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CLINICAL ARTICLE

Experiences and beliefs of Malawian women who have delivered with a traditional birth attendant

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ABSTRACT

Objective: To explore the beliefs and experiences of Malawian women who have delivered with a traditional birth attendant (TBA). *Methods:* In a qualitative study, 20 face-to-face in-depth interviews and three focus group discussions were conducted between February and May 2013. Women aged 18 years or older and who had a history of delivery with a TBA were recruited from three health centers in Lilongwe District. Their responses were independently coded, and content analysis was used to develop themes and subthemes. *Results:* A total of 46 women participated. Most participants cited difficulties relating to transport and/or unsupportive or unavailable husbands as factors that prohibited their delivery at a health facility. Most had not had a specific delivery plan. The participant responses indicated a discordance between knowledge and practices for safe delivery. *Conclusion:* Strategies to decrease deliveries with TBAs should focus on helping women to develop delivery plans to cope with the potential social or situational obstacles of getting to a facility. Women desire health facilities that provide quality care, emotional support, and personalized care during labor and delivery.

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1. Introduction

Malawi has one of the highest rates of maternal and neonatal mortality in the world. In 2010, the maternal mortality ratio was estimated at 675 deaths per 100 000 live births, and the neonatal mortality ratio was 31 deaths per 1000 live births [1]. Traditional birth attendants (TBAs) are community-based providers of care during pregnancy, childbirth, and the postnatal period who operate independently of the health system and are not formally trained [1]. Rates of obstetric complications and maternal and perinatal death are higher when TBAs attend delivery than when skilled birth attendants are present [2]. However, the 2010 Malawi Demographic Health Survey [1] showed that, although 95% of pregnant women received prenatal care with a skilled birth attendant, only 73% delivered in a health facility. A TBA was present for 14% of women, and the remaining 13% delivered with a patient attendant, a relative/friend, or alone [1,3]. Therefore, in 2012, Malawi set the target that 85% of pregnant women should receive skilled care at delivery by 2015 [4].

The primary objective of the present qualitative study was to explore the beliefs and experiences of Malawian women who had delivered with a TBA. The goal was to better understand the factors that lead women to deliver with a TBA rather than at a health facility, with an eye to facilitating the implementation of interventions that reduce the frequency of deliveries with TBAs.

2. Materials and methods

The present study was a qualitative investigation of women aged 18 years or older who had a history of any delivery with a TBA. Purposive sampling was used for participant recruitment at three health centers—Kawale Health Center, Area 25 Health Center, and Area 18 Health Center—in Lilongwe City in central Malawi. In 2013, these three health centers served 15% of all women who attended prenatal visits in Lilongwe District [5]. Approval for the present study was granted by the National Health Science Research Committee (NHSRC) in Malawi. All participants provided informed consent by signing the NHSRC-approved consent form in Chichewa (the local language); those who were illiterate provided a thumbprint.

The participants were recruited from the prenatal clinics, antiretroviral therapy clinics, and under-5 clinics of the three health centers. Research assistants and health facility staff sensitized women to the study through announcements, and women who were interested would seek further information from the research assistants. Nurses at each facility also referred interested and eligible women to the research assistants. Pregnant women attending these clinics can choose to deliver at their local health center or the Lilongwe District maternity hospital, also known as Bwaila Hospital.

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An iterative process was used to develop an interview guide (Supplementary Material S1) for in-depth interviews and focus group discussions. During study design, it was determined that approximately twenty face-to-face in-depth interviews and three focus group discussions would be needed to reach data saturation. All interviews and focus groups were conducted in Chichewa between February 1 and May 31, 2013. The interviews and focus group discussions took place in a private area at the health center from which the participants were recruited. The in-depth interviews were completed and analyzed before recruitment for the focus group discussions began, so that information from the interviews could be used to inform the guide for focus group discussions. The in-depth interviews were performed by a research assistant, whereas the focus group discussions were led by G.H. and N.C. All interviews were recorded with a digital recorder, transcribed, and translated into English for analysis. One of the authors (G.H.) performed quality assurance checks of the interviews to ensure that they were being correctly transcribed and translated.

After every three to five in-depth interviews and after each focus group discussion, the authors met as a group to discuss emerging themes for further exploration, amending the interview guide as needed. Basic demographic and reproductive health data were also collected.

