guidelines, and the aspirations of community members on the ground, whose lives are directly affected by this Policy. In this study, what those most at the receiving end of the policy implementation wished for, was a restored and effective link between TBAs and SBAs. In their view, this linkage could save the lives of women and babies in the most hard-to-reach rural areas. Yet, paradoxically, it is with the same goal in mind of saving women’s lives and reducing maternal mortality that the Policy separated SBAs’ knowledge and practice from TBAs and redefined TBAs roles in the first place, with the consequence of a rupture of their previous linkages. This is a key finding, and the discussion in Chapter 9 will return to this disjunction between strategies depicted as working for maternal mortality reduction, and what some communities say works or does not on the ground.

7.7 Conclusion: weighing the options for delivery care is about more than ensuring safety for mother and baby

Chapters 5, 6, and 7 have presented the findings which built the theory of *weighing the options for delivery care* in rural areas of Malawi. Throughout, the main categories have been defined, explicated, the conditions under which they arose has been revealed, as well as their interconnectedness (Charmaz 2006). The categories have thus created “conceptual handles” (Charmaz 2006, p.92), to understand the processes at play in weighing the options for delivery care in this setting. They have shown the multiplicity of factors weighing in the decision-making of rural women, some which have been researched in the past, and some for which new insight is offered. For instance, the interplay of the barriers which prevent women from complying with the Policy, and from attending at facilities, has been made salient. The establishment of the authoritative knowledge in childbirth which underlies the Policy and other forms of co-existent devaluated knowledge has been highlighted to explain also why women may waiver between concordance and secret non-compliance. The added barriers that the 2007 Policy Guidelines and TBA ban have involuntarily created for women by breaking the existing linkages between the TBAs and SBAs and leaving a gap in their CoC, has also been exposed. In presenting the four main categories, the three preceding Chapters have unveiled the complexities and interrelations between the intrinsic factors- e.g. women’s perceptions and beliefs- and extrinsic barriers which weigh into womens actions and decisions regarding their delivery care. The following chapter brings all the findings together, in the grounded theory presented in this study.

8 Chapter 8: Summary of the theory ‘Weighing the options for delivery care in rural Malawi’

That is what we were saying, that people like us, women, are all different. Because if we had one mind, maybe we would come together but because we are different, each one of us when they take the pregnant person they themselves only know what they are going to do. It's true that this law says everyone who wants to deliver she has to go to the hospital in good time, even there at the hospital when she goes for antenatal clinic they tell her: ...you are supposed to come here at the hospital or else, you are supposed to go to the district hospital, depending on the pregnancy. But for us on our own we do not pay much attention to the issue (Woman, focus group W04)

8.1 Introduction

The above powerful quote almost summarises the entire study and makes clear the challenges of adopting a one size fits all approach for maternal mortality reduction, and offering one solution only; skilled birth attendance. Not all women are the same, not all women's needs and experiences are the same. This chapter presents a summary of the theory which has emerged from the findings: *weighing the options for delivery care* in rural Malawi. It offers an answer to the main research question which was “*What do what community actors' perceptions of the 2007 Policy Guidelines and of the effects of its implementation, reveal about their decision-making and delivery care-seeking behaviours in rural areas of Malawi?*”. In keeping with the constructivist GT approach, which is interpretive in nature and “gives priority to showing patterns and connections” (Charmaz 2006, p.126), this theory not only offers a deeper understanding of community actors' lived experiences of the implementation of the 2007 Policy Guidelines, but also of how those lead to particular actions. The theory is articulated around a core category- *weighing the options for delivery care-*, and four other main categories- *between concordance and secret non-compliance, encountering barriers, considering proximal help, and breaking of linkages in the continuum of care*, all of which “show how the core category works in the lives of participants” (Glaser 1978, p.93), particularly in women's lives.

Figure 29 below is a visual model of the overall theory *weighing the options for delivery care* which accounts for the way in which women- and those who support them- make decisions regarding their delivery care within the context of the implementation of the 2007 Policy Guidelines and TBA ban. The core category is thus placed in the yellow box at the bottom of the funnel diagram. The other four main categories in the figure encompass the factors which come into play, and interconnect with the core category. They show how the Policy has entered the lifeworld of women and communities, and shaped the strategies they form to way available options for their delivery care. This is why the three main categories of *between concordance and secret non-compliance*, *encountering barriers*, and *considering proximal help* are placed in bubbles within the funnel diagram, alongside their subcategories. The main categories presented in the bubbles in the diagram overlap because the process of *weighing one's options for delivery care* in rural areas of Malawi comprises of factors which are related and inter-dependent. The fourth main category of *breaking of linkages in the continuum of care* is presented with its subcategories as an overall black circle because it represents the context of the 2007 Policy Guidelines within which women weigh their options. This last main category is presented along a partition between community level and health system level, themselves represented in square boxes within and outwith the large black circle. This is because although the factors represented in the bubbles all interact at the community level interface, whereas the breaking of linkages in the CoC happens at the interface between community and health facility level (symbolised by a wall between them).

8.2 Weighing the options for delivery care in rural Malawi

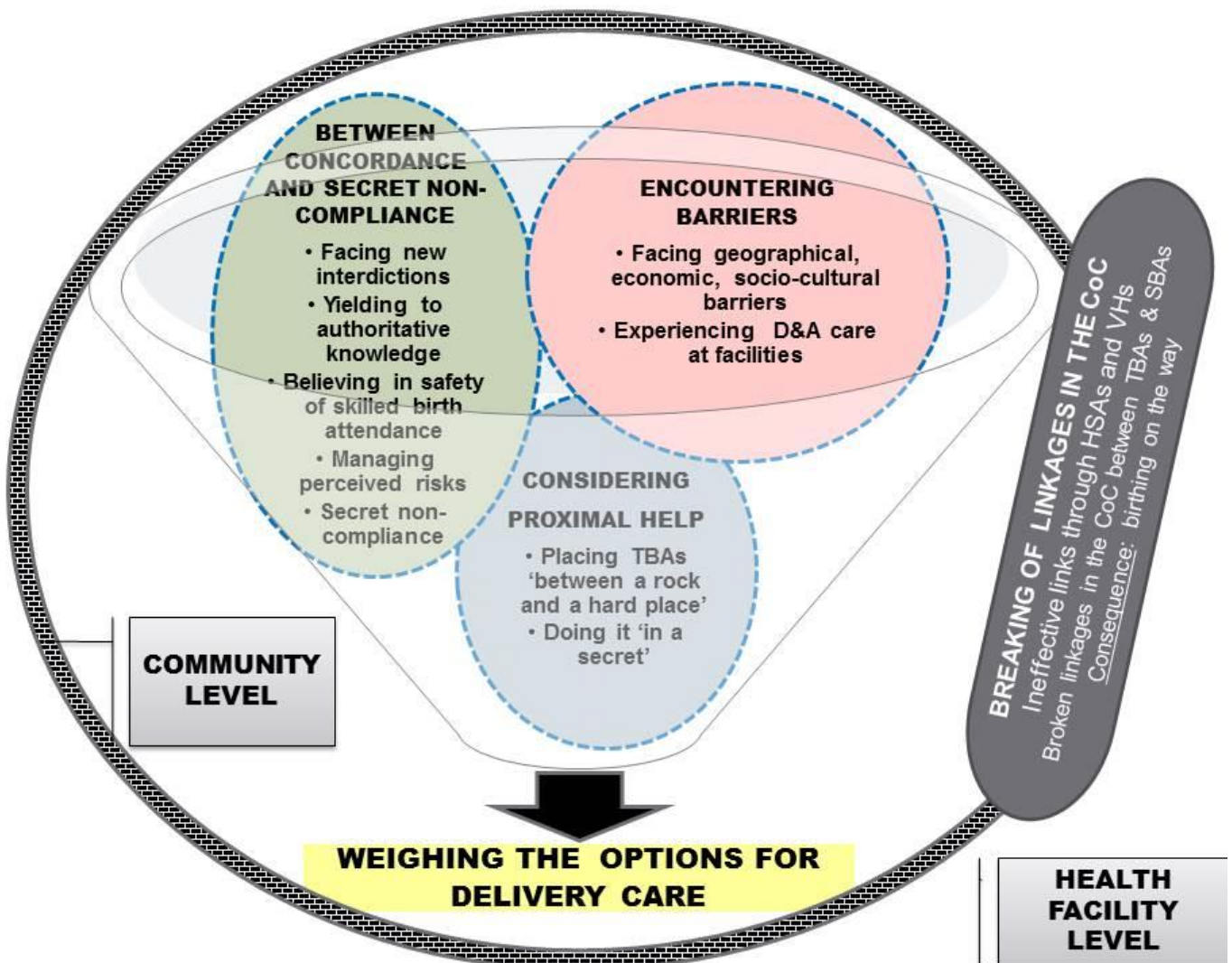


Figure 29. Weighing the options for delivery care. A grounded theory of community actors' perceptions of the 2007 policy guidelines in rural Malawi

The aim of this study, as expressed in section 1.4, is to provide a bottom-up, multi-actors' perspectives analysis of the implementation of a particular policy for maternal mortality reduction in Malawi. This Policy, the Guidelines for Community Initiatives for Reproductive Health (Republic of Malawi Ministry of Health 2007a), promotes institutional deliveries and has banned TBA utilisation. It was designed to contribute to maternal mortality reduction through community mobilization and empowerment. Alongside other policies for maternal mortality reduction (Phoya 2014, National Statistical Office of Malawi 2015, Colbourn,

Lewycka et al. 2013) it was based on the evidence of what works best, namely skilled birth attendance strategies (Kassebaum, Bertozzi-Villa et al. 2014, Campbell, Graham et al. 2006, UN Inter-Agency and Expert Group on MDG Indicators 2015, Van Lerberghe, Matthews et al. 2014). These policies alongside important investments in Malawi's health system in the past fifteen years, have yielded significant decreases in Maternal mortality reduction (Colbourn, Lewycka et al. 2013), as well as an increase in skilled attendance at delivery, now estimated at 87% in 2014 (United Nations Statistics Division 2016).

However, a recent article on the impact of the TBA ban has recently asked “what are the welfare implications of a ban on informal attendants and is this a good policy? (Godlonton, Okeke 2016, p.125). Banda also expressed similar concerns in her study when she stated, regarding the 2007 Policy Guidelines and TBA ban, that policymakers “had distanced themselves from reality and made decisions meant to cut off the poor, rural, disempowered mother from the only source of help she had in her harsh environment” (2013, pp. 190-91). The theory presented here offers one assessment of this policy, from the perspective of more community actors than either of these aforementioned studies. It does not wish to diminish the tremendous efforts and significant achievements the Malawi Government have made in the past decade in the area of maternal health. However, what it reveals is a disconnect between the 2007 Policy Guidelines intentions and rural women's lived experience of its implementation. In doing so, this study brings a deeper understanding not only of what potentially influences the decision-making of the 87% of women who currently deliver at facilities in Malawi, but also, more crucially, of the 13% who do not (United Nations Statistics Division 2016). The theory *weighing the options for delivery care* exposes some of the reasons behind those women's actions. It demonstrates that in this LIC setting, within this policy context, women in rural communities continue to opt for different pathways to childbirth. However choosing an option for delivery care- whether home, NOP, or facility- is rarely the product of a straightforward rational decision, but rather the product of a cognitively and socially constructed process.

This process is not based only on whether or not women believe in the safety of skilled birth attendance, and yield to the authoritative biomedical knowledge in childbirth. It is not simply dependent on whether they perceive childbirth risks as ever present, or whether they juggle the *new interdictions* in their own way, when they find themselves *between concordance and secret non-compliance* with the 2007 Policy Guidelines. Nor is the choosing of an option for

delivery care solely determined by the barriers they encounter. For instance, encountering geographical, economic, or other socio-cultural barriers, may not always stop them from attempting to deliver their babies at a health facility, whereas a prior negative experience birth at a facility may tip the scale in favour of birthing at home or with a TBA in secret. The weighing of options for delivery care happens at the interface of all these concurrent factors, which is why the bubbles in Figure 29 have dashed boundary lines and are juxtaposed. The theory explicated below shows that no matter how women weigh their options for delivering their babies, they have been met since the 2007 Policy Guidelines by a *breaking of linkages in the continuum of care* between community and health facility. This has further consequences on the decisions they make and the options that they eventually choose. Ultimately, the theory reveals the interface in which the 2007 Policy Guidelines and TBA ban meet the decisions-making and “the different interests, relationships, modes of rationality and power“ (Long 2001, cited in Lehmann, Gilson 2013, p.360) of women in rural communities. In the following sections, the four main categories which the findings have elucidated in Chapters 5, 6 and 7 are summarized and explicated to show how they interconnect and form the theory.

Between concordance and secret non-compliance with the Policy provided the background to the women’s “modes of rationality” (Long 2001, cited in Lehmann, Gilson 2013, p.360) regarding the options on offer for their delivery care. It presented their own perceptions of the 2007 Policy Guidelines and TBA ban, and how those intersected with other actors views (Chapter 5). It can be argued that those perceptions partly lead women to adopt a number of potential positions regarding the 2007 Policy Guidelines: whether of concordance, compliance or secret non-compliance. This policy therefore, at ground level can be alternatively accepted, negotiated and resisted (Gilson, Raphaely 2008). Although women may agree (be in concordance) with the intent and strategy proposed by the Policy, they still view it as imposed from the top-down down, with little consultation, which makes some of them reluctant to comply with it, leading to maybe internal struggles.

