

Factors that Affect Maternal Care Seeking Behaviour and the Choice of Practitioner(s) during Complications: the Case of Mang'anja Tribe in Malawi

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Abstract

Despite the high prevalence rate of maternal mortality coupled with under-utilisation of health services, little attempt has been made in Malawi to explore and document people's understanding and beliefs about causes and appropriate treatment of the major complications that are medically believed to be the causes of maternal deaths. Any difference between the insider's and the biomedical perceptions of what is a serious maternal complication is dangerous because it may delay seeking of lifesaving care. This study was therefore, designed to elicit and explore the local explanatory associated with the major biomedical cause of maternal mortality (haemorrhage) among Mang'anja tribe in Malawi and how these influence care seeking behaviour. Descriptive qualitative research design was adopted and data was collected using Kleinman's 'explanatory model interview guide' from 25 respondents. The findings generally suggest that being aware of maternal danger signs is not enough to provoke a trip to the appropriate healer. Since it is the cause not the effect of the maternal complications that determines care seeking, a shift in approach of health education provided to pregnant women is recommended.

Keywords: Malawi, maternal health, explanatory model, care seeking, haemorrhage

1. Introduction

In response to the high level of avoidable maternal deaths (500, 000 per year), the Safe Motherhood Initiative (SMI), "a global effort to reduce maternal mortality [by] half by the year 2000" was launched over 20 year ago (1987) by the World Bank and two United Nations (UN) agencies (SMI, 2007). The SMI is generally driven by four major pillars: provision of family planning, high quality antenatal care (ANC), clean and safe delivery, and essential obstetric care (SMI, 2007). Although progress has been noticed in some of these pillars, overall, the SMI still failed to achieve the goal it set (ibid). In 2000, the UN reaffirmed its desire to improve the lives of people around the world with the setting of Millennium Development Goals (MDGs). Goal five has similar intentions as SMI only that its target is to reduce the maternal mortality ratio (MMR) by 75% between 1990 and 2015. But with only less than three years to go, there is little hope that this goal will be realised as not enough progress has been registered (UN, 2010; 2011).

Although maternal mortality is unacceptably high in almost the whole developing world, sub Saharan Africa is the most affected area with over half of the deaths occurring in the region (UN, 2011). Malawi is one of the sub Saharan countries with high maternal mortality ratio (MMR). According to the 2010 Malawi Demographic and Health Survey (MDHS), the country's MMR stood at 675 per 100,000 live births, which is well above the average MMR for sub Saharan Africa. In its quest to reduce maternal deaths, the government of Malawi through the Ministry of Health is strongly committed to both SMI and MDG5. In addition, the 'Road Map for Accelerating the Reduction of Maternal and Newborn Mortality and Morbidity in Malawi' was drawn up in 2005 to accelerate the attainment of the MDG5.

Despite these efforts by the government and other stakeholders to improve the quality and accessibility of maternal health care services, it has been noted that their utilisation in Malawi remains very low. For instance, MDHS (2010) documented that only about 46% of pregnant women fully patronise ANC, over 30% of deliveries are still conducted outside health facilities and about 48% of women don't receive the much needed postnatal care. The implication of this is that the said efforts are not yielding the intended results of reducing maternal mortality. For instance, against several government and stakeholder commitments, MMR increased in Malawi from 620 in 1992 to around 1000 between 1996 and 2004 (National Statistic Office [NSO], 2000; 2010). It is not fully known why many pregnant women don't seek biomedical care but one recognisable fact is that little or no attention has been given to how women in specific cultures in Malawi perceive or define medical obstetric problems. White (2002) noted that "in some settings, the difference between the emic, or cultural insider's perception, and the biomedical perception of what is a serious obstetrical problem may delay lifesaving care". This study therefore wanted to elicit and explore local understanding (explanatory model) associated with one of the major biomedical causes of maternal mortality in Malawi (haemorrhage) and how these influence care seeking behaviour. More specifically, the study wanted to (1) examine how people view the state of being

pregnant, (2) establish the local perception of haemorrhage and (3) understand the type(s) of maternal care sought during complications and why.