Responses from the interviews were independently coded using content analysis by two study authors (J.R. and G.H.), after which J.R. developed a codebook on the basis of the codes. The investigators then all met to discuss the codes and to develop themes and subthemes. Analysis focused on three domains: reasons for delivery with a TBA, experiences during the delivery with a TBA, and finding solutions to reduce or eliminate future deliveries with a TBA.

3. Results

A total of 46 women participated. Seven in-depth interviews were conducted at both the Area 25 and Area 18 Health Centers, and six were conducted at Kawale Health Center. The focus group discussions included 10 participants at Area 25, six participants at Kawale, and 10 participants at Area 18.

Most participants were aged 26–35 years, and had completed primary school (Table 1). All but six women were multiparous, and 31 of the 46 women had three or more living children. Although the present study focused on deliveries with a TBA, many participants had also delivered at a health facility, but they were not asked whether the deliveries with TBAs had occurred before or after their deliveries at the health facilities.

All participants reported attending at least one prenatal visit at a health facility during their pregnancy that ended with delivery by a TBA, despite the fact that they faced significant difficulties with transportation. Most women walked or took one or several minibuses, at times in combination with a bicycle hire, to get to their nearest health center. In addition to living at what they described as a long distance from a health center, the challenges the women encountered during childbirth included going into labor in the middle of the night when it was difficult to find transport, delaying going to the hospital for too long, and an inability to afford travel costs. Several participants also reported facing other transport barriers. One woman (aged 35 years, five living children, three deliveries with TBAs) did not leave her village because the operation of minibuses had been halted because of political and economic instability when she needed to get to a facility.

When asked whether they had a feasible plan for where they would deliver their children, many women explained how both a lack of money and a poor understanding of labor interfered with their intention to deliver at a health facility. For example, one woman (aged 20 years, two living children, one delivery with a TBA) explained that she did not recognize the signs of labor, which, coupled with a lack of financial resources, led to her unplanned delivery with the TBA. Many participants who had intended to deliver at a health facility did not plan how they would overcome the logistical barriers and had no backup plans or money.

Apart from transportation difficulties, many women faced complex challenges in terms of male involvement in their pregnancies and deliveries. Five women who participated in in-depth interviews explicitly mentioned their partner's absence and/or an avoidance of responsibility on his part when asked why they delivered with the TBA. One woman

Table 1
Demographic and reproductive health characteristics of the participants (n = 46).[a]

Characteristic	Value
Age, years	29 (20–40)
18–25 years	15 (33)
26–34 years	28 (61)
≥35 years	3 (7)
Tribe	
Chewa	22 (48)
Tumbuka	2 (4)
Ngoni	10 (22)
Yao	6 (13)
Lomwe	2 (4)
Mang'anja	2 (4)
Tonga	1 (2)
Sena	1 (2)
Marital status	
Married	42 (91)
Widowed	1 (2)
Divorced/separated	3 (7)
Religion	
Christian	42 (91)
Muslim	1 (2)
Traditional African	2 (4)
No religion	1 (2)
Education	
None	2 (4)
Primary school	36 (78)
Secondary school	8 (17)
Occupation	
Farmer	8 (17)
Housewife/caretaker	23 (50)
Owner of a small business	13 (28)
Civil servant/teacher	2 (4)
Number of pregnancies	
1	5 (11)
2	6 (13)
3–5	28 (61)
6–7	7 (15)
Number of stillbirths	
0	41 (89)
1	3 (7)
2	2 (4)
Number of living children	
1	6 (13)
2	9 (20)
3–5	30 (65)
6	1 (2)
Number of deliveries with a TBA[b]	
1	28 (72)
2	10 (26)
3	1 (3)
Number of women who had also delivered at a health facility	
Yes	39 (85)
No	7 (15)
Age of youngest child delivered by a TBA[c]	
Stillbirth	2 (7)
<1 year	6 (21)
1–2 years	6 (21)
>6 years	15 (54)
Age at first birth	
≤14 years	2 (4)
15–19 years	24 (52)
20–35 years	20 (43)

Abbreviation: TBA, traditional birth attendant.
[a] Values are given as mean (range) or number (percentage).
[b] Percentages do not add up to 100% because of missing data.
[c] Numbers do not add up to 46 because of missing data.