The terms compliance and concordance are borrowed here from the language of medicine-taking, and applied innovatively to the area of health policy implementation analysis. Compliance would traditionally refer to a doctor’s instruction to their patient to comply with taking the medicine prescribed (Pound, Britten et al. 2005), and concordance to the patient’s agreement to do so. Here, it is used to refer to compliance with the policymakers or policy

implementers recommended course of action, namely that women make “appropriate decisions and take timely actions” (Republic of Malawi Ministry of Health 2007a, p.3) with regards to their delivery care. The appropriate decision inferred is to attend at facility with a SBA for delivery, and to abstain from using the now banned TBA, or from delivering at home. Adherence to the prescribed course of action is strongly recommended by the authorities, and carries the weight of their authoritative power and knowledge. It is presented as the only option to keep women safe in childbirth, and to avoid maternal or neonatal deaths. By contrast TBAs are presented as a risky and unsafe option, because of TBAs’ limited and traditional knowledge in childbirth. This theory argues that rural women are in concordance with at least the intent of the Policy, and are *believing in the safety of skilled birth attendance*, or at least in its symbolic safety. As a result of this, a higher value is placed on the authoritative biomedical knowledge of SBAs, whilst other forms of knowledge in childbirth are devaluated, which is the change the Policy aimed to bring. Nonetheless the findings showed that ‘believing’ in the safety of institutional deliveries does not necessarily lead to compliance with the Policy, because compliance does not rely solely on women’s agreement with what is proposed. Even though the Policy comes hand-in-hand with *new interdictions*, and sanctions for non-compliance, some women still continue to make what are described by some as the ‘wrong’ decision. Godlonton and Okeke advanced a number of rationales for this:

It may be that these women do not know that nearby facilities are high-quality (not entirely implausible because this means they have some idea of the overall distribution of quality), or they do not have good information about the returns to an institutional delivery in a high-quality facility, or perhaps they have good information about the returns on average but think (wrongly) that their individual returns are low (i.e., they perceive themselves as not ‘needing’ to give birth in a health facility) (Godlonton, Okeke 2016,p.125)

Godlonton and Okeke, in their quantitative study, present women’s decisions as conditioned mainly by their judgements around the quality of the facilities they have access to. Yet the theory here advances that some women’s positions of *secret non-compliance* with the Policy may have deeper, more multi-faceted reasons.

Firstly, despite the authoritative power of the biomedical knowledge in childbirth to which women yield, the findings show that other knowledge continue to co-exist. Both the knowledge of TBAs, and the women’s own embodied knowledge of women continue to support some beliefs in ‘normal’ births (Sargent, Bascope 1997, Davis-Floyd, Sargent 1997).

This may for instance be true of multiparous women who may have had some normal birth experiences with TBAs, or even at facilities. Those who have had normal, uncomplicated births at TBAs or at home may perceive less of a need to attend at facilities, despite being told it may be risky. Despite the prominent discourse of the dangers of TBA-assisted deliveries, and despite the fines incurred for calling upon TBAs, some women in rural areas continue to view TBAs as capable to assist with those normal deliveries, and thus may continue to seek their services; Even though this may seem in contradiction with their apparent concordance with the Policy intent and the strategy of skilled birth attendance. Women's decisions to comply or not to comply with the Policy are motivated at once by their awareness of what they must do (obey the law or face sanctions), what they believe (facility/SBA is safer if complications arise, but less necessary for normal deliveries) and how they perceive risks in childbirth. Although the findings showed that both SBAs and women do acknowledge that there are potential childbirth risks, they tend to manage those differently. Where SBAs see ever-present risks and complications that they attempt to pre-empt, women in this study see unpredictable problems to be dealt with as and when they arise. These risk management behaviours condition their modes of action. Women may, for instance, still opt to turn secretly to TBAs for delivery because they hope it will be a normal birth, and only turn to facilities when complications arise at a later stage. This has been raised also in another recent study in Malawi (Ryan, Hamela et al. 2015). Nonetheless, as the second category in this theory expresses below, positions of concordance, compliance or secret non-compliance are not the only factors in women's weighing their options for delivery care. Women also encounter significant extrinsic barriers which prevent their access to skilled birth attendance, and thwart their compliance with the 2007 Policy Guidelines and TBA ban.

Encountering barriers is the category accounting for some of the external barriers which stand in the way of women making what the Policy views as the "appropriate decisions" and taking "timely actions" regarding delivery care (Republic of Malawi Ministry of Health 2007a, p.3). As explained in Chapter 6, there is extensive literature describing the practical barriers women face in accessing maternity and delivery care in LICs (Ensor, Cooper 2004, Gabrysch, Campbell 2009, Bohren, Hunter et al. 2014, Sacks, Masvawure et al. 2016, Oyerinde, Harding et al. 2012, Parkhurst, Rahman et al. 2006, Campbell, Calvert et al. 2016). In this study, the findings showed how *facing geographical, economic, and socio-cultural barriers* interconnect but also may combine with *experiencing disrespectful and abusive care at facilities* and tip the scale for women, in favour of non-compliance with the 2007 Policy

Guidelines. Undoubtedly, distance and transport were major barriers for women in this study, as were economic barriers, and women's varying degrees of power and autonomy within their household. However the findings pointed out that those have also been exacerbated by the Policy implementation. This is because it cut out proximal support and indirectly raised the costs of attending at facilities (for instance by promoting staying at waiting homes, and the purchase of items necessary for birth-preparedness). But the biggest contribution the theory makes to exposing 'encountering barriers', is in revealing the importance of poor experiences of care received by some women at health facilities. Building here upon studies investigating disrespectful and abusive (D&A) in Malawi (Seljeskog, Sundby et al. 2006, Chanza, Chirwa et al. 2012, Simwaka, de Kok et al. 2014, Kumbani, Chirwa et al. 2012, Banda 2013) the findings showed how, for some rural women, this may be the ultimate barrier which leads them to non-compliance with the Policy. In this, the theory presented here agrees less with Godlonton and Okeke's rationale (2016) regarding women's judgment on facility quality overall, and more with Kumbani, Chirwa et al's (2012) and their evidence that women do make judgement on what they perceive as either 'good' or 'unsatisfactory' delivery care. In their study, Kumbani, Chirwa et al state that:

Women want to have a nurse midwife available when they are in labour and during delivery. Women's perceptions of staff as being unhelpful and uncaring by not offering comfort or being absent contributed vastly to women's dissatisfaction with their care in labour...If women are not well treated in health facilities, they will continue going for antenatal care but not return to deliver in health facilities. (Kumbani, Chirwa et al. 2012, p.11)

Not only may dissatisfied women not return to facilities, they may instead return in secret to TBAs, whose interpersonal care they perceive as superior. The interplay of this last barrier with the others extrinsic ones –albeit potentially more important barriers- has been noted in another study in Malawi. This was a descriptive study with a convenience sample of 253 mothers from a rural Southern district (Chanza, Chirwa et al. 2012). The authors of that study found that the most important factors influencing women to stay at home for their deliveries were distance, cost, and the negative and disrespectful behaviour of some SBAs towards them. The theory presented here contends that the cumulative effect of those barriers, added to intrinsic positions of non-compliance are what prevail on women to consider *proximal help* for their deliveries, rather than skilled birth attendance.

Considering proximal help reveals one of the strategies applied by women weighing their options for delivery care in this study, within the constraints of the barriers they face and the interdictions brought by the new Policy. What is meant by this category is that, in the context of the above, some women at least considered- and some acted upon- delivering with a ‘banned’ TBA. This often happened ‘in secret’ due to the prescriptive nature of the 2007 Policy Guidelines. However this study uniquely shows that women also turned to proximal help because they preferred the interpersonal care delivered by TBAs, and not exclusively, as has been reported elsewhere, because of TBAs’ geographical proximity (Izugbara, Ezeh et al. 2009, Prata, Passano et al. 2011, Ebuehi, Akintujoye 2012, Pfeiffer, Mwaipopo 2013, Ryan, Hamela et al. 2015, Banda 2013). The women and other community actors in this study talked of the closeness of their relationship with TBAs. The empathy TBAs showed to women also drove women to them, even more so when women had had previous negative interpersonal relationships with SBAs.

Nonetheless, actually turning to the proximal help of TBAs as an option for delivery care presented them with major difficulties. It placed TBAs between what this study labelled ‘between a rock and hard place’: stuck between wishing to abide by their new redefined roles as referral agents, but still called upon by women. TBAs were drawn in to help because of their close social relationships with women in their communities, as well as by their own empathy, and the distant call of their perceived vocation. This is why this category was labelled *considering proximal help* rather than obtaining proximal help, because inherent to this action is a dilemma both for women and TBAs (Banda 2013). For women, a dilemma of whether to turn to TBAs and potentially face sanctions, and for TBAs a dilemma whether to help and perhaps face sanctions or being blamed if deliveries went wrong. Here the theory gains depth by revealing how women’s actions and intentions impact also on that of others and vice-versa. For instance, the data shows that some TBAs rejected women who presented to them in emergencies. Although this was in an effort to comply with the 2007 Policy Guidelines and the ban, it could also result in them being later scorned by their community members for doing so. Conversely, if a woman in need was rejected by this compliant TBA, she sometimes opted to return home for her delivery, rather than to go to the health facility, and ended up either delivering by herself, or with relatives. If exposed, the news of this home delivery could reach the VH, who thus fined both the woman and anyone who had helped with a home delivery. If on the other hand, the woman made a desperate attempt to reach the facility when an emergency occurred, after having been rejected by a TBA, she risked

encountering the wrath and rudeness of the SBA, who may blame the woman for being unprepared.

These complex social relationships, in rural areas, have consequences for the successful implementation of the 2007 Policy Guidelines and TBA ban. Opting for one over the other options for delivery care could potentially have grave consequences. For instance because of the element of secrecy in secret non-compliant behaviours, some TBAs failed to escort women in time to facilities when they required urgent help, for fear of being blamed, placing them at higher risk of injury. This was further complicated by the fact that, even though TBAs are allowed to help in “unavoidable circumstances” (Republic of Malawi Ministry of Health 2007a, p.11), they had in practice neither the means- financial or regarding transport and linkages- to enact referrals nor to escort women to health facilities when necessary. This points to another disconnect between the Policy and its actual implementation: it has banned TBAs from conducting routine deliveries, and redefined them as referral agents and escorts without giving them the means to fulfil these new roles, thus perhaps setting them up to fail again (Banda 2013). TBAs, if they were enabled to fulfil their new roles may offer a vital link in the continuum of care from community to facility. Instead, the implementation of the 2007 Policy Guidelines and TBA ban have resulted in a *breaking of linkages in the continuum of care (CoC)*, and this rupture of linkages has become the context in which rural women now weigh their options for delivery care, in order to keep themselves and their babies safe.

The **breaking of linkages in the continuum of care (CoC)** is shown in the visual model of the theory presented in Figure 29 as an overall black circle, pictured as a wall, because it represents the context in which women have to consider all the factors represented by the three previous main categories to weigh their options for delivery care. That context of a breakage is not one that facilitate the CoC necessary to best achieve the intended goals of the 2007 Policy guidelines. As expressed in section 1.2.2.4 an effective continuum of care dictates that a women must be able to receive the care she requires at any point in her lifetime, as well as at the most appropriate level for her needs. Linkages between the different levels in the space dimension of the CoC (household, community and facility) are key to this effectiveness (Kikuchi, Ansah et al. 2015, Kerber, de Graft-Johnson et al. 2007, Singh, Story et al. 2016, Pasha, Goldenberg et al. 2010, The Partnership for Maternal, Newborn and Child Health 2010). The *breaking of linkages in the continuum of care* is the result of a radical change from the situation prior to the 2007 Policy Guidelines and TBA ban, when women

could use TBAs for routine deliveries, and when some TBAs had some means to help arrange referrals. Furthermore, the training of TBAs by SBAs in the past had established a basic relationship between them, which fostered collaboration, and which is now lacking. There another disconnect is revealed between the intention of the Policy, to mainly replace the CoC which existed through TBAs in the past by a link through other community-based actors-VH and HSAs- and the implementation, in which these new linkages have not materialised. As a result, the gap has become wider. TBAs and SBAs are no longer communicating or collaborating but “*cut*” from one another. As a result, because adequate health system referral mechanisms from community to facility are still lacking, a number of rural women are birthing *on the way*, in difficult and sometimes unsafe conditions. Birthing in fear when complications occur at a TBA, or birthing alone in unsanitary conditions by the side of the road cannot be what those women had in mind when they weighed their options for delivery care. This is the interface where the implementation of the 2007 Policy Guidelines meets the lived experience of women, and confronts their aspirations. Those aspirations are that rural women and those supporting them aspire to the restoration of *bi-directional linkages* between TBAs and SBAs. What they want are linkages based on mutual recognition, trust, and fostered by enabled communications. Yet, instead the breaking in linkages in the CoC aggravated by the Policy has now become another barrier to surmount for women, another extrinsic element to fracture in when weighing their options for delivery.

In this, it can be argued that the 2007 Policy Guidelines and TBA ban have failed some of the women they intended to protect. In this way, the Policy has fallen dramatically short of fulfilling the expectations of those most out of reach, of a safe delivery, and of high-quality maternal health services. Therefore this study argues that as long as the health system in Malawi lacks the capacity to provide adequate and integrated services to all mothers and new-borns in all areas of the country, a blanket ban on TBA utilisation may have turned out to be short-sighted at best. Yet it is not too late, a decade on, this Policy can be assessed, revisited, even amended to suit better the needs of women in remote rural areas. The Discussion and Conclusion Chapter which follows uses current literature from the SSA region to make some recommendations to policymakers and professionals on how this may be done. It also evaluates how the theory presented answered the research questions posed, and presents the theoretical contributions it made to the field.

9 Chapter 9: Discussion and conclusion

The maternal health community must invite, include, and incorporate the voices of women themselves into writing the future of maternal health. Too often, women's voices are silenced, ignored, or reported only second hand. Women must be given the platform and power to shape their own futures in the way they wish. (Langer, Horton et al. 2014, p.601)

9.1 Introduction

The final chapter of this thesis discusses the theoretical and practical implications of the study and provides some recommendations for policymakers and organisers of maternal health development programs. The Chapter begins by evaluating the theory's fitness in answering the research questions posed (section 9.2), and also reflects on the credibility (section 9.3) and limitations (section 9.4) of the study. Section 9.5 discusses the original contributions to theoretical concepts of authoritative knowledge in childbirth (manifesting through health Policy implementation), and of bottom-up health policy implementation analysis. Section 9.6 describes the original contribution to empirical knowledge, whilst provides 9.7 makes some recommendations for policy and practice. Section 9.8 concludes the thesis.

