SCHOOL OF MEDICINE AND HEALTH SCIENCES

ASSESSMENT OF FACTORS INFLUENCING A PREGNANT WOMAN'S CHOICE OF PLACE OF DELIVERY IN CHIPEMBE: A PHENOMENOLOGICAL STUDY

BY

RICHARD VICTOR KALE

BSPH19218681

BSc PUBLIC HEALTH

SUPERVISOR: MRS. ANNIE SILONDWA

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DECLARATION

I, Richard Victor Kale, do hereby declare that this research entitled **Assessment of factors influencing a pregnant woman's choice of place of delivery in Chipembe: a phenomenological study** represents my own work. It has been guided by my supervisor in accordance with the guidelines for Degree of undergraduate in Public Health at the University of Lusaka. This research under the topic mentioned above has not been submitted elsewhere at the University of Lusaka or any other university.

Name: Richard Victor Kale ID: BSPH19218681

Signature: Richard Kale Date: 8th May, 2023

SUPERVISOR

Name: Mrs. Annie Silondwa

Signature: _____

Date: 8th May, 2023

DEDICATION

I dedicate this work to my late mother, Ms. Violette Gerts who departed when I was only 11. Her vision to see me through my ambitions was cut short in 2005. Ever since her demise, her last words of encouragement and the promises I made to her on her death bed are the only thing I have left which keep me going. I know one day I will see the light and her soul will be proud of me wherever it sits.

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I would be remiss if did not thank my adopted mother, Elisabeth Winsborough-George and Ian, for their invaluable support since 2011. I cannot imagine my life without you both.

To the following: Karen Beattie and Dave Hopson, thank you for being a part of my story.

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LIST OF ACRONYMS

ANC—Antenatal Care

EDD —Expected Date of Delivery

eMTCT —Elimination of Mother to Child Transmission

HIV —Human Immunodeficiency Virus

MCH —Maternal and Child Health

MMR ——Maternal Mortality Ratio

NAT —Nucleic Acid Testing

PPH —Post-partum haemorrhage

RHC —Rural Health Centre

SDA —Seventh-day Adventist

SDG —Sustainable Development Goal

SSA —Sub-Saharan African

TBA —Traditional Birth Attendant

UNILUSREC —University of Lusaka ethics committee,

WHO —World Health Organization

ZNPHI —Zambia National Public Health Institute

ABSTRACT

Background: The health of a mother contributes greatly to the health of the unborn child. All decisions a pregnant woman makes affect the unborn baby. About 2.4 Million neonatal deaths were recorded in 2019 and 293 maternal deaths recorded in 2017 world over. It was estimated that 56% of maternal deaths were from Sub-Saharan Africa. In Chipembe community, pregnant women do not have the privileges that women who live in cities and big towns enjoy. The bad roads, poor modes of transport, lack of formal jobs, limited business opportunities, illiteracy, lack of formal private health care providers, lack of exposure etc. are few of the many barriers that hinder them from accessing care. These obviously affect their health seeking behaviour. Place of delivery is an important contributing factor to a safe delivery. Therefore, a pregnant woman must choose a place of delivery that will guarantee a safe delivery. This study sought to investigate factors which influenced pregnant women's choice of place of delivery in Chipembe community.

Methods: This was qualitative study approach, using a Phenomenological study design and data collection tools were a questionnaire, theme table and phone recorder. The sampling method employed the principle of saturation. The data were analysed using thematic analysis method.

Results: The most patronised place of delivery in Chipembe Community among the participants was Chipembe Mission Rural Health Centre. Factors that influenced participants' choice of place of delivery included: the first-time-mother and multiparous-mother policy, which forced participants in the category to deliver from the Nyimba District Hospital or any other similar level Hospital or higher; Distance to the nearest health centre; HIV Positive status; Anaemia; Financial/Economic status; History of abortion; No delivery room in the local health centre; staff attitude; illiteracy; Having a friend who is a health worker; Gifts/incentives; Fear of complications; and many more.

Conclusion: The study findings fit into the Three-Delay Model of health seeking behaviour by pregnant women. Factors such as lack of knowledge about their right to choose, illiteracy, parity etc. are typical examples of the first delay. The Second-Delay includes distance to the Health Centre, poor roads, and financial/economic status. The Third-Delay includes staff attitude, practitioner's skill and others.

Keywords: Place of delivery; pregnant women; Chipembe

CHAPTER ONE

This chapter gives a brief background on place of delivery and its impact on maternal and child health. It also briefly describes Chipembe community as the population of interest. Thereafter, a statement of the problem, study justification, objectives and research questions will follow in that order.

1.0 Background/introduction

Maternal mortality and neonatal deaths are global challenge in maternal and child health. Low-income countries have persistently topped the list in these statistics (Shajarizadeh and Grépin 2022). Approximately, 2.4 million neonatal deaths in 2019 and 293 thousand maternal deaths 2017 were reported the respective years, adds Shajarizadeh and Grépin (2022).