2. Theoretical base

2.1. Explanatory model

Kleinman (1980) articulated one of the most important and popular concept in medical anthropology called 'explanatory model' (EM), which basically reveals how people make sense of their ill-health. Formally defined as "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (Kleinman, 1980, p.105), the concept generally scrutinizes how patients interpret the cause and progress of the illness and how they think it should be treated. Explanatory models (EMs) are held by both patients and practitioners, and they provide their perception of ill-health in terms of: the cause of the illness; why it has occurred; what the condition does to the body and the appropriate treatment (Winkelman, 2009). The EM approach recognises the importance of patients' personal views of their health problem in diagnosing as well as treating illnesses.

2.2. Illness causation

When conceptualising their EMs, patients usually ascribe the aetiology of their ill-health to various objects or people. On top of the biomedical paradigm, which attributes the aetiology of malady to germs and or bio-physiological changes in the body (Winkelman, 2009); Helman (1990) describes four other theories of illness causation, which ascribe ill-health to the following: firstly, the individual patient. For instance, the individual is blamed for not taking good care of his/her diet, hygiene, smoking and others. Secondly, ill-health is attributed to the natural world; in particular, the environmental factors like climatic conditions (i.e. excessive cold). Thirdly, the aetiology is sometimes placed in the social world. Blame here is put on sorcery, witchcraft and others. The supernatural world is not spared; ill-health can also be caused by direct actions of supernatural entities like gods and spirits. For instance, illness is seen as a divine punishment for sinful behaviour. Helman noted that these theories are not mutually exclusive but he is silent on how the illnesses are specifically ascribed to various causes.

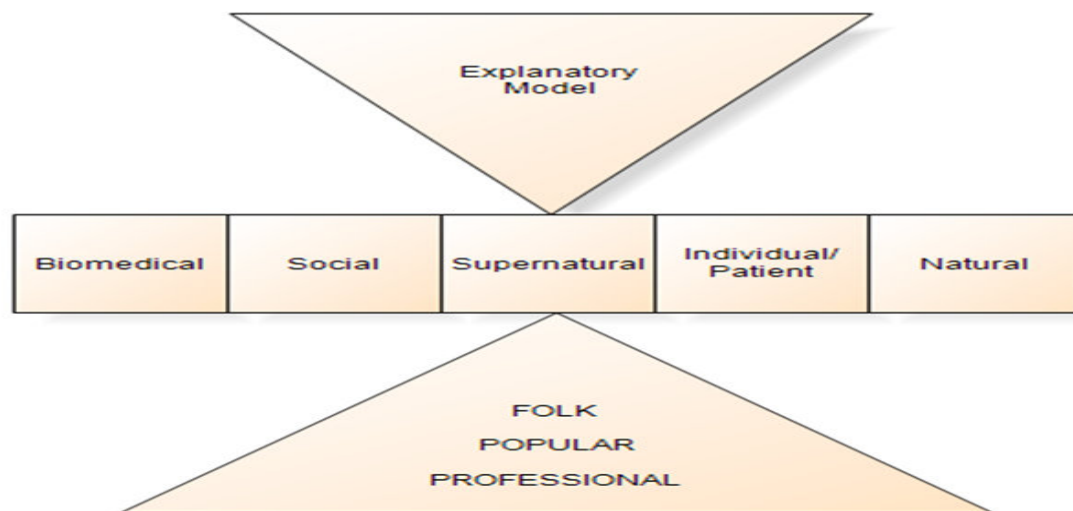


Figure 1: Conceptual framework showing that it is the EM that determines the aetiology of ill-health, which, in turn, dictate the appropriate type (s) of care.