9.2 Evaluation of the theory's fitness to answer the research questions

This thesis was designed to investigate community actors' perceptions of a Policy for maternal mortality reduction advocating for institutional deliveries and including a ban on TBA-assisted deliveries in Malawi. By exploring rural community members' lived experiences of this Policy's implementation – particularly women and TBAs-, it aimed to identify how it may influence the manner in which they weigh their options and make decisions- regarding their delivery care. The study also focused on how linkages between the community and the health system have been perceived since the advent of the 2007 Guidelines for Community Initiatives for Reproductive Health.

As reported earlier in the thesis, Malawi is a low income country where the majority of people live in rural areas and face significant barriers to access skilled birth attendance (Leslie, Fink et al. 2016, Marks, Dietsch et al. 2016, Joseph, da Silva et al. 2016). This study adopted a multi-actor perspective in order to compare different perceptions of the Policy and of its implementation on the ground. The theory presented centred on women because they are those most affected by the Policy (e.g. they are the ones who can no longer access TBAs for deliveries and must make their way to facilities instead). However the theory also highlighted women's relationships with TBAs because the Policy changed TBAs roles radically, and this has had an important impact on them and the support they may give to women in labour in their communities. Overall the aim of the theory was to provide a coherent interpretation of the factors and processes at play in the delivery care decision-making of rural women- and of those who support them- since the advent of the 2007 Policy Guidelines. The constructivist grounded theory (CGT) approach was chosen because of its inductive, interpretive and constructivist nature. Rather than start with a priori hypotheses of the factors influencing participants' actions, it enabled the researcher to interpret those actions and decisions from the data gathered. The constant comparison method allowed for contrasting the perceptions of the different actors throughout, thus revealing areas of agreement, contradiction, or opposition.

In the first section below, the theory is evaluated to assess if it indeed adequately answered the research questions presented in 1.4.

The main research question, which framed the overall aim of the study, asked:

What do what community actors' perceptions of the 2007 Policy Guidelines and of the effects of its implementation, reveal about women's decision-making and delivery care-seeking behaviours in rural areas of Malawi?

The below assesses whether each sub-question was subsequently answered by the grounded theory and its supporting findings, in order to provide a clear narrative of the social phenomenon under scrutiny. The first sub question asked:

What are community actors' perceptions of the 2007 Policy Guidelines and TBA ban?

In answer to this question, the data revealed that community actors perceived the Policy as a top-down policy about which they had little consultation and which they could not change.

The participants felt that the Policy had the strength of a law or decree, and as such must be obeyed. They perceived the Policy as firstly remote and as prescriptive, and secondly strictly enforced locally by the sanctions put in place by VH. The enactment of bylaws, by those with the most authority in the community, meant that community members (women, men TBAs) felt they could be punished for failing to comply with the Policy (e.g. delivering at home). These bylaws reinforced the VHs' authority and made them de facto Policy implementers, rather than possible enablers or chains in the link of the CoC between community and facility. The data revealed also that women (and those who support them) are often in concordance with the notion of safe, SBA-led hospital deliveries. They believe that the health facility will have the equipment required, and the SBA the knowledge required, to address any complication which may occur in childbirth. By contrast, they perceived TBAs knowledge as insufficient, and their resources as inadequate to address said complications, although sufficient for the conduct of normal deliveries. In this way, women's views differed from those of the Policy implementers (VH, SBA, OMS) that TBAs practice is inherently risky and that the blame for deaths and injuries falls upon them. As for the TBAs themselves, their own perspectives revealed that they too agreed with the spirit of the Policy, even though they perceived their own skills and ability in a much more positive manner. The findings exposed the way in which the authoritative biomedical knowledge in childbirth has gained further dominance through the dissemination of this Policy, and embedded itself in the minds of the women, as a symbolic guarantee of safety.

The main contradiction however, is that concordance with the Policy's intended goals did not necessarily translate into compliance with the Policy's recommended course of action (to only deliver at facilities with SBAs). Some women did comply somewhat reluctantly, mostly because they feared potential fines for home delivery. Women also perceived childbirth risks differently than SBAs and policymakers, so even if they believed that facilities were safer or better, they did not necessarily make their way there in time. Sometimes this was because they believed in the normal process of birthing, sometimes this was because they would address complications only as and when they arose, and sometimes because they had no means to address those. Women also sometimes kept their accidental or planned non-compliance a secret, in order to avoid being sanctioned or scorned.

Therefore with regards to the first sub-question (below), the theory revealed an intricate web of intrinsic factors which influenced women when they weighed their options for their

delivery care. Perceptions of the Policy itself revealed tensions, contradictions between believing on the one hand in its intention, but resenting or resisting in some ways its implementation.

With regards to the second sub-question:

What are the perceived effects of the implementation of this Policy and how does it affect women delivery care-seeking decisions?

The findings revealed some of the ways in which the 2007 Policy Guidelines had aggravated the barriers women already faced to seek skilled birth attendance. With regards to distance and transport barriers, The Policy affected women's circumstances because they were no longer able to count on the help of proximal TBAs to help or arrange referrals. Although the Policy had devolved to VHs the role of procuring transport in emergencies, for the most part VH had not been able to provide such help to women (e.g. bicycle ambulance). This therefore left some women further stranded in cases of emergencies, and proved a significant added barrier to their compliance. With regards to economic barriers, the fines which had accompanied the advent of the 2007 Policy Guidelines were described as potentially adding significant hardship. So did, indirectly, the birth-preparedness advice which came with the Policy (e.g. recommending the purchase of certain of items for delivery at facility). The findings demonstrated that for the poorest women in rural areas who could not afford those items, this could become another reason they opt for home deliveries. The theory revealed the impact of the interplay between all those extrinsic barriers or barriers placed on women externally by their context and circumstances. There were interactions between economic and socio-cultural barriers, for instance when husbands remained unsupportive or simply refused to procure the finance needed for institutional deliveries. This influenced women's choice to remain at home or delayed their facility deliveries. The findings showed these barriers had a cumulative effect, for example, where a woman could not afford transport to facility, and instead called upon a TBA to help her deliver, and later turn incurred a fine (for her, the TBA and anyone else who may have assisted).

More uniquely, the findings showed also how previous experiences of disrespectful or neglectful care at facilities could become the ultimate factor '*tipping the scale*' in favour of women's non-compliance with the 2007 Policy Guidelines At the cusp between intrinsic and extrinsic barriers, this was one interface where what women aspired to in terms of 'good' care

came into sharp contradiction with what they experienced. On the one hand, women wished to be welcomed well and supported throughout their labour (as used to be the case at TBAs), yet on the other hand they were sometimes treated harshly or neglected at facilities by some SBAs. This again conditioned some of their reactions/actions, by either convincing them not to return to facilities instead continuing to use TBAs, or by leading them to accept some ill-treatments at facilities in order to receive the care they needed. The theory demonstrated that this deficit in quality interpersonal care has been aggravated by the implementation of the 2007 Policy Guidelines because it has removed the TBAs-who excelled at interpersonal care-from an active involvement in births. Instead many more women are now making their way to ever busier and sometimes under-staffed facilities, where the care they expect is simply not available. And as far as TBAs are concerned, they too are placed between a rock and a hard place, willing to help still, but also anxious to comply with their new roles and fearful of the potential repercussions if they do not. Because of this, some TBAs have been rejecting women presenting to them, and instead have simply signposted them to facilities. In some cases, the consequence is that some TBAs, because of their compliance have been scorned by their own communities. It is also quite possible that the longer TBAs are banned and the more they become deskilled, since they no longer practice routinely. Therefore, despite their confidence in their own ability, if they and women agree to deliver together 'in a secret' despite the ban, the outcomes may not always be successful, and may be disastrous if complications occur.

Therefore, with regards to the second sub-question, the perceived effects of the 2007 Policy Guidelines implementation were seen as multi-faceted, cumulative and affected women's delivery care decisions in substantial ways. Perhaps the most important effect is that the Policy has in many ways limited the options for women, by withdrawing proximal help, and at the same time aggravating some of the barriers.

Regarding the final sub-question:

What is the impact of the Policy implementation on the links between community and health system for the continuum of care?

Here, the findings focused on the post-2007 Policy Guidelines context in which women are weighing their options for delivery care, particularly in terms of the linkages necessary to ensure a CoC between community-level and health facility level for delivery care. The

theory demonstrated clearly in answer to this question that the Policy had marked an important change. This was particularly true of the links between TBAs and SBAs. The data showed that prior to 2007, both birth attendants had had contacts with each other through trainings, supervisory visits and other meetings, which had fostered some understanding and some level of trust and co-operation. This had meant, practically, that some TBAs had been willing and able to call upon SBAs to take over where they could not address complications. It had meant also that some SBAs welcomed TBAs into the facility when they brought women to them, and involve them, thus ensuring a form of continuity of care. In this respect, in the past, TBAs had been viewed by their community peers as insiders into the Government's strategies. However after training was halted, and the TBAs were banned in 2007, these linkages broke down, and the gaps in the CoC from rural community to facility widened, leaving some women stranded even further. Here, the theory revealed the disjunction between the intent of the Policy, which was to provide some links through VH and HSAs as expressed in section 7.3 (instead of TBAs whom were assigned the sign-posting and occasional escorting to facilities), and the reality of the impact of its implementation on the ground. HSAs, onto whom too many tasks have been shifted, may well conduct antenatal visits, but cannot offer proximal help for deliveries. First they are not trained to conduct deliveries, and secondly they are not located in the village where women live and usually look after several villages. VH, even though they were given great responsibilities by the 2007 Policy Guidelines and the PISM, have, in practice, focused on their roles on monitoring compliance, rather than on providing emergency transport for referrals to facilities (partly also because they do not have the means to do so). This has not fostered collaboration between TBAs, community members and VH, but rather has reinforced the authority of VH, and perhaps led to further power imbalances in rural communities (after all a VH can more or less place a fine at his/her discretion on any woman or TBA in their village). As a result, some women and TBAs are meeting in secret for deliveries, to avoid the scrutiny of the VH, as much as to avoid attending at facilities.

Moreover, more importantly for the CoC, the findings revealed that the connections between TBAs and SBAs are now "*cut*". Instead there is now perceived mistrust, and enmity between TBAs and SBAs. These findings revealed here the biggest disconnect between the intent of the 2007 Policy Guidelines- to ensure the safety of all mothers in childbirth- and what partly resulted from its implementation: women delivering with no one present, or before arrival at facilities because no linkages could be found at community level. This situation was in

contradiction with what rural women- and those who support them in their decisions- aspire to, which is the restoration of bi-directional linkages and communication between TBAs and SBAs, to deliver an effective CoC.

Overall, the theory worked to answer the main research question by interpreting how rural women- and those who support them- perceive and operationalise the 2007 Policy Guidelines and TBA ban, within the context of other intrinsic and extrinsic factors. It revealed how the Policy implementation weighed on their decisions, and conditioned some of their actions, in favour of compliance, secret non-compliance, or in any other way. Above and beyond this the study also attempted to give a voice to the aspirations of rural women, TBAs and other community members, with regards to what they perceive as ‘good’ delivery care, and as an optimal CoC. The study did so by grounding the findings in a wide scope of data, constantly comparing multiple perceptions, and developing “strong logical links between the gathered data and [the] argument and analysis” (Charmaz 2006, p.182). This analysis gave meaning to the categories which formed the theory presented in Figure 29.

Hearing the voices of women and of TBAs (who are also women) matters not simply because they are affected by the Policy, but also because one of the stated goal of the 2007 Policy Guidelines was:

empowering women, their partners, families and the community to make appropriate decisions and take timely actions especially when there are complications in pregnancy and childbirth, and to take a leading role in identifying, planning, implementing, monitoring and evaluating interventions in RH issues in general.” (Republic of Malawi Ministry of Health 2007a,p.3)

Yet the theory has shown that in some ways, the Policy has restricted the choices of women further, and made it harder for their aspirations to be heard (lack of consultation, lack of social accountability and advocacy) and for them to make choices that suit their own needs. This is not empowering women. In a country like Malawi, where gender disparity and gender inequalities are still prevalent (United Nations Development Programme. 2015), it is key that the voices of women be heard with regards to maternal health policy strategies. Unless those marginal voices are heard, Governments and development programmes cannot claim to include all the women they are attempting to reach (Cornwall 2003), all the women they wish to come to facility and deliver their babies safely.

9.3 Other Criteria for evaluating the theory: credibility and originality

This study draws its credibility from the familiarity it has built with the phenomenon under scrutiny (Strauss, Corbin 1990, Charmaz 2006). The researcher immersed herself in data from multiple sites and multiple actors' perspectives, using constant comparison to compare data site to site, and case to case, from groups of actors in one site to another. These multiple perspectives and location give the study credibility and resonance, they helped deepen the tentative categories. By seeking and contrasting the lived experiences of a number of actors of this Policy- both implementers and beneficiaries- the study was able to build a more complete narrative. A broad range of empirical actions and reactions have been rendered through the findings, enough for the reader to understand the claims made by the theory presented.

This theory has resonance because it is anchored in a number of categories which together provide a full interpretive account of the lived experiences of the implementation of this policy. This study has also challenged received ideas, for instance about what barriers prevent women from accessing skilled birth attendance, and about the nature of TBAs knowledge and skills. In terms of originality, the categories present a fresh insight into the complexity of rural women's decision-making for delivery care as related to a particular policy implementation. Furthermore, theoretical and practical contributions to knowledge are made, which are detailed in sections 9.5 and 9.6.