More than 56% of maternal deaths occur in Sub-Saharan Africa (SSA). The high maternal mortalities stand in the way of Africa's 2015 agenda of attainment of Sustainable Development Goals (SDGs), specifically to Goal Three, which seeks to promote the health of all reproductive age women". Target 3.1 specifically requires SSA countries to reduce the maternal mortality ratio (MMR) to less than 70 deaths per 100,000 live births by the year 2030 (Adde, Dickson & Amu 2020)

According to Zambia National Public Health Institute (ZNPHI) (2019), Zambia reported 674 maternal deaths (MMR: 183 deaths per 100,000 live births) in 2018. These deaths were attributed to direct causes such as post-partum haemorrhage (PPH), and indirect causes such as delay in seeking health care. Chipembe is one of the remote health facilities that records a significant number of maternal and neonatal deaths in Zambia.

Chipembe is a rural community located East of Nyimba District of Eastern Zambia. The community is built along the Great East Road. It has four schools – Kambakuwa Day Secondary School and Kalambakuwa Primary School, Kabvuma Secondary School, and Nyatubanda Primary School- and one clinic – Chipembe Mission Rural Health Centre. The Chipembe Community, in this description, refers to the population within the Chipembe Mission RHC catchment area.

Chipembe Mission RHC catchment area has over 8,200 people. The catchment area is divided into zones. Zones help the clinic manage the catchment area in terms of outreach services. However, it also offers services to outside catchment area patients, travelling from Mozambique borders such as Nzuni, Laundani and Malima.

Chipembe Mission RHC records over 20 births per month. But not all these births take place at this clinic. Some of the most common away-from-the-Chipembe Clinic deliveries are hospital deliveries, home deliveries, health post deliveries and away from the district deliveries. Maternal deaths, still births, and delayed births are common problems faced by this community.

Since I began observing this community, I have realised that most of the victims of maternal deaths, still births and postpartum complications had either a home delivery or the mother did not attend antenatal care (ANC) services. Measures to discourage and curb home deliveries have been implemented but there are still a few cases of home deliveries being recorded. In November 2021, a baby born at home to an HIV positive mother tested positive on Nucleic Acid Test (NAT). This and many cases of similar nature bordering around Maternal and Child Health make me wonder why such women chose the place of delivery.

This research will help answer the questions as to why women in this catchment area choose a particular place of delivery and how the clinic can join hands with the community leadership to promote safe motherhood. Findings of this study will help the facility to implement health policies according to the needs of the community.

1.1 Statement of the problem

The World Health Organisation (WHO)'s policy on Maternal and Child Health (MCH) for developing countries recommends institutional delivery in order to ensure a safe delivery of a baby (Chinkhumba 2014). Most cases of maternal deaths, neonatal deaths and mother to child transmission of HIV recorded in Chipembe have a history of non-institutional delivery. Facility management of deliveries will offer opportunities for early recognition of pregnancy related complications and facilitate timely provision of life saving basic and comprehensive emergency obstetric and perinatal services. Despite having a Health Centre, some pregnant women have opted for home delivery and delivery far from Chipembe. Unfortunately, some of these decisions lead to regrettable health outcomes maternal deaths, neonatal deaths and mother to child transmission of HIV. No study has been conducted in a remote community such as Chipembe to investigate what influences expectant mothers' choices for place of delivery.

1.2 Justification of the study

The health of an expectant mother determines the health of the baby she is carrying (Chinkhumba 2014). Maternal mortality and infant mortality are linked to preventable causes such as place of delivery. Place of delivery is one of the major determinants of a safe and healthy delivery. This study will identify factors that influence women's choice of place of delivery. The findings in this study will provide evidence that will inform policy formulation, and implementation in Maternal and Child Health services at community level. It will, in turn, make Zambia achieve the Sustainable Development Goal (SDG) 3.1 which states "to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by the year 2030." It will also add to the current knowledge in Maternal and Child Health.

1.3 General research objective

To assess factors influencing a pregnant woman's choice of place of delivery.

1.4 Specific research objective

1. To determine how an expectant mother chooses a place of delivery
2. To assess factors beyond a pregnant woman's control affecting her decision
3. To establish the sufficiency of available alternatives for a places of delivery.

1.5 Research questions

1. How does an expectant mother choose a place of delivery?
2. What factors beyond a pregnant woman's control affect her decision?
3. How sufficient are available alternatives for places of delivery?

CHAPTER TWO

In this chapter, past work done by other authors is being reviewed and briefly discussed to identify gaps that support this study.

2.0 Literature review

Global level studies

Maternal mortality and mortalities of babies and are global health concerns. Although the World Health Organisation (WHO) have made a substantial progress in prevention of these deaths and in elimination of mother to child transmission (eMTCT) of HIV, statistics still show that some regions of the world are still struggling with this problem. Regions such as Asia, South America and Africa are topping the list in Maternal and neonatal death tolls (Roser and Ritchie 2013).