3. Methods

3.1. Setting of the study

The fieldwork for this study was conducted among Mang'anja ethnic group in Chikhwawa, Malawi. Malawi is located in the southern part of Africa. It is bordered to the north by Tanzania; to the south by Mozambique; and to the west by Zambia. The country is divided into three regions (north, central and south) which are further partitioned into 28 districts. It has the population of around 14 million of which about 85% stay in the rural area (NSO, 2008; DHS, 2010). Chikhwawa district is mainly composed of Mang'anja (60%) and Sena (30%) ethnic groups and it has one of the worst maternal health indicators in Malawi. Mang'anja as a group was chosen because it is the largest tribe in the area. No specific villages were chosen in the district; the setting was simply defined by the presence or absence of the concerned ethnic group members and not geographically.

3.2. Study design

In order to elicit explanatory models from respondents, a qualitative research design was preferred (David and Sutton, 2011). Interview guides, which were designed based on Arthur Kleinman's 1978 interview guide, were developed. The guides basically elicited three main themes about the maternal complications from the patient's perspective: what causes it, how it affects them, and the possible treatment. More specifically, respondents were asked about their views about haemorrhage which is the main cause of maternal deaths in Malawi and many other developing countries (Geubbel, 2006; UN 2010, 2011). In-depth interviews were the only tool that was used to collect data. The choice of this tool was purely on methodological grounds. Firstly, by its nature, the Kleinman's explanatory model interview guide fits well with in-depth Interviews. In addition, the aim of the research was to elicit individual explanatory models and that automatically fits well with in-depth interviews, which are also good at drawing out an individual perspective of an issue (Bryman, 2001).

Data was collected in July 2012 (three weeks) and Dec - Jan 2013 (four weeks) in the same area. Participants were mainly women who have at least one child. In particular, the respondents were ten pregnant women, ten old women, three traditional birth attendants and two traditional healers. The age range of the respondents ranged from 15 to 55 years. Participants were purposefully recruited and interviewed in their villages. All the interviews were done in the main local language (Chichewa).

3.3. Data management

All the interviews were transcribed and translated to English. The Nvivo qualitative data analysis software was used throughout the data analysis process. All the transcripts were first transferred to Nvivo and read in great detail in order to identify any recurrent pattern. All items relating to the same topic were coded to similar nodes. This was followed by axial coding, which connect the substantive codes above (Punch, 1998). Analytical activities were conducted in a circular way, whereby tasks were repeated, overlapped, or conducted simultaneously which enabled deep penetration of the data.

3.4. Ethical considerations

Before fieldwork, the study proposal went through a formal assessment by the Durham anthropology's ethics committee in United Kingdom. In Malawi, the study was also duly approved by the National Health Science Research Committee (NHSRC) as well as district and community authorities. Informed consent was also administered to all the respondents.

4. Findings

4.1. The local perception towards the state of being pregnant

Notwithstanding the high degree of importance that almost all communities give to children and pregnancy, being pregnant is generally seen as a dangerous status. Even the two popular local names for pregnancy – '*pakati*' (life or death) and '*wodwala*' (sick woman) – clearly signal how pregnancy is perceived as clarified by one traditional healer: "*We call them 'sick women' because pregnancy come with so many illnesses as I have already talked about. These illnesses disappear once a woman has delivered. Therefore the whole period of pregnancy the woman is a patient.*" Additionally, all respondents said that pregnant women are relatively vulnerable to ill-health. A young pregnant woman reasoned like this: "*because the thing [foetus] inside me is extracting energy from my body, I am always weak compared to the time I was not pregnant; that is why I frequently suffer from fever.*"