9.4 Limitations

As with most studies, there were financial and time constraints to this study. Ideally a longer time spent in the field may have allowed for more analytical reflection between the waves of data collection (perhaps leading to further theoretical sampling). More time would have allowed for more triangulation of methods. For instance some observation of SBA's relationships with women in labour wards could have been carried out. And perhaps also some observation of or TBA and women relationships.

Another limitations of the study was that the researcher was not a Chichewa speaker and thus relied on her research assistant and subsequently on her translators to translate some of the data gathered. A thorough knowledge of the local language would have helped the researcher gain deeper understanding of the culture and context in which TBAs, men and women live,

and of what they related in interviews and FGDs. Cross-cultural and cross-language research is problematic in many ways, one being that in this situation, the knowledge produced is

bound by the existence of a ‘triple subjectivity’ in the field: researcher, research assistant and researched. These three figures shape and condition the development of field research by seeking, contributing to, eliciting or limiting the attainment of data (Caretta 2015, p.490)

Inevitably managing this situation requires trust between researcher and research assistant, and there is always a risk that in translation meaning may be altered. In selecting and supervising the assistant, the researcher selected someone with an understanding of the context of women in rural areas, who was also approachable and sensitive. The researcher and research assistant had debriefs at the end of the days when interviews and FGDs were conducted, and exchanged impressions, and thoughts.

One of the study’s challenges was the high number, and the diversity, of the interviews and focus groups conducted. Pragmatically, this presented a challenge for the coding and analysis of that amount of data. This was partly overcome by the decision to bring key actors to the fore in the analysis (such as TBAs and women), and using others as counterpoints in arguments. In this study, as in any qualitative study a number of alternative interpretive accounts could be drawn from the data (Charmaz 2006, Corbin, Strauss 2008). Focusing particularly on the accounts of women and TBAs helped developed categories further and build the theory which can best answer the research questions

9.5 Original contribution to theoretical concepts

9.5.1 Manifestations of the authoritative knowledge in childbirth in the Policy process and implementation

The concept of authoritative knowledge in childbirth was developed in the field of anthropology and thus has remained mainly concerned with exploring constructions of childbirth knowledge, showing how the authoritative knowledge established its supremacy and by revealing the power relations manifest between attendants and women (Sesia 1997, Jordan 1997, Davis-Floyd, Sargent 1997, Davis-Floyd, Pigg et al. 2001, Davis-Floyd, Davis 1997). Although this thesis showed clearly that this is the case in Malawi, the theory development also added to theoretical developments of the concept of authoritative

knowledge (AK), by showing how it manifested itself throughout the entire process of Policy implementation, which, to this researcher's knowledge, has not been done before.

Firstly, the authoritative knowledge in childbirth manifested itself in the content of the Policy. The 2007 Policy Guidelines, by the very fact that they contained a ban on TBA deliveries, not only promoted skilled birth attendance as the safest and best way to avoid maternal deaths, but promoted it over the alternative skills and knowledge of TBAs. By banning TBAs -and applying sanctions for their use- the Policy distinctively asserted the supremacy of the biomedical knowledge and management of childbirth. At the same time it clearly signalled that the alternative knowledge of TBAs does not count, is 'wrong', or at least is unsafe. The 2007 Policy Guidelines abide by the authoritative evidence that "it is now abundantly clear that the availability and utilization of quality Emergency Obstetric Care (EmOC) and the assistance of skilled attendants at childbirth are critical prerequisites for the reduction of maternal and neonatal mortality" (Republic of Malawi Ministry of Health 2007a, p.1). The discourse of risks in childbirth which formed the background of the PISM campaigns helped reinforce the AK supporting the skilled birth attendance strategy as "legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions" (Jordan 1997, p.58). This Policy implementation resulted in a clear demarcation between traditional and biomedical knowledge in childbirth, as was clearly demonstrated by the theory. By separating the roles of TBAs and SBAs – with the former as mere sign posters and the latter presented as experts who can deal with any childbirth complications- the Policy led to further devaluation and dismissal of TBAs.

Secondly, the authoritative knowledge in childbirth manifested itself in the dissemination and implementation of the Policy, which was done from the top down, distilled from the Government authority onto communities. As Jordan stated, AK is usually "associated with a stronger power base (structural superiority)" (Jordan 1997, p.56). The implementers of this policy (VH, SBAs) were those with the stronger power base, as well as those who believed in the superiority of the biomedical AK in childbirth, or at least, and in the case of the VH, who bought into the notion. VH were additionally those who could apply sanction for non-compliance with the Policy Guidelines. This 'structural superiority' made it difficult any other form of knowledge or way of birthing to be seen as legitimate. In all those aspects, it can be argued that the 2007 Policy Guidelines in fact institutionalised and perennial zed the superiority of the biomedical authoritative knowledge in childbirth.

9.5.2 Maternal health policy implementation analysis from the ground up: hearing the voices less heard

As expressed in Chapter 3, health policy analysis in general is mostly concerned with macro-level processes, and the influence of global policies and policy networks on the content and context of policy (Exworthy 2008, Shiffman, Quissell et al. 2016). Gilson and Raphaely conducted the first literature review of health policy processes in LMICs , and selected 164 articles- 32 of which related to maternal and reproductive health- concerned with empirical analyses of policy changes in LMICs (Gilson, Raphaely 2008). Of the articles concentrating specifically on the implementation of policy (which they labelled ‘IMP’), Gilson and Raphaely found that :

Although policy implementation essentially occurs at sub-national levels, 40% (31) of IMP articles exclusively consider experience at the international/ national interface or national level... The articles focusing on actors, meanwhile, examine: local and national level actors’ views about the extent of actor participation in health policy processes ...how the interests, values and beliefs of different actors shape the implementation of policies, including public health care providers and ...and how, in implementation, health staff resist and reformulate a range of policies (Gilson, Raphaely 2008, p.299).

These findings were confirmed by other reviews (Sato, Gilson 2015, Gilson, Palmer et al. 2005, Gilson, McIntyre 2005, George, Rodríguez et al. 2015, Walt, Shiffman et al. 2008, Erasmus, Gilson 2008). Erasmus et al more recently conducted a review of 85 articles focusing particularly on health policy implementation (Erasmus, Orgill et al. 2014). It highlighted that surprisingly few studies were concerned particularly with the role of local actors in policy implementation, despite the fact that actors have been described as key to the process of policy (Buse, Mays et al. 2012). They noted the articles were mainly concerned with policy implementation outcomes (was it successful?) and policy implementation improvement (how can it get better?). Currently, particularly in LICs, the field of health policy implementation analysis to be “is small, fragmented and of somewhat limited depth” (Erasmus, Orgill et al. 2014, p.ii47).

Moreover few bottom-up health policy implementation analysis studies concentrate on the roles and perspectives of those at the receiving end of policy implementation such as patients, beneficiaries or community members (Scott, Mathews et al. 2012). They often focus instead on the perspectives of implementers (health staff, health administrators). However the perceptions of beneficiaries matter to understanding and evaluating the impact of policy and

policy change at community level. This grounded theory qualitative study aimed to help fill this gap by focusing primarily on the perceptions of those whose voice is less heard, those at the receiving end of maternal health policy implementation: namely mostly women.

Firstly the theory revealed the manner in which women and other community actors perceived the Policy and its implementation strategy (as top-down and prescriptive). From this it built an interpretation of how this influenced the actions of some of rural women with regards to their compliance or non-compliance with the Policy. Secondly, with regards to the 2007 Policy Guidelines implementation, the theory revealed some of its unforeseen outcomes. It showed the disconnect between the intent of the Policy (to ensure safe deliveries for all women; to provide some form of linkage for the CoC) and some of its actual consequences on the ground (some women delivering unattended or in unsafe conditions; broken linkages between community and health system). Finally it offered some solutions which could improve the situation, in the words of the women themselves, and of the community actors who support them in making decisions regarding their delivery of care. This study points to the potential of bottom-up policy implementation analysis for providing both retrospective ground views of Policy- including the challenges and obstacles they create- , as well as highlighting potential future modifications to existing policies for the future which take into account the voices least heard in the process.

9.6 Original contributions to empirical knowledge

Current literature regarding the provision, accessibility, and quality of childbirth care worldwide, states that although there has been an overall increase in skilled attendance at birth, there remain substantial national and sub-national discrepancies between urban and rural populations, as well as richer and poorer (Campbell, Calvert et al. 2016, Koblinsky, Moyer et al. 2016, Joseph, da Silva et al. 2016, Graham, Woodd et al. 2016, Miller, Abalos et al. 2016, Singh, Story et al. 2016, Orobato, Austin et al. 2016). Most of those reviews start from the premise- backed by the evidence laid out in Chapter 2- that skilled birth attendance is the pre-requisite to reducing maternal mortality, and to ensure safety. From there, the reviews ask:

what steps can be taken in the next 5 years to catalyse action toward achieving the Sustainable Development Goal target of less than 70 maternal deaths per 100 000 livebirths by 2030, with no single country exceeding 140? What steps can be taken to

ensure that high-quality maternal health care is prioritised for every woman and girl everywhere? (Koblinsky, Moyer et al. 2016, p.2307)

The recent literature also acknowledges that one strategy for maternal mortality reduction may not fit all contexts since evidence shows that there are major gaps in the provision of health system based delivery care across the board, but particularly in remote rural areas (Sharma, Leslie et al. 2017, Joseph, da Silva et al. 2016). A recent article stated that:

governments and policy makers can no longer pretend to provide life-saving care, using phrases such as skilled birth attendant and EmOC to mask poor quality ... Either all women who enter into labour should be within travelable distances to comprehensive facilities, or if they can only reach lower-level facilities, these must have well-functioning maternal care, with excellent strategies for linkage to emergency medical services. (Campbell, Calvert et al. 2016, p.2203-2204)

For the most part, a number of rural women- such as the ones who took part in this study- are not located within a short distance of facilities, nor do they have any the functional linkage to EmOC mentioned above. For many women, the pathways to delivery are multiple, they are uncertain, and they can vary from one pregnancy to another.

The first original contribution to empirical knowledge this thesis makes is to offer a “deeper understanding” (Charmaz 2006, p.153) of the phenomenon of what leads those rural women to choose the pathways to delivery care they do, within the constraints of policies such as the 2007 Policy Guidelines. The theory presented here, *weighing the options for delivery care*, does this by showing there is no simple binary choice between SBA-attended birth at facility or unassisted home delivery, between safe and unsafe options. Women want safe deliveries, and believe that this is better delivered on the whole at facilities, but they also want to be treated respectfully, a feature of their experience with TBAs and not always the case at formal health care facilities (Ryan, Hamela et al. 2015). Therefore the options women choose vary not only because of the real practical barriers they encounter, but also because of personal beliefs, previous experiences, because of different perceptions of risk and because of personal preferences. Furthermore the options available are different for women in hard-to reach rural areas, where recent evidence show the poorest quality of biomedical birth care is often delivered (Sharma, Leslie et al. 2017, Joseph, da Silva et al. 2016, Campbell, Calvert et al. 2016). They can also be further limited by Policy decisions, such as the one described in this study, which cut out proximal help (TBAs) for some of the most hard to reach rural women.

This study's second original contribution is to move away from the well-researched and debated issue of whether TBA training is effective or ineffective to reduce maternal mortality, and to depict instead their lived experiences of policies which have banned their utilisation. Very few recent studies have done this in any depth (Rishworth, Dixon et al. 2016, Cheelo, Nzala et al. 2016). By adding to this particular body of literature, this study reveals the pressures on TBAs- financial, emotional and those related to social relationships in their community-, some of their reactions, and how these interconnect with women's care-seeking behaviours.

Furthermore, by helping fill the gap in maternal health policy implementation analysis from the perspective of those impacted upon in hard to reach rural areas, this study reveals an important paradox. This paradox is that Policies such as the Malawi 2007 Policy Guidelines, by offering only one delivery option (in a facility, with a SBA) to guarantee safety, are in fact placing some of the most vulnerable pregnant women in rural areas, at a higher risk (e.g. of complications, BBAs and births with NOP). This highlights a major disjunction between the intent of such policies for maternal mortality reduction and the potential impacts of its implementation. Furthermore, this disconnect can fragment local communities by reducing openness (e.g. encouraging deliveries with TBAs in secret) and reducing effective communications between TBAs and SBAs. Future research needs to build on this thesis and to uncover why, for instance, even though skilled birth attendance has increased by 11% since the TBA ban and maternal mortality has declined, a recent study suggested a lesser decline has happened regarding new-born mortality (Godlonton, Okeke 2016). Godlonton and Okeke have ventured a number of possible reasons for this, such as the fact that more women may be delivering with friends or relatives thus placing their new-borns at risks, or may be caused by the low quality of care available at some rural facilities.

With a decade of insight, it may be time to ask if an outright blanket ban of TBAs was the best policy, in a health system which, according to women and SBAs alike, is not yet fully able to cope with the influx of women presenting at facilities for their deliveries (Banda 2013, Bradley, Kamwendo et al. 2015), or with their expectations of 'good' care (Kumbani, Chirwa et al. 2012). As Graham and Varghese state:

There is indeed a need to do things differently: to reposition quality on the pathway to achieving mortality reduction goals. This repositioning requires something else to be done differently: to routinely and robustly monitor quality along the continuum of

care, including users' perspectives as well as providers' (Graham, Varghese 2012, p.e5)

Social accountability has received increasing attention the last few years (Bustreo, Requejo et al. 2012, Freedman, Kruk 2014, Koblinsky, Moyer et al. 2016, Freedman, Schaaf 2013), as has the discussion on the legal duty of care on the part of biomedical providers (Rowe, Moodley 2013). Maternal health policies which are designed and implemented from the top-down, as the one described here, lack social accountability. What is meant by social accountability here is that top-down policy implementation makes it difficult for community members to hold policymakers accountable, and to make them more responsive to their needs (Lodenstein, Dieleman et al. 2013, Freedman, Kruk 2014). For instance the 2007 Policy Guidelines and TBA ban were issued with little consultation of women in hard to reach rural areas, and the application of sanction for non-compliance, both of which curtailed community members' ability to hold the authorities accountable. It can be argued that hearing the voices of those least heard and least consulted about policy implementation may be a first step towards strengthened social accountability. Therefore the recommendations below aim to support a drive for increased social accountability, or bottom-up accountability (Lodenstein, Dieleman et al. 2013, p.2). Those are aimed at increasing the responsiveness of maternal mortality reduction strategies to the situation and the needs of women in the poorest, most remote rural areas.

9.7 Recommendations for Policy and practice

The responsibility to provide accessible, affordable, comprehensive, quality of maternity and delivery care to all women in Malawi befalls upon the Government and its representative. In the past decade this Government, through its investment, its policies (Republic of Malawi Ministry of Health 2007b, Republic of Malawi Ministry of Health 2012, Republic of Malawi Ministry of Health 2009, Republic of Malawi Ministry of Health 2007a), and its Presidential Initiative for Safe Motherhood, has showed strong commitment and dedication in the pursuit of such goals, as well as laudable progress (Phoya 2014, National Statistical Office of Malawi 2015, UNICEF., WHO. 2015, UNICEF 2015). The Government has also worked tirelessly to increase human resources for maternal health (including training more NMT and CMAs), and to raise awareness through Safe Motherhood media campaigns, despite considerable financial constraints and a heavy burden of diseases (McCoy, McPake et al. 2008, AHWO 2009).

However with regards to the particular 2007 Policy Guidelines and TBA ban, the time may now have come to take stock, in light of the evidence presented in this thesis and two other recent studies (Godlonton, Okeke 2016, Banda 2013) which together currently form the body of literature on this particular subject of the TBA ban. As Godlonton and Okeke suggest below, this Policy needs to be assessed in terms of all of its outcomes:

The a priori effect of the ban on health outcomes is ambiguous. It would depend on the composition of women who were previously using informal birth attendants, the direction and extent of substitution, and the relative differences in marginal health products. If post-ban all informal sector births shifted to the formal sector, then assuming higher quality on average, mortality would almost certainly decline. If instead, women opted to stay home and deliver unassisted, then one might expect mortality to increase. Furthermore, mortality might increase because of the additional stress imposed on women attempting to reach formal health facilities during labour, or because informal attendants went underground and practiced in secret. In the latter case, mothers who experienced complications might be more reluctant to go to a formal health facility for fear of being penalized (Godlonton, Okeke 2016, p.114)

It can be argued that with regards to the impact of this Policy, a narrow and exclusive focus on the percentage of skilled birth attendance and the ratio of maternal mortality reduction misses part of the story. It tells little of women's assessment of the quality of care they receive at facilities, or of what motivates their delivery care-seeking decisions. For instance, research is needed on the impact which sanctions for home deliveries may have on the poorest and most vulnerable women in rural areas, both financially and emotionally (Chamberlain 2013, Greeson, Sacks et al. 2016). New interventions may need to be deployed instead, to encourage or incentivise women to attend at health facilities for deliveries (Morgan, Stanton et al. 2013). One such intervention could be to encourage birth-preparedness by providing the poorest women in rural areas with basic birth boxes or bundles containing the essential items they need for their facility delivery (see Figure 23). Those could be distributed through women's groups for safe motherhood or the VHC and VH. If women are to travel to facilities, rather than use the proximal help of TBAs, the Government may wish to work with stakeholders in the community and at facilities to find solutions to bridge the gaps in available and affordable transport (Campbell, Calvert et al. 2016, Koblinsky, Moyer et al. 2016). One possible solution would be to provide as many villages as possible with bicycle ambulances (perhaps by ensuring that VHS and VHCs utilise the income from fines to purchase those), or to provide the poorest mothers with transportation vouchers, as has been done recently in Uganda (United Nations. 2015). Efforts need to be increased also to provide greater numbers of ambulances at hospitals and health centres for

referral transportation, as has been done successfully in some regions of Ethiopia (Graham, Woodd et al. 2016), and in countries such as Cambodia and India (Campbell, Calvert et al. 2016). A new linking role could be attributed to TBAs, as in Sierra Leone where a study highlighted the added benefits of providing motorbike ambulances and using TBAs to promote their use (Bhopal, Halpin et al. 2013).

The evidence from this study points to the fact that banning and cutting off of TBAs, which has resulted in them becoming ‘outsiders’ in the safe motherhood strategies may be short-sighted. This thesis has shown that they are still key stakeholders in Malawi, and have a moral and social investment in the well-being of pregnant women in their communities. Besides, women in this study expressed a desire for them to be better linked into the health system, which points to the possibility of a more active engagement for TBAs. This could be done in a number of ways, as shown in a review by Byrne and Morgan (2011). That review showed how TBAs have been integrated in the health systems in a number of countries in the past. They presented a model (reproduced below) of how this can be done according to the particular legal status of TBAs (banned, registered), and to the strength of the health system concerned. Integration can take the form range from enabling TBAs to support skilled birth attendance, acting as a link to health facility, or more directly as part of the referral system or even sharing maternity care with SBAs at facilities.

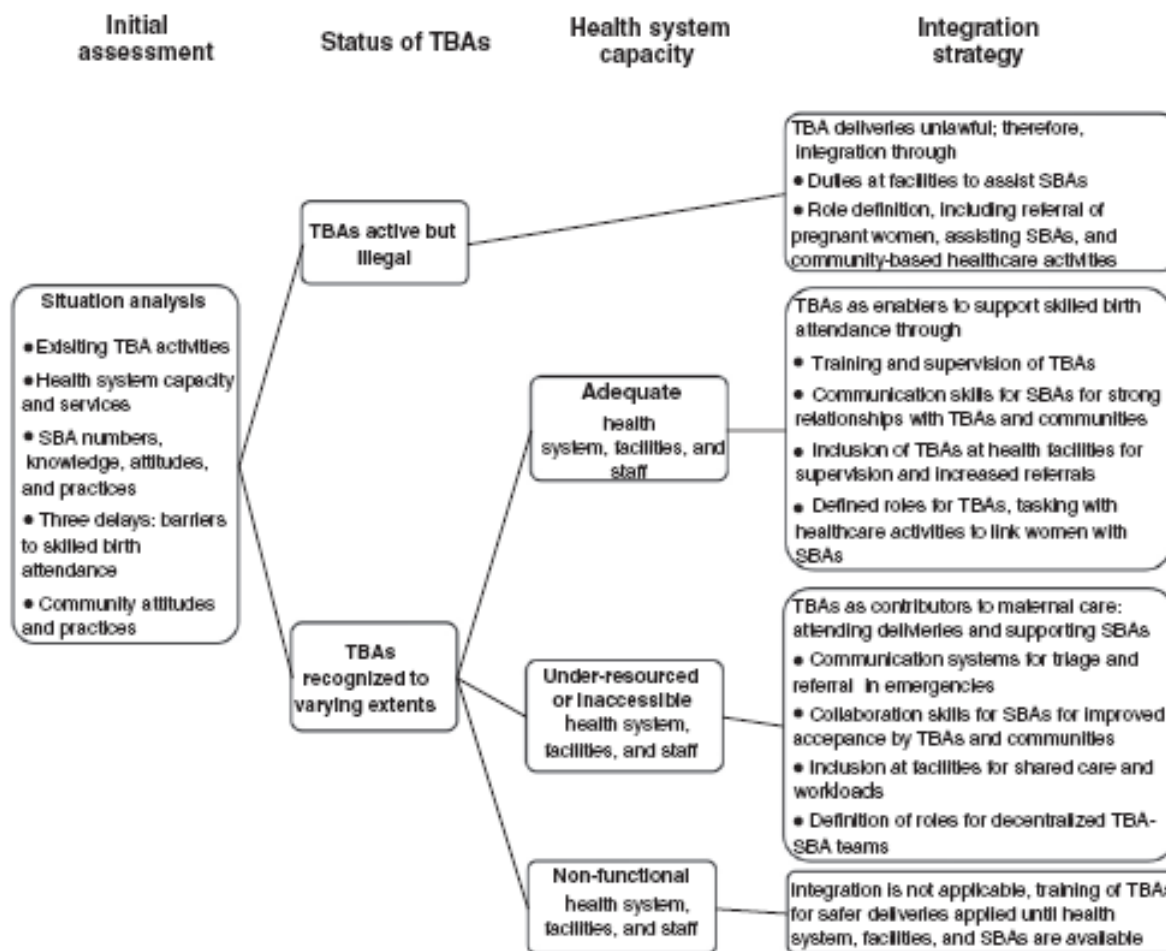


Figure 30. Byrne and Morgan’s “Context-appropriate application of traditional birth attendant integration strategies “ (2011, p.192)

Based on the evidence it provided of TBAs willingness to be involved, and on women’s aspirations to restored links between them and SBAs this study suggests that without revisiting the ban on TBA utilisation for routine deliveries, there is a number of ways in which TBAs could still be actively involved in maternal mortality reduction strategies in Malawi. Some are suggested below, supported by evidence of successful TBA involvement in programmes in Sub-Saharan African countries all from the last decade.

Firstly, TBAs could be trained, particularly in rural areas, to undertake very particular tasks, in support of maternal and neonatal mortality reduction. For instance recent studies in the SSA region have showed success in providing TBAs with training to avert neonatal mortality (Gill, Phiri-Mazala et al. 2011, Yeboah-Antwi, Hamer et al. 2014), which is also still

prevalent in Malawi. In Zambia, for instance, the LUNESP project trained TBAs- for 2 weeks with refresher courses over 3-4 months- in carrying simple neonatal resuscitation protocols, and equipped them with the necessary drugs and materials to put this in practice. The project had a knock-on effect on TBAs referring women with complications, because they felt valued, and integrated into the health system (Gill, Phiri-Mazala et al. 2011). Another pilot project in Zambia successfully trained TBAs in the prevention of mother-to-child-prevention of HIV by instructing them on how to perform rapid saliva-based HIV testing at home births and administering drugs at the onset of labour and syrup to the infant after birth (Brennan, Thea et al. 2014). A similar project in the district of Lilongwe in Malawi also had positive results in instructing 21 TBAs from the area in HIV PMTCT measures and the administration of single dose nevirapine to mothers and infants (Hamela, Kabondo et al. 2014). The study reported that “168 HIV positive women were identified by TBAs. Of these, 86/168 (51.2%) women received nevirapine and 46/168 (27.4%) HIV exposed infants received nevirapine “(2014, p.27). Even though the lack of transport and referral had an impact on the results, as well as the reluctance of some women to disclose their HIV status to TBAs, it showed that the linkages between TBAs and facilities could be strengthened with positive outcomes. For instance, Gill, Phiri-Mazala et al ventured that, notwithstanding the low levels of literacy of some TBAs, they could make a positive contribution:

For example, oral misoprostol is highly effective at controlling postpartum haemorrhage; TBAs could be trained to provide this medication as part of routine care, reducing maternal morbidity and buying precious time in which to transfer critically ill mothers to higher levels of care. Similarly, TBAs could be trained to manage puerperal sepsis, either as a “first dose and go” strategy or administering a full therapeutic course in the community (2011, p.81).

Even if the Malawi Government opted for a less integrated approach, willing TBAs in rural areas of Malawi could be provided with mobile phones (and solar chargers), and a small stipend, to enable them to contact their nearest health centre in the eventuality that a woman may present to them with early onset labour, or with a complication, and thus they could be part of enabling timely referral.

Secondly, some non-clinical tasks could possibly be shifted to TBAs(e.g. as birth companions accompanying women to hospitals), thus playing to their skills in interpersonal care and lightening the burden of overworked SBAs. A recent intervention in Somaliland (Pyone, Adaji et al. 2014), used the redefinition of TBAs roles to actively engage them as

health promoters and birth companions for women. TBAs were actively encouraging women to seek skilled care and they were given a remuneration of \$5 for each woman they referred or escorted to the facility. The project resulted not only in a four-fold increase of women receiving skilled maternity care at the local health centres, but also fostered a new understanding for TBAs and communities of the complications and risks of home deliveries. TBAs also regained recognition and value for their key roles. The study also stressed that TBAs willingly accepted their new roles and that the project resulted in an improved relationship and a building of trust between them and SBAs. In this case, SBAs worked more positively with TBAs, welcoming them at facilities and providing them feedback on the care and birth outcomes of the women they had brought to the facility. Over the 4 years of the project the study stated that "pregnant women reported being more confident about accessing facility-based maternity care owing to the improved attitude of the SBAs, who were reported to be more supportive than they had been previously" (Pyone, Adaji et al. 2014, p.43). Interestingly, when the payment for referring and escorting women ceased, although the TBAs were unhappy about this, they continued to refer and escort women, which seems to point to a motivation other than monetary for their involvement (as was stressed in section 5.5). A similar programme in rural Kenya, which recruited and trained TBAs as active health promoters to educate women about the safety of delivering at facility, and which offered them a small stipend for every woman they brought to deliver at the facility, significantly improved the rate of skilled birth attendance (Tomedi, Stroud et al. 2015). It is possible that lessons learnt from such interventions hold value for countries such as Malawi, particularly in rural areas.

Thirdly more linkages could be built not just with TBAs, but involving all community members working together to ensure the safety of women and babies in their community. This was, after all, the goal of the Guidelines for Community Initiatives for Reproductive Health (Republic of Malawi Ministry of Health 2007a). For instance, a study from Ghana's rural Upper East Region reported lately on a Government programme of Community-based Health Services and Planning. In this programme, 200 compounds were built, where community health officers trained as midwives, could provide delivery services to local women (Sakeah, McCloskey et al. 2014). In the project all actors worked together: men building bricks for the building, VH providing land and labour, Government providing staff and equipment, and TBAs and Women's Groups working together to encourage women to

attend at the new local health centres. There, TBAS were escorting women who needed it to the new compounds to receive adequate care. They had contacts with SBAs at facilities, some of whom, in an unprecedented way, used money from delivery fees to give it to TBAs or to buy soap for them, to thank them for their support. The study reported also that, as a result, TBAS were no longer seen as obsolete by community members, but that they “accorded TBAs and volunteers “respect” and “recognition”, which [was] an incentive to them” (Sakeah, McCloskey et al. 2014, p.6). Even though the programme did face important challenges in terms of transport to the compounds, shortages of drugs and other socio-cultural barriers, it perhaps provides an interesting blueprint for health policymakers and health officials in Malawi.