More specifically, respondents stated that '*Kuchepamagazi*' (anaemia), Malaria, bleeding, miscarriage, poverty, and violence against women are the most serious maternity problems. Almost every woman mentioned 'shortage of blood' as a serious maternal problem and various causes were cited such as excess sunshine, malaria, poor diet, witchcraft and overworking. One woman said: "*When it is hot, our blood boils and evaporates just like boiling water.*" Most women noted that shortage of blood is very dangerous because a pregnant woman needs more blood to share with the foetus and if the blood is not enough, either the woman or the foetus (or both) would die. The word Malaria is mostly used interchangeably with fever. Mosquitoes, rainfall, overworking and the pregnancy itself are the major causes of Malaria that were mentioned by the respondents. Many women also reported that violence against them, often perpetrated by their own husbands in form of beating, is a serious problem. More than half of the women were once beaten by their husbands during pregnancy. This is regarded as a serious issue because it can lead to obstetric complications as noted by one woman: "*some [women] are beaten while pregnant, so when the time to deliver comes they miscarry because of being beaten. Some also suffer from abdominal pain due to the same problem of being beaten.*" Other problems that were mentioned include: headache, hunger, dizziness, stomach-ache, swelling, painful legs, nausea, vomiting, blurred vision, fainting, high blood pressure, witchcraft and caesarean section.

Although many women consider the problems above very disturbing, still, most of them said that these problems are part of pregnancy that a woman cannot do without. These problems are seen to be so attached to pregnancy to the extent that some of them are thought to be signs of pregnancy. When asked how she discovered her

pregnancy, one woman said, *"I stopped menstruating, I was experiencing nausea and vomiting, I suffered from Malaria and I was also feeling backache ..."*

4.2. Local perception of major obstetric problem – Haemorrhage

Although haemorrhage is the leading cause of maternal mortality in Malawi (Geubbels, 2006), very few respondents voluntarily mentioned it as one of the maternal complications. However, this did not stop the researchers from probing their perception or understanding of the same. A closer look at haemorrhage from the participant's perspective revealed that there are two sides of bleeding during pregnancy as well as postpartum. While some respondents believed that it is a health problem, the majority look at it from another angle.

On one hand, bleeding is seen as serving important functions that help to sustain pregnancy. Bleeding during the early months of pregnancy is thought to be a bloom that sweeps the menstruation leftovers from previous months so as to create a good atmosphere for the foetus to develop. One old woman said *"... blood is very dangerous; it can kill the baby in the womb. Therefore, menstruating in the early months is important to remove all the remaining blood in the woman's uterus ..."* Apart from that, bleeding during pregnancy is also seen as something which women inherit from their parents. Respondents argued that some women have less sensitive bodies which take time to respond to pregnancy; that is why they continue menstruating: *"some women are just insensitive to pregnancy so they continue menstruating."*

Bleeding towards the end of pregnancy is perceived in a more similar way to how it is seen in the early months. A number of respondents reported that menses towards the end of pregnancy clear the birth canal for smooth delivery. Although they failed to mention the specific things which need to be cleared, but they insisted that the delivery passage needs to be cleaned beforehand: *"... the blood removes the dirt in the passage so that the thing [the baby] should come out uncontaminated."* But not all women bleed during pregnancy and I wondered how come these women still deliver healthy babies and one woman had a simple answer for me: *"yes, they don't bleed; but women have different ways of removing the dirt. Others clear the passage through urine, vomits, faeces, and fluids [discharged via vagina]."*

Just like bleeding during pregnancy, postpartum bleeding also serves a function. Respondents generally said that blood and all other wastes associated with the foetus needs to be removed from the body after delivery. According to the participants, if these things are not cleaned, a woman may die because of what they called 'mtayo' (rotten stuff associated with foetus): *"... blood and foetus wastes that remain in the womb after delivery are very dangerous. If left unclean, this stuff can kill a woman."* Therefore, little bleeding is seen as not having enough pressure to remove these leftovers; a local midwife said that *"we expect them to bleed heavily for one or two days then slowly may be for up five days."* It was also reported that there is a local remedy for those who don't bleed enough after delivery: *"... we insert a funnel in the vagina and water mixed with herbs are poured into the womb to clear the leftovers."*