The above evidence from programmes in similar contexts as Malawi in the Sub-Saharan African region suggest the potential for more active, non-delivery related, roles for TBAs, in co-operation with SBAs and other health staff. A unique project in Zambia enrolled CHW and TBAs in teams to work to common goals within a community-based new-born and childcare intervention (Yeboah-Antwi, Hamer et al. 2014). It concluded:

This study shows the feasibility of creating and deploying teams of volunteer community-based providers of relatively younger, better schooled, predominantly male CHWs and older, less schooled, female trained TBAs in a rural setting. Most of the important teamwork dimensions – i.e., mutual support, team cohesion, comprehension of team goals and objectives and communication – were highly present in the teams. Additionally, most teams performed many of the joint tasks. About two-thirds of the active teams were categorized as high performing (Yeboah-Antwi, Hamer et al. 2014, p.5).

All of the programmes and interventions mentioned above not only brought some positive outcomes for women (more timely referrals, increased use of facilities, averted mortality or morbidity for them and their babies), they also vastly improved relationships between TBAs and SBA, increasing mutual recognition, communication, and trust. Restoring those links in Malawi could only benefit women in remote rural areas and improve the linkages they require for an effective continuum of care. It can be argued also that such linkages can save lives, and therefore their impact deserves further investigation. If anything, this thesis has demonstrated that despite the radical change the 2007 Policy Guidelines brought in terms of their roles, and despite the manner of its implementation, TBAs are still willing and able to

support the work of SBAs and of the Government. In light of such evidence, time has perhaps come to enable all to start “*singing the same song*”.

9.8 Concluding remarks

Gilson and Raphaely pose that “by generating understanding of the factors influencing the experience and results of policy change, such analysis can inform action to strengthen future policy development and implementation” (Gilson, Raphaely 2008). This study has revealed such lived experiences as well as the unintended consequences of a maternal health policy implementation, particularly for the poorest, most remotely located women in rural areas of Central and Southern Malawi. The grounded theory has provided an interpretive account of some of the factors and social processes contributing to the decision-weighting, and delivery care-seeking behaviours of those women. It has highlighted the positions of a number of actors within these social processes, revealing their conflicting views, as well as their common beliefs and aspirations. In doing so, it has demonstrated that:

people’s interactions with maternal health services are never only about attaining health outcomes. These interactions are also about aspirations to have some control over their birth experience, to be treated with dignity and respect, and to use their choices around childbirth to signal who they are and who they want to be (Freedman 2016, p.1)

The concluding Chapter of this study has highlighted that there is no one size fits all when it comes to strategies promoting skilled birth attendance and tackling maternal mortality reduction. In Malawi, a significant percentage of the population is still too far from facilities, and there are socio-economic inequalities, as well as rural and urban disparities (human resources for health are concentrated in urban areas) with regards to maternal health. As a result, more women and their babies are still dying in rural areas (Colbourn, Lewycka et al. 2013, Republic of Malawi Ministry of Health 2011, Leslie, Fink et al. 2016). Some of the recommendations made in this chapter could help address this imbalance, and merit further investigation. The social processes and factors revealed by this theory could potentially cut across other empirical settings with regards to maternal health-care seeking behaviours in LIC- particularly in rural areas of Africa-. The theory could be amended and applied to other areas of maternal health policy implementation analysis, for instance, those concerned with the reasons for which rural women may not return to facilities for all their antenatal visits

despite being instructed to do so, or why some fail to put in place birth-preparedness and complication avoidance plans despite being enjoined to do so. Analysing maternal health policy implementation in this way, not only from the perspectives of those less heard, but also from multiple perspectives, may help policymakers and social development programs organisers to re-evaluate policies.

At the heart of this debate is the extent to which social accountability matters in policy, and the extent to which the views and aspirations of a small portion of rural community members should be taken into account by the Government and Policy makers. Can it be argued that a Policy works because it is serving the greatest number of women? Can it be argued that a Policy works because skilled birth attendance is increasing overall and maternal mortality declining overall? This study argues that the Government of Malawi has a duty of care to **all** mothers and babies, in urban and rural areas alike, rich or poor . This thesis argues that the 2007 Policy Guidelines could be updated and amended to achieve this, by bringing forth creative, inclusive, collaborative and contextualized solutions in remote rural areas. This can be done without compromising the goals of maternal mortality reduction, and without having to revert the TBA ban. The rural women of Malawi need and want this, more importantly, they deserve it.

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Appendix 1: Fieldwork timeline

February 2013:

- Arrive in Malawi (Lilongwe, 1st Feb 2013)
- Preliminary visits to Site1 and Site2 (Nkhoma and Mchinji)
- Data collection in Site 1 (Nkhoma)
- Return to Lilongwe for Early coding and on-going data analysis

March 2013

- Prepare second phase of fieldwork and arrive in Site 2 (Mchinji)
- Data collection in Site 2 (Mchinji)
- Return to Lilongwe for focused coding and on-going data analysis

April-May 2013

- Return to Site 1 for additional FGDs with VHs
- Prepare second phase of fieldwork and arrive in Site 3 (Malosa)
- Data collection in Site 3 (Malosa)
- Travel to Zomba for a few CMA interviews
- Travel to Nathenje (near Site 1) for TBA interview (deviant case)
- Return to Lilongwe for focused coding and on-going data analysis
- Undertake more OMS interviews in Lilongwe
- Organise all transcriptions and translations
- Return to Scotland (1st June 2013)

Appendix 2: List of interviews and focus group discussions unique reference codes

Unique code	Description
FSBA01, etc.	Focus group discussion with Skilled Birth Attendants
FTBA01,etc.	Focus group discussion with Traditional Birth Attendants
FVH01, etc.	Focus group discussion with Village Headpersons
H01, etc.	Focus group discussion with men (the H originally stood for Husband)
HSA01, etc.	Focus group discussion with Health Surveillance Assistants
OMS01, etc.	Interview with Other Main Stakeholder
SBA01, etc.	Interview with Skilled Birth Attendant
TBA01 etc.	Interview with Traditional Birth Attendant
TBA02-03	Group interview with Traditional Birth Attendants
VH01, etc.	Interview with Village Headperson
VH02-03	Group interview with Village Headpersons
W01, etc.	Focus group discussion with women

Appendix 3: Participants information sheet and consent form

INFORMATION SHEET

Name of the Researcher:

Dzina la Ofufuza

Name of Research Assistant/ translator:

Dzina la othandizira kafukufuku/ womasulira

I am Isa Uny, a student at Queen Margaret University in Edinburgh (Scotland). I am doing research about how the changing role of Traditional Birth Attendants (TBAs) is viewed in this area. My study has been approved by the National Health Sciences Research Committee in Malawi. I am going to give you information and invite you to be part of this research. Before you decide, you can talk to Alister Munthali at the Centre for Social Research (University of Malawi, address: P O Box 278, Zomba. Tel: +265888822004.)

Please ask questions as I go along if something is not clear to you.

Ine dzina langa ndine Isa Uny, ndipo ndine wophunzira kusukulu yaukadaulo ya QUEEN Margaret ku Edinburgh dziko la Scotland. Ndipo ndikupanga kafukufuku wofufuza ntchito ndiudindo wa azamba kudera lino. Kafukufukuyu waloledwa kuti achitike ndiabungwe loyang'anira za akafukufuku m'malawi muno a National Health Sciences Research . Ndikufotokozerani ndondomeko yonse yokhudzana ndi kafukufukuyu komanso ndikukupemphani kuti mukhale mbali ndigawo lakafukufukuyu. Mwina musanapange chiganizo mukhonza kulankhula ndi Alister Munthali aku bungwe lopanga kafukufuku ku Zomba womwe keyala yawo ndi university of Malawi, P.O Box 278, Zomba ndipo lamya yawo kapena telefoni yawo ndi 0888822004

Chonde funsani mafunso pamene kafukufukuyu akuchitika ngati simunamvetse bwino

Purpose of the research (*Cholinga cha kafukufuku*)

Women and their families sometimes use the services of Traditional Birth Attendants (TBAs) and also of doctors, nurses, midwives when women are pregnant or giving birth. We want to learn more about how you view the changing role of TBAs in supporting pregnant women. What I am interested in is your own view, your opinion.

Amai woyembekezera ndimabanja awo thawi zina amagwiritsa ntchito azamba komanso anamwino achipatala, madokotala ndi ena otelo panthawi yomwe iwo ali woyembekezera kapenanso panthawi yobereka. Ife ngati wofufuza tikufuna kudziwa zaudindo a zamba kudera lino panthawi imene akuthandiza amai woyembekezera. Chomwe ife mgati wofufuza tikufuna kudziwa maganizo anu inuyo ngati azamba

Selection of participants & interview(*Kusankha ofufuzidwa ndi kafukufuku*)

This research will involve your participation in an interview that will take about one hour. I will be there with a research assistant who speaks Chichewa, so you can use your own language. We can do this interview where and when you want. You are being invited to take part in this research because I feel that your experience can help me understand how TBAs'

changing role is perceived in this area. Your participation in this research is entirely voluntary. It is your choice to participate or not. You can stop the interview at any time.

If you do not wish to answer any of the questions during the interview, just say that and I will move on to the next question. If that is acceptable to you the interview will be audio-recorded (*show device*), but the information recorded is confidential, and no one will see your name or know who said what. The recording helps me to listen to what you said later and understand and analyse it better. The recording will be kept in a locked place and destroyed after 5 years.

Kafukufukuyu ndikupempha kuti mukhale nane ndikundithandiza ndimayankho anu munthawi pafupifupi mphindi imodzi. Ndipo panthawi yakafukufukufukuyu ndikhala ndi ondithandizira amene amalankhula Chichewa ndiye mukhale womasuka kulankhula Chichewa. Kafukufukuyu tikhonza kupangira pamalo amene inu eni mingasankhe komanso nthawi imene inu ngati wofufuzidwa mukufuna. Tsopano ndikukupemphani kuti mutenge nawo mbali pakafukufuku ameneyu ndipo ine ngati wofufukwa ndikukhulupirira kuti inuyo luso lanu la a zamba mudera lino lindithandiza kumvetsetsa undindo ndinso momwe udindo wanuyu umawonedwa mudera lino. Muli womasuka kutenga nawo mbali, kapena kukana kutenga nawo mbali, mutha kusankha kutemga mbali kapena ayi, komanso kusiyira panjira ngati mwatopa.

Ngatinso simukufuna kuyankha mafunso ena panthawi imene tikupitirira ndimafunso, nenani kuti funso limenelo sindiyankha ndipo ine ngati wofufuza ndipita pafunso lina. Ngatinso kuli kotheka ndipemphe kuti panthawi yomwe ndikufufuza ndijambule mau pa wailesi yotenga mau (iyi) koma dziwani kuti izi palibenso wina amene akamvetsera koposa ine ndiwondithandizirawa basi, palibe akawone dzina lanu, kapena kuti ananena zakutizakuti ndindani. Kujambula mau kukandithandiza ine kemvetsera zomwe inu munanena tikamaliza kafukufukuyu kuyi ndikazilembe bwino, ndipo wailesiyi ndikaibisa mumalo otseka bwino ndiloko ndipo ndi idzaphwasulidwa patapita zaka 5.

Risks & benefits (*Kuwopsya ndikukoma kwake*)

As we are talking about pregnant mothers and babies, which in Malawi can sometimes be difficult. If you feel uncomfortable talking about some experiences, remember you do not have to answer any question you don't want to and can take a break too.

There will be no direct benefit to you in taking part, but your participation is likely to help us find out more about how people view the role of TBAS, and their contacts with doctors/nurses midwives. We hope this will help women in Malawi in the long run.

You will not be paid to take part in the research. However, if it has cost you to come here today, I will reimburse travel expenses to a maximum of [KW_____] (*according to local acceptable rate for similar studies*)

Popeza tikhala tikulankhula za amai oyembekezera ndi ana, zinthu zomwe ku Malawi kuno zimakhala zovuta Kapena ndinene kuti zachinsinsi zosakambira pagulu, pamene inu mukuona kuti simungathe kufotokoza malinga ndizomwe mwakhala mukuziona, kumbulirani kuti muli omasuka kusayankha funso loterelo, kapenanso kunena kuti mukufuna kupuma kaye.

Palibe cholowa chilichonse kwainu kutenga nawo mbali pakafukufukuyu, koma mayankho anu atithandiza kupeza malingaliwo anu patchito ya azamba, ndinso ntchito ya anamwino ndi momwe mumalumikizirana ndiso kukumanilana.

Komanso palibe malipiro ena aliwonse amene mulandile pakutenga nawo mbali pakafukufukuyu. Koma ngati mwagwiritsa ntchito ndalama iliyonse kuti mubwere kuno, ngati

transport ine ndikubwenzerani ndalama zosapitirira MK.....) ngati momwe zakhala zikukhalira ndimakafukufuku ena olingana ndiuyu.

Confidentiality & sharing the results of the study

I will not be sharing information about you or what you said in this interview to anyone to protect you. The recording and all your answers will stay private. When we come to type up the interview to look at it closer, it will have a number on it instead of your name. Only I will know what your number is and I will lock that information up.

Results of this research will be written in my dissertation (a big book) and may be in a journal or magazine in the UK or Malawi. No names will appear in there. It will help us understand more of the situation in Malawi but the findings will not affect your work or position in the community in any way. If you like, I will try to share the results of this research with you before it is published (*by email or text if you provide a mobile phone or through the hospital and HSAs*).

Kusunga chinsinsi komanso kugawana nanu zotsatrira zakafukufuku Sindidzaulura zainu kapena zomwe inu munene pakafukufuku ameneyu pokutetezani inuyo. Zonse zomwe inu mutakambe ndizonse zomwe ine nditajambule zisungidwa mwachinsinsi, m'malo mwa dzina lanu potaipa tikaikapo nambala. Ndi ine ndikha amene ndikadziwe nambala yanu ndipo zonses ndikakiyira. Zotsatira za kafukufukuyu zikalembedwa muchibuku chachikulu ku Ulaya ndinso kutumizidwa ku Malawi. Maina aliwonse ngakhale maina a malo sakawonekamo. Koma zikatithandiza kumvetsetsa kwambiri m, mene ntchito yauzamba ilili ki Malawi ndipo sizidzakhudza ntchito yanu ndipang'ono pomwe mudera lanu lino. Ngati mungakonderetsedwe ndikhonza kudzatumiza zotsatira za kafukufukuyu asanatsindikizidwe mumabuku ngati mungandipatse address yanu. Mungapezenso zolembedwazo kudzera kuchipatala ndinso kwa HSA

Do you have any questions?

Mungakhale ndimafunso ena aliwonse?

Contacting me

If you have any questions, you can ask them now or later. If you wish to ask questions later, you can contact me at: iuny@qmu.ac.uk or 0881920392 **MANY THANKS**

Mungandipeze bwanji

Ngati muli ndimafunso mukhonza kundifunsa pano kapena nthawi ina. Ngati mungafune kufunsa mafunso nthawi ina mukhonza kundilemba lamya mu adiresi iyi iuny@qmu.ac.uk, kapena imbani telefoni iyi..... nthawi yomwe ndiliku Malawi kuno.

CONSENT FORM- Chikalata chovomereza ketenga nawo mbali pa kafukufuku

I have read the information about the study information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Ndawerenga ndondomeko yonse yakafukufuku, kapena andiwerengera zonse zokhudzana ndi kafukufukuyu. Ndakhala ndimpata wofunsa mafunso onse amene ndinali nawo ukhudza

kafukufukuyu, ndiponso mafunsowo andiyankha bwinobwino ndipo ndakwanitsidwa ndimayankhowo. Ndikuvomereza kutenga nawo mbali pakafukufukuyu mosaumiririza.

Print Name of Participant _____

Code:

Nambala

Dzina la wofufuzidwa

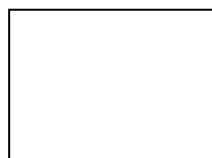
Signature of Participant _____

Saini ya wofufuzidwa

Date _____

Tsiku

Day/month/year *Tsiku/ Mwezi/ chaka*



If illiterate:

Ngati ali wosalemba kapena kuwerenga

Print name of witness _____

Participant symbol of consent
Chidindo cha wofufuzidwa

Dzina la mboni (Wothandizira kafukufuku)

(Research Assistant)

(cross, drawing, fingerprint etc)

Signature of witness _____

kapena mtanda, kapena chala,

Saini yamboni

Date *Tsiku* _____

Day/month/year *Tsiku/ Mwezi/ Chaka*

Appendix 4: Interview schedules

WOMEN

1- GENERAL QUESTIONS

a- **Where do you and women you know go to when they are pregnant or giving birth?**

Kodi amayi adela lino amapeza kuti thandizo akakhala oyembekezera komanso pobeleka?

- **Has there been any changes in the past few years?**

Kodi pakhala pali kusintha kwina kulikonse pa zaka zingapo zapitazi?

c- **Where do you think is best for women to give birth? Why?**

Mukuganiza kuti malo abwino kubelekela/kuchilira mwana ndi ati? Chifukwa chiyani?

2- THE WORK OF TBAs AND THE WORK OF DOCTORS/ MIDWIVES/ NURSES

a- **What does a doctor/ midwife/ nurse do to help women when they are pregnant or in delivery?**

Kodi madotolo ndi anamwino amagwila ntchito yanji kwa amayi panthawi yakuyembekezela komanso pobeleka?

b- **What does a TBA do to help women when they are pregnant?**

Nanga azamba amathandiza bwanji amayi pamene akuyembekezela?

c- **Do you think there is a difference between the care TBA give women and the care they get from doctors, nurses or midwives? What is the difference?**

Kodi mukuganiza kuti pali kusiyana kulikonse pachisamalo chimene a zamba kapena madotolo/Anamwino amapeleka kwa amayi matenda akayamba, ndipo kusiyanako nkuti?

d- **Do you think there is a difference between the way TBA welcome and handle the women and the way nurses or midwives do it at the hospital? What is the difference?**

Mukuona ngati pali kusiyana kulikonse pa chisamaliro chomwe azamba amakupatsani kapena momwe amakulandilirani ndi chomwe anamwino/madokotala amapereka mukapita kuchipatala?

e- **How do you feel when you meet TBAs or talk to them? What do you think of them?**

Kodi mumamva bwanji mukakumana ndi azamba kapena mumaganiza zotani zokhudzana ndi iwowa?

f- **How do you feel when you meet midwives or nurses, doctors or talk to them? What do you think of them?**

Kodi mumamva bwanji mukakumana ndi adokotala/anamwino kapena mumaganiza zotani zokhudzana ndi iwowa?

3- LINKAGES BETWEEN TBAs AND DOCTORS/ MIDWIVES

a- **Have you or women you know ever been accompanied to hospital by a TBA ? Why or why not?**

Kodi mukudziwa amayi alionse omwe adapelekedwa ndi a zamba kuchipatala, ndipo chifukwa chani adawapelekeza/sadawapelekeze?

- **How were you and the TBA welcomed by the midwife or nurse?**

Kodi mukapita kuchipatala ndi azambawo anamwino amakulandirani bwanji?

b- **What do you think doctors/ midwives/ nurses and TBAs think about each other?**

Kodi magulu awiriwa amawonana/kuganizilana chiyani pantchito zawo?

c- **In your area are there contacts (linkages) between doctors/nurses/midwives and TBAs?**

Kodi pali kulumikizana kulikonse kapena kukumana pakati pa madokotala/ achipatala ndi azamba?

- **What contacts?**

Kukumana kwake ndikotani?

d- **Do you think there should be more contacts (linkages) between doctors/ midwives and TBAs ?**

Kodi ndikoyenela patakhala kulumikizana/kukumana kowonjezera pakati pa azamba ndi achipatala?

- a. **How could this work?**

Mgwirizano/ kukumana kwake kungamayende bwanji?

e- **What do you think should be the role of TBAs in future?**

Kodi mukuganiza kuti udindo wa azamba ukuyenela kukhala wotani kutsogolo kuno?

f- **Do you think in 20, 30 years there will still be TBAs?**

Mukuganiza kuti zaka 20 kapena 30 zikubwerazi azambawa adzakhala akupezekabe/ kugwirabe ntchito yawo?

MEN

1- GENERAL QUESTIONS

a- **Where do women go to here when they are in labour or pregnant?**

Kodi amayi akudela lino amapeza kuti thandizo matenda akayamba?

- **b- Has there been any changes in the past few years?**

Kodi izi zakhala zikusintha?

c- **Where do you think is best for women to give birth? Why?**

Mukuganiza kuti malo abwino kubelekela/kuchilira mwana ndi ati? Chifukwa chiyani?

2- THE WORK OF TBAs AND THE WORK OF DOCTORS/ MIDWIVES

a- **What does a doctor/ midwife/ nurse do to help women when they are pregnant or in delivery?**

Kodi madotolo and anamwino amagwila ntchito yanji kwa amayi panthawi yakuyembekezela komanso pobeleka

b-What does a TBA do to help women when they are pregnant?

Nanga azamba amathandiza bwanji amayi pamene akuyembekezela

g- Do you think there is a difference between the care TBA give women and the care they get from doctors, nurses or midwives? What is the difference?

Kodi mukuganiza kuti pali kusiyana kulikonse pachisamalo chimene inu a zamba kapena madotolo/Anamwino amapeleka kwa amayi matenda akayamba, ndipo kusiyanako nkuti?

h- And Do you think there is a difference between the way TBA welcome and handle the women and the way nurses or midwives do it at the hospital? What is the difference?

Mukuona ngati pali kusiyana kulikonse pa chisamaliro chomwe azamba amakupatsani kapena momwe amakulandilirani ndi chomwe anamwino/madokotala amapereka mukapita kuchipatala?

i- How do you feel when you meet TBAs or talk to them? What do you think of them?

Kodi mumamva bwanji mukakumana ndi azamba kapena mumaganiza zotani zokhudzana ndi iwowa?

j- How do you feel when you meet midwives or nurses, doctors or talk to them? What do you think of them?

Kodi mumamva bwanji mukakumana ndi madokotala/anamwino, mumaganiza zotani zokhudzana ndi iwowa?

3- LINKAGES BETWEEN SBAs AND DOCTORS/ MIDWIVES/ NURSES

a- Have you or other men ever accompanied expecting women to the hospital when in labour? Why?

Kodi mudayamba mwapelekeza amayi oyembekezera kuchipatala matenda atayamba ? Chifukwa chiyani?

- **How were the woman and the TBA welcomed by the midwife or nurse?**

Kodi mukapita kuchipatala ndi azambawo anamwino amakulandirani bwanji?

b- What do you think doctors/ midwives/ nurses and TBAs think about each other?

Kodi magulu awiriwa, amawonana/kuganizilana chiyani pantchito zawo

c- In your area are there contacts (linkages) between doctors/nurses/midwives and TBAs?

Kodi pali kulumikizana kulikonse kapena kukumana pakati pa madokotala/ achipatala ndi azamba?

- **What contacts?**

Kukumana kwake ndikotani?

d- Do you think there should be more contacts (linkages) between doctors/ midwives and TBAs ?

Kodi ndikoyenela patakhala kulumikizana/kukumana kowonjezera pakati pa azamba ndi achipatala?

- **How could this work?**

Mgwirizano/ kukumana kwake kungamayende bwanji?

e- What do you think should be the role of TBAs in future?

Kodi mukuganiza kuti uundo wa azamba ukuyenela kukhala wotani kutsogolo kuno?

f- Do you think in 20, 30 years there will still be TBAs?

Mukuganiza kuti zaka 20 kapena 30 zikubwerazi azambawa azakhala akupezekabe/kugwirabe ntchito yawo?

TBAs- TRADITIONAL BIRTH ATTENDANTS

1- THE WORK OF AZAMBA

a- How did you learn your skills as a TBA (azamba)?

Kodi luso lanu la Zamba mdalipeza bwanji?

- **How long have you been azamba?**

Ndi nthawi yaitali bwanji mwakhala mukugwira ntchito ya uzamba?

b- Around here, where do women go when they are pregnant or to deliver? Why?

Kodi kudela lino amayi oyembekezera amapeza kuti chinhandizo pobeleka/oyembekezera ndipo chifukwa chain?

- **Has there been any changes in the past few years?**

Kodi pakhala pali kusintha kwina kulikonse pa zaka zingapo zapitazi?

c- Do women still come to you for help in delivery? When do they come to you? What do you do for these women?

Kodi amayi amabwelabe kwainu kufuna chithandizo? Kodi amayiwa mumawathandiza bwanji?

- **Are there time you need to refer women to the hospital? Why?**
Ilipo nthawi ina yomwe mumatha kuwalozera amayiwa kuchipatala, ndipo chifukwa chani?
- **How many women do you see in a week now? Is it different from before?**
Pasabata imodzi mumakumana ndi azimayi angati ndipo pali kusiyana kulikonse ndi m'mbuyomu?
- **How many for delivery?**
Angati wodzabeleka?
- **If you deliver a baby now, are there consequences? do you need approval to deliver a woman?**
Mukabeleketsa mwana panopa, mumakuna ndi mavuto ena aliwonse? Mukufunika kutenga chilolezo kuti muchite izi?
- **What other pregnancy things do you give help on? How many do you see for help on other things?**
Zinthu zina zokhudzana ndi uchembere zomwe mumapereka ndi chani ndipo ndi anthu angati omwe amabwera kudzafuna thandizoli?

d- Where do you think is best for women to give birth? Why?

Kodi mukuganiza kuti malo abwino kuchilira amayi ndiwati? Chifukwa chiyani?

2- TBAS ENCOUNTERS WITH SBAs

- a- **If you have to refer a woman to the health centre or hospital, do you go with them? Why or why not?**
Ngati mwamulozera mayi kuchipatala, mumatha kumupelekeza? Chifukwa chani/sichifukwa chani?
- **How are you welcomed by the midwife or nurse? Do you see them at the hospital?**
Mumalandilibwa bwanji ndi anamwino?
- b- **Have you had contacts with doctors, midwives, nurses in the past? What kind of contacts?**
Panali kukumana/ngwirizano uliwonse pakati pa inu azamba ndi achipatala? Ndipo ngwirizanowo umakhudzana ndi chani?
- **What about now, do you have contacts with them?**
Nanga panopa ngwirizanowo/kukumanako kulipobe?

3- TBAS VIEW ON THEIR ROLE AND SBAS ROLE IN HELPING WOMEN

- a- **Do you think there is a difference between the care you give women and the care they get from doctors, nurses or midwives? What is the difference?**
Kodi mukuganiza kuti pali kusiyana kulikonse pachisamalo chimene inu a zamba kapena madotolo/Anamwino amapeleka kwa amayi matenda akayamba? Kusiyanako nkotani?
- b- **Do you think there is a difference between the way you welcome and handle the women here and the way nurses or midwives do it at the hospital? What is the difference?**

Mukuona ngati pali kusiyana kulikonse pa chisamaliro chomwe inuyo azamba mumapeleka kapena momwe mumalandilira amayi ndi chomwe anamwino/madokotala amapeleka mukapita kuchipatala?

a- How do you feel when you meet midwives, nurses or doctors, or talk to them? What do you think of them?