On the other hand, other respondents acknowledged that menstruating or bleeding during pregnancy could be a sign that something is wrong. Many participants mentioned that it might be an indication that the pregnancy is not stable. One of the traditional healers observed that bleeding during pregnancy simply means that the pregnancy has been or about to be terminated. Other participants noted that bleeding during pregnancy is unsafe because it may lead to anaemia, *"... I know bleeding is risky because it left the woman with too little blood to share with the baby; so the baby can die."*

Those who believe that bleeding serves a function see it as a natural process, which needs neither explanation nor treatment. However, around three major causes of bleeding emerged especially from those who see it as a health problem. Firstly, respondents said that it is as a result of poor diet. It was argued that a malnourished pregnant woman has less strength to turn the blood into a foetus. Therefore, the failure or the roughness of the formation process of the foetus results in release of either all or some of the blood, which were supposed to be used to form a foetus. This is sometimes followed by miscarriage. Secondly, other respondents attributed it to witchcraft. They believed that because of personal reasons like jealousy, a woman may be bewitched. One of the local healers explained: *"... sometimes it is an act of witchcraft in our villages. Some evil spirits may just want to kill the baby because of jealousy or other things."* Lastly, others believe that it is the breaking of taboos that lead to bleeding. For instance, one old woman said: *"during 'mwambowamimba' (ceremony organised for first time pregnant women) we advised them when to stop sexual intercourse. If they ignore this, then it may result in bleeding because they disturb things inside."*

4.3. Types of maternity care sought during complication

4.3.1. Home remedies

Most of the problems which are not perceived to be serious or that are regarded as normal during pregnancy rarely provoked a trip to any care provider. Home remedies or just a change of behaviour is considered enough to get rid of the problem. For instance, women reported that they did not seek any special care for problems such as vomiting and nausea, swollen, headache and dizziness because are not serious enough to warrant a care seeking trip. One woman had this to say: *"... when serious problems appear we of course go to the hospital but*

not dizziness and vomiting, these are not issues to worry about. We always know that they will disappear after childbirth.” While acknowledging that these problems are indeed minor, some women still reported adopting self-medication. One woman said this: “... *it may be costly to go to the hospital with these small issues, most time we just buy ‘Panado’ (painkiller) from nearby shops.*” Likewise, almost all the women who believe that haemorrhage is normal reported that they did not seek any specific care when they experienced it during their previous pregnancies. However, few women mentioned that they went to the hospital to get blood pills because they were afraid that they would not have enough blood to keep their pregnancy. Others employed self-medication: “... *I was worried that I would have run short of blood. So I used ‘avocado leaves’ and they helped to restore my blood level.*” Change of behaviour or lifestyle also emerged as a common therapy for a number of problems.

4.3.2. Traditional care

All respondents agreed that many women use traditional medicine to treat or prevent various maternity problems. Many women reported that they visit the traditional healers to seek help when they suspect that their pregnancy was not stable. Several women praised the traditional herbs as very efficient in preventing pregnancy loss due to witchcraft. One woman recalled this: “*when I started bleeding, I knew that this pregnancy would not survive if I just sit down. So I went to get the herbs to settle it.*” Some women also reported using ‘*mchape*’ (washer) to clean their wombs when they were suffering from abdominal pain. This is to clear the menstruation leftovers, which are thought to be the cause of abdominal problems during pregnancy. Just like wastes need to be removed after delivery, so are wastes after a miscarriage/abortion has occurred. Traditional midwives reported that they offer cleaning services to women, which also include protection against future miscarriages. Additionally, it was also reported that sometimes traditional help is sought as an alternative or complementary to biomedicine because some problems respond better to traditional than western medicine.