Kodi mumamva bwanji mukakumana ndi madokotala/anamwino kapena mumaganizira zotani zokhudzana ndi iwowa?

c- Do you think there should be more contacts between TBAs and the doctors/nurse/midwives?

Kodi ndikoyenela patakhalala kukumana koposa apa?

• *How could this work?*

Kukumana kumeneko kungakhale bwanji

d- Are you happy with your new role? Do you miss what you used to do as azamba?

e- What do you think should be your role in the future?

Kodi udindo wanu mukuwona kuti udzakhale wotani kutsogoloku?

f- Do you think in 20, 30 years there will still be TBAs?

Mukuganiza kuti zaka 20 kapena 30 zikubwerazi azambawa adzakhala akupezekabe/kugwirabe ntchito yawo?

SBAs- SKILLED BIRTH ATTENDANTS

1- THE WORK OF SBAs

a- How did you learn your skills as doctor/midwife/ nurse?

b- What do you do for women who are pregnant or in delivery? How long have you done it?

c- Around here, where do women go when they are pregnant or in delivery?

• Has there been any changes in the past few years?

d- Where do you think is best for women to give birth? Why?

2- SBAS ENCOUNTERS WITH TBAS

b- Do TBAs in this area refer women to the health centre or hospital? When?

• Have you had contacts with TBAs who came in with a woman they referred to the health centre/ hospital?

c- Do you sometimes meet TBAs in the work you do in other ways? (*how? When? Was it different in the past?*)

d- How do you feel when you meet TBAs or talk to them? What do you think of them?

3- SBAS VIEW ON TBAS ROLE & LINKAGES

b- Do you think there is a difference between the care you give women and the care they get from TBAs? What is the difference?

c- Do you think there is a difference between the way you welcome and handle women here and the TBAs do it? What is the difference?

d- In your area are there contacts (linkages) between doctors/nurses/midwives and TBAs?

- *What contacts?*

e- Do you think there should be more contacts (linkages) between doctors/ midwives and TBAs ?

- *How could this work?*

f- What do you think should be the role of TBAs in future?

g- Do you think in 20, 30 years there will still be TBAs?

HSAs-HEALTH SURVEILLANCE ATTENDANTS

THE WORK OF HSAs

e- **What do you do for women who are pregnant?**

Kodi mumawathandiza bwanji amayi akamayembekezera ngakhalenso matenda akayamba?

f- **Around here, where do women go when they are in labour or to deliver?**

Kodi amayi amapeza kuti thandizo matenda akayamba komanso pochila?

- **Has there been any changes in the past few years?**

Kodi pakhala pali kusintha kwina kulikonse pa zaka zingapo zapitazi?

g- **Where do you think is best for women to give birth? Why?**

Mukuganiza kuti malo abwino kubelekela/kuchilira mwana ndi ati? Chifukwa chiyani?

HSAs ENCOUNTERS WITH TBAS

a- **Do you have contacts with TBAs in the work you do?**

Kodi mumalumikizana ndi azamba pogwila ntchito yanu?

- **What kind of contacts?**
Kukumana kwanu nkotani?

b- Do TBAs in this area refer women with to the health centre/ clinic/ hospital? Why?

*Kodi azamba akuno amatumiza amai oyembekezera kuchipatala?
Nanga ndipazifukwa ziti?*

c- How do you feel when you meet TBAs or talk to them? What do you think of them?

Kodi mumamva bwanji mukakumana ndi azamba kapena mumaganiza zotani zokhudzana ndi iwowa?

HSAs VIEW ON TBAS ROLE & LINKAGES with SBAs

a- What do you think doctors/ midwives/ nurses and TBAs think about each other?

Kodi magulu awiriwa amawonana/kuganizilana chiyani pantchito zawo?

b- In your area are there contacts (linkages) between doctors/nurses/midwives and TBAs?

Kodi pali kulumikizana kulikonse kapena kukumana pakati pa madokotala/ achipatala ndi azamba?

- **What contacts? Kukumana kwake ndikotani?**

c- Do you think there should be more contacts (linkages) between doctors/ midwives and TBAs?

Kodi ndikoyenela patakhala kulumikizana/kukumana kowonjezera pakati pa azamba ndi achipatala?

- **How could this work? Mgwirizano/ kukumana kwake kungamayende bwanji?**

d- What do you think should be the role of TBAs in future?

Kodi mukuganiza kuti udindo wa azamba ukuyenela kukhala wotani kutsogolo kuno?

e- Do you think in 20, 30 years there will still be TBAs?

Mukuganiza kuti zaka 20 kapena 30 zikubwerazi azambawa adzakhala akupezekabe/ kugwirabe ntchito yawo?

VHs-VILLAGE HEADPERSONS

1- THE WORK OF VHS

a- What is your role regarding pregnant women or women in labour in your area?

b- Around here, where do women go when they are in labour or to deliver?

Kodi amayi amapeza kuti thandizo matenda akayamba komanso pochila?

- **Has there been any changes in the past few years?**

Kodi pakhala pali kusintha kwina kulikonse pa zaka zingapo zapitazi?

c- Where do you think is best for women to give birth? Why?

Mukuganiza kuti malo abwino kubelekela/kuchilira mwana ndi ati? Chifukwa chiyani?

2- VHs ENCOUNTERS WITH TBAS

a- What is your role regarding the TBAs in your area?

b- What do you think is the role of TBAs nowadays? What do they do for pregnant women now?

c- Do TBAs in this area refer women with to the health centre? Why?

Kodi azamba akuno amatumiza amai oyembekezera kuchipatala? Nanga ndipazifukwa ziti?

d- How do you feel when you meet TBAs or talk to them? What do you think of them?

Kodi mumamva bwanji mukakumana ndi azamba kapena mumaganiza zotani zokhudzana ndi iwowa?

3- VHs VIEW ON THE WORK & LINKAGES of TBAs with SBAs

a- Do you think there is a difference between the care TBA give women and the care they get from doctors, nurses or midwives? What is the difference?

Kodi mukuganiza kuti pali kusiyana kulikonse pachisamalo chimene a zamba kapena madotolo/Anamwino amapeleka kwa amayi matenda akayamba, ndipo kusiyanako nkuti?

b- And Do you think there is a difference between the way TBA welcome and handle the women and the way nurses or midwives do it at the hospital? What is the difference?

Mukuona ngati pali kusiyana kulikonse pa chisamaliro chomwe azamba amakupatsani kapena momwe amakulandilirani ndi chomwe anamwino/madokotala amapereka mukapita kuchipatala?

a- What do you think doctors/ midwives/ nurses and TBAs think about each other?

Kodi magulu awiriwa amawonana/kuganizilana chiyani pantchito zawo?

b- In your area are there contacts (linkages) between doctors/nurses/midwives and TBAs?

Kodi pali kulumikizana kulikonse kapena kukumana pakati pa madokotala/ achipatala ndi azamba?

- **What contacts? Kukumana kwake ndikotani?**

c- Do you think there should be more contacts (linkages) between doctors/ midwives and TBAs?

Kodi ndikoyenela patakhala kulumikizana/kukumana kowonjezera pakati pa azamba ndi achipatala?

- *How could this work? Mgwirizano/ kukumana kwake kungamayende bwanji?*

d- What do you think should be the role of TBAs in future?

Kodi mukuganiza kuti udindo wa azamba ukuyenela kukhala wotani kutsogolo kuno?

e- Do you think in 20, 30 years there will still be TBAs?

Mukuganiza kuti zaka 20 kapena 30 zikubwerazi azambawa adzakhala akupezekabe/ kugwirabe ntchito yawo?

OMS-OTHER MAIN STAKEHOLDERS

GENERAL QUESTIONS:

- What is your role regarding pregnant women/ safe motherhood?
- How long have you been doing that work? Have you seen any changes?

THE WORK OF SBAs & TBAs

- In Malawi today where do women go for help when they are pregnant or in birth? Why?
- Has this changed over time?
- Where do you personally think women should deliver? Why?

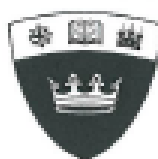
MAIN STAKEHOLDER VIEW ON TBAS CHANGING ROLE & POLICY CHANGES

- What is the role of TBAs today in supporting pregnant women and women in labour in Malawi?
- What is your personal opinion of the changes in policy regarding the role of TBAs in Malawi over time?
- Do you personally meet TBAs in your work? How do you feel when you meet them?

2- LINKAGES TBAs/SBAs

- Do you think there is a difference between the care TBAs give women and the care they get from doctors, or midwives in hospitals, health centres or clinics? *What is the difference?*
- Do you think there is a difference between the way TBA welcome and handle the women and the way nurses or midwives do it at the hospital? *What is the difference?*
- What do you think doctors/ midwives/ nurses and TBAs think about each other?
- Do you think there are linkages or contacts between doctors/nurses/midwives and TBAs today? *What links?*
- Do you think there should be more linkages or collaboration between doctors, midwives and TBAs? *How could this work?*
- What do you personally think should be the role of TBAs in the future?
- Do you think in 20, 30 years there will still be TBAs? *Why or why not?*

Appendix 5: Ethical approval letters (QMU and NHSC Malawi)



Queen Margaret University

EDINBURGH

Name: Isabelle Uny
Status: PhD Student
Subject Area: IHHD
School: Health Sciences

Lucy Clapson
Registry Officer
Queen Margaret University
Queen Margaret University Drive
Musselburgh
East Lothian EH21 6UU

Tel: 0131 474 0000
Email: lclapson@qmu.ac.uk

18 October 2012

Dear Isabelle

Ethical Approval – Exploring the perceived role of Traditional Birth Attendants in maternal health in Malawi

Thank you for your response to the letter that I sent you following consideration of your application by the Research Ethics Panel.

Dr Jane McKenzie, Convener of the Panel, has reviewed your response to the points you were required to address, and has confirmed that she is happy to take Convener's Action to grant full ethical approval for your research.

A standard condition of this ethical approval is that you are required to notify the Panel, in advance, of any significant proposed deviation from the original protocol. Reports to the Committee are also required once the research is underway if there are any unexpected results or events that raise questions about the safety of the research. Please find the appropriate form for this enclosed.

We would like to thank you for your co-operation and wish you well with your project.

Yours sincerely

A handwritten signature in black ink, appearing to be 'LC'.

Lucy Clapson
Secretary to the Research Ethics Panel

**QUALITY ENHANCEMENT UNIT
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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

21st December 2012

Isabel UNY
Queen Margaret University

Dear Sir/Madam,

RE: Protocol # 1113: Exploring the perceived role of Traditional Birth Attendants in maternal health in Malawi

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has reviewed and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER** : NHSRC #1113
The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : 21/12/2012
- **EXPIRATION DATE** : This approval expires on 20/12/2013
After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** : All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on Telephone No. (01) 789314, 08388957 or by e-mail on doccentre@malawi.net
- **Other**:
Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.

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FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: Dr.C.Mwanzambo (Chairman), Prof M(fiso) Bango (Vice Chairperson)
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00003905 FWA00002976)

Appendix 6: Example of an advanced memo

Category: Being between concordance, compliance and no-compliance with the Policy
(09/06/2016)

Being between concordance, compliance and non-compliance with the Policy is about the varying degrees of compliance with the course of action recommended by the 2007 policy Guidelines. It is related to more intrinsic factors (how community participants perceive the policy, how they resist it or resent it). Here I am borrowing from the language of medicine taking to apply it to policy implementation:

- **compliance** = "*The action or fact of complying with a wish or command*" " The following by a patient of a recommended course of treatment—e.g., taking all prescribed medications, adhering to a recommended diet and exercise plan
- **concordance**= in agreement "*A negotiated, shared agreement between clinician and patient concerning treatment regimen(s), outcomes, and behaviors; a more cooperative relationship than those based on issues of compliance and noncompliance.*

Concordance is different, here it is related to whether or not women and other actors like TBAs are in agreement with the spirit of the Policy, even that the strategies proposed are the best one (e.g. the hospital is the safer, better option). It appears that most participants are in concordance (save maybe TBA14, who is also resisting the implementation of the Policy, she is a deviant case as far as compliance is concerned; her relationship to other TBAs who comply with the ban requires exploration).

Participants maybe in concordance with the policy but not necessarily compliant with it, for a number of reasons. It may be that the barriers that stand in their way (geographical or economic etc) prevent compliance. It appears to be also that some of the participants (particularly women and TBAs) are opting for non-compliance (and the secrecy of that act; which requires further exploration; participants do not wish to express their non-compliance, because of the fines). TBA07 is at the other end of the compliance spectrum, ultra-compliant with her redefined roles, does that mean she is better treated, does that mean she is more valued? Or her skills?

For the TBAs compliance depends also about their being '*stuck between a rock and a hard place*'. This subcategory has come out of the feeling I have had in interviews with TBAs that their redefined roles puts them in a difficult if not impossible position regarding potential compliance with their new roles. On the one hand they have been banned from delivering and only are supposed to give advice or refer to hospital women for ANC and deliveries; however on the other hand yet women do come to them in pleas for help (owing to different socio-cultural and economic factors, see Chanza article). *If they do not comply and* If they assist women with deliveries (without prior Chief approval, in some areas), they risk fines which they do not have money to pay, and the bad press from hospital personnel. *However if they* If they reject women and refuse to give help, as per their defined roles they risk women scolding them, blaming them for what problems they may incur at home deliveries, or

saying they are unkind. This leaves TBAs feeling torn, they can be shunned by the community whom does not fully understand or accept that they cannot help. The way TBAs speak in interviews and FGDs convey some feeling that they are helpless, at the mercy of what the Government (the top) . There is uncertainty about their future (it feels like either way it is out of their hands). With some the way they describe their compliance with their new roles sounds more like resignation than acceptance.

(this memo was later extended and developed for the final writing)