4.3.3. Biomedical care

Almost all women reported that they sought maternity care at least once at the hospital either during current or previous pregnancies. The superiority, reliability and effectiveness of the western medicine are some of the reasons that attracted women to seek biomedical care. Many respondents observed that it is only at the medical facilities where high standard type of care is provided. Some went as far as saying that local healers and midwives know nothing and that they just want to earn a living from cheating people: “... *these old women (local midwives) are liars, they don’t know how to treat problems but they still insist to help people. I can’t go there, never. The clinicians at the hospital are the right people to consult because they are well-trained in science and they know what they are doing not these uneducated witches [traditional healers].*”

Although many women said that they seek care at the hospital; most of them do not know why they go there. When asked why they go to antenatal care, most pregnant women responded that they just go there because they are supposed to; no specific clinical reasons were provided. In fact, they were all aware that they need to visit the hospital; but for them, the visits are just habitual. It was also noted that communities have put in place penalties that are given to women who do not seek medical care. During the interviews, it was frequently reported that all women who fail to seek medical care and consequently deliver in their villages are liable to a penalty in form of a goat or the equivalent in cash.

5. Discussion

This discussion examines four of five main questions that explanatory models seek to explain: course of illness (i.e. severity), aetiology, pathophysiology and treatment (Kleinman, 1980).

5.1. General perception of pregnancy: normality of complications

The study has revealed that pregnancy is perceived in various ways among the Mang’anja. Although a source of honour to parents, it has been noted that pregnancy is also one of the most dangerous episodes in the lives of women. The names ‘*pakati*’ and ‘*wodwala*’ that pregnant women are known by speak clearly about their situation. This observation is not new; Helman (1990) also declared that in all societies, pregnancy is seen as a risky period which calls for special ceremonies, practices and taboos. But surprisingly, aside from complaining about the dangers that the pregnancy poses, women were also quick to point out that the problems are normal. This is a disturbing observation because these problems are at the same time regarded as life threatening. A closer look at this confusion brings to mind Winkelman’s (2009) remarks that illnesses are experienced and interpreted within a cultural context, which defines the seriousness of the condition. This basically implies that although the pregnancy is generally considered as a ‘life or death’ situation, at the same time the threats it poses has been culturally internalised and normalised. With this normalisation, it should not be surprising that even when their life is in danger, pregnant women among the Mang’anja people do not seek care to remedy the maternal complications they experience.

5.2. Haemorrhage: the necessary evil

It was also interesting to note that not everyone perceives haemorrhage as a problem. Many participants argued that bleeding serves important functions in their bodies. It is basically not known how these explanations come about because even the respondents themselves were unable to locate the source. However, it was clear that this knowledge is culturally acceptable and it is passed on from one generation to another through ceremonies such as '*mwambowamimba*'. It has been established that bleeding is seen as providing cleaning services to the uterus in the early months, and to the birth passage, in the last few weeks of pregnancy. And after delivery, the function is to clear the wastes that the baby left behind in the uterus. In fact, little bleeding is seen as unhealthy because it lacks enough pressure necessary to remove the dirt. Similarly, Chiwuzie and Okolocha (2001) reported that Ekpoma women in Nigeria go further to induce bleeding after delivery to ensure that their uterus is duly cleaned. These observations differ slightly to what White (2002) found among the Khmer women in Cambodia, who believe that bleeding during pregnancy serves to wash the face of the baby. However, the common perception of bleeding among Khmer, Ekpoma and Mang'anja is that they all see it not as an obstetrical problem but rather as serving important functions necessary to sustain pregnancy and the life of the woman. These observations are very dangerous because they can hinder timely and appropriate care seeking.

5.3. Care seeking practices: Medical syncretism

While many studies have worked on the assumption that biomedical is the only type of care available to pregnant women (Curry, 1990; Gleit, 2002; Myer & Harrison, 2003), this study has revealed that at least three sources of maternal care are available to women: home remedies, traditional, and medical care. The most important observation however, is not these types of care but rather how they are chosen in times of need. The findings of this study confirm the lay theories of illness causation that were put forward by Helman (1990). The underlining link is that the choice of care is largely dependent on the way the illness is perceived. For instance, illnesses which were regarded as normal or less severe to women rarely provoke a trip to any healer. Respondents reported that illnesses like headache, blurred vision and swollen legs are normal in pregnancy and indeed very few of these cases were taken to the practitioner. This is in line with the health belief model (HBM), which basically asserts that the perception of the severity of the illness is one of the determining factors for care seeking behaviour (Croyle, 2005). However, unlike HBM, it has been noted that it is not only the severity of the illness that matters but also whether the treatment is required at all since other illnesses though dangerous are considered 'normal' or 'necessary'. This study has showed that there are some maternal problems that the mang'anja tribe believes need no action as delivery itself is considered the ultimate treatment.

It was further noticed that most people who ascribed the obstetrical problems to witchcraft mentioned traditional care more often than not as the appropriate treatment. Most of them argued that hospital is irrelevant to their problems which were often defined as either witchcraft or taboo based. This probably stems from the belief that biomedicine cannot successfully diagnose or treat illnesses emanating from witchcraft as observed by Chapman (2003) and Chiwuzie & Okolocha (2001) in Mozambique and Nigeria respectively. But what is not known is how the causes of these illnesses are defined as witchcraft based or not. It is possible that some naturally caused problems are attributed to witchcraft thereby delaying use of appropriate care. More research on this is recommended.

Many women also reported receiving antenatal and childbirth care from the biomedical facilities. However, what is clear about biomedical care is that women failed to justify why they sought the care or even to state the importance of the services they were given. Further exploration of this issue revealed that not all women seek biomedical care voluntarily; power and authority of those in high positions forced them to utilise health facilities through imposition of penalties. It is not known whether this is a sustainable strategy or not, further research is required.

In general, although types of care are usually discussed separately (see Chapman, 2003; Arps, 2009), their utilisation does not necessarily follow the same trend. The findings of this study have confirmed the existence of medical syncretism, the use of different kinds of treatment at the same time (Pool & Geissler, 2008).

6. Conclusions

Previous studies have documented that raising awareness of women on the danger signs of obstetrical problems is crucial for the realisation of safe motherhood and MGD5 (see White, 2002; Hailu et al., 2010; Pembe et al., 2009). The assumption is that pregnant women may seek appropriate care on time if they are familiar with these danger signs. However, explanatory models elicited from Mang'anja people suggest that being aware of these danger signs is not enough to provoke a trip to the appropriate healer. For instance, some of the danger signs are also considered part and parcel of pregnancy – normal. This study has therefore, failed to find evidence that knowledge of risk factors influence women's decision to seek appropriate care.

It has been observed that the insider's definition of appropriate care is not fixed; it is a function of the definition of the illness itself. For instance, this study has showed that women's knowledge of bleeding as a dangerous

complication did not automatically illicit a journey to a medical facility; most of them reported utilising other modes of healing. This study therefore, has established that it is the perceived causes of the obstetrical complications embedded in people's explanatory models that determine whether care would be sought or not and from whom. Interestingly, the perceived causes of these complications are in turn affected by the traditional beliefs and practices surrounding the issue of pregnancy, childbirth and postpartum. The existence of medical syncretism also implies that although each complication has a targeted healer, other practitioners are also consulted. Social, economic and political factors such as transport cost, availability of facilities and government policies also play an important role.

7. Recommendations

In order to improve utilisation of medical facilities, a shift in approach of health education provided to women is recommended. Since it is the cause not the effect of the complications that determines care seeking, women need to be told the specific causes of these complications and the underlying physiological processes in a way they can easily understand in order to improve care seeking. Authorities can also take advantage of the available local structures like 'mwambowamimba' ceremony to deliver messages to women and communities. But before such initiatives are put in place, there is a need to understand how the local explanations of illness causation are developed.

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