That a pregnant woman needs health care attention, a supportive family and a supportive social circle cannot be overemphasised. She needs constant support and monitoring throughout gestation in order to ensure a safe delivery of a healthy baby. Preparation for child delivery starts right in the first trimester. Sometimes preparations start before conception. Place to deliver her baby is an important consideration an expectant mother must make before her expected date of delivery (EDD). "Providing pregnant women with a choice of where to give birth is a policy goal in some European countries and also a high priority for some user associations" states Sandall (2015).
Having the right to choose where to receive antenatal care and to deliver a baby from does not make sense if options are limited for the client. Therefore, it is important that an expectant mother has enough options to choose from according to her needs and wishes. A health care provider, however, may guide an expectant mother to aid her informed choice. The goal of Antenatal Care (ANC) is to ensure the safe delivery of a healthy baby and the health of the mother.

Global Maternal mortality statistics are unacceptably high. Estimates for 2017 show that some 810 women die every day from pregnancy- or childbirth-related complications around the world (WHO 2019). Ollove (2018) reports that, although the world had seen a steady decline in the number of women dying from childbirth over the past three decades, there had been a notable outlier -the United States. "Here the maternal mortality rate has been climbing, putting the United States in the unenviable company of Afghanistan, Lesotho and Swaziland as countries with rising rates." adds Ollove (2018).
According to Coxon (2017), UK women often did not feel they had a choice of place of birth, or believed their choice was limited to deciding between two or more hospitals. Women described needing to actively seek out information, especially if they were considering birth in a non-

hospital setting. Coxon (2017) further reported that many women felt that hospital was the safest setting for birth, and that this was the normal or expected birth setting. Key attributes which contributed to the sense of safety were access to medical staff and facilities, pain relief being available and not needing to transfer.

Coxon (2017) disclosed that some women's accounts often drew on their own previous experiences of birth and some felt that if something were to go wrong, giving birth in a hospital would protect the home from being a site of bad memories. Nevertheless, hospital Obstetric Units (OU) were also perceived to be anxiety-provoking or impersonal and, for women in remote and rural areas, the distance and travel time to OU were off-putting) (Coxon 2017). This study by Coxon (2017) was based on data from the UK alone and it was specific to straightforward pregnancies. It was not a phenomenological study in a rural site such as Chipembe.

Rahman (2021) attributed several factors in decision making process by Pregnant Asian women. South-Asian women from urban areas, having a secondary and higher level of education and higher education levels of their husbands, middle and upper-income households, women having higher ANC visits, watching TVs and husbands with high-income families were found statistically significantly associated with increased facility delivery (Rahman 2021). The study focused on urban women who were categorised into educated and uneducated. It did not include women living in rural areas who might be facing certain challenges unique to rural set ups such as the remote Chipembe Community in Zambia.

In Nepal, the maternal mortality ratio is 281 per thousand live births, among which 40% mortality occurs during home delivery. Home delivery was found to increase the risk of maternal and neonatal mortality and morbidity due to the birth not assisted by skilled attendant (Dhakal et al 2017). This study, linked maternal and neonatal mortality to place of delivery.

Dhakal et al. (2017) reviewed in the Nepal study that the decision about where to deliver the baby was taken by both mother and her partner (51.6%), followed by mother alone (23.7%). Among the home delivery, 59% of the births were attended by Traditional Birth Attendants (TBAs) followed by medical personnel (20.5%). Among 39 mothers who had home delivery, 26 (66.7%) said that home delivery was easy and convenient, followed by previous deliveries at home (48.7%), continuity of care at home (25.6%), and precipitated labour (20.5%). Among 54 mothers, who had institutional delivery, 77.8% reported safety, followed by fear of complication at home

(70.4%), emergencies attended faster (51.9%) and decision of family members (27.8%). The results showed that there was no association between the age, religion, family type, occupation of mother and the place of delivery. The study was quantitative and thus did not include in depth narration of participant's experiences.

Regional studies: African and Sub-Saharan African.

There is a huge discrepancy in maternal mortality rates (MMR) between developed countries and developing countries (Gebregziabhera et al 2019). WHO (2014) reported that 99% of maternal deaths occur in developing countries and over 50% occur in Sub-Saharan Africa. "The maternal mortality ratio in developing countries is 240 per 100000 births versus 16 per 100000 in developed countries. There are, however, further large disparities between countries, with few countries having extremely high maternal mortality ratios of 1000 or more per 100000 live births" (WHO 2014).

In 2017 196,000 pregnancy and childbirth related complications were recorded in Sub-Saharan Africa alone (Arero et al. 2021). It was further unveiled that about seventy-five per cent maternal and neonatal deaths occur outside health facilities. Arero et al. (2021)'s study, the study approach was mix method and the design was cross-sectional. Thus, the study did not explore the participant's experiences more than a phenomenological study would.

Mahama (2019) reported in his study in Ghana that about 81% of women he interviewed expressed willingness to deliver from a hospital but due to circumstances such as labour starting at an unexpected time, some of them delivered from home. He (Mahama 2019) further disclosed that some women preferred home deliveries due to traditional beliefs and the need to show their husband their strength and prowess in maternal activities. Mahama's study was also a mixed method. It lacks indepth discussions from the participants.

Another study in Ghana, Gangtaba (2021) found that more 75% of participants thought facility delivery was the best. However, a little above one-quarter (25.5%) of the respondents stated that disrespect by health care providers is the major reason why women deliver at home.

In Nigeria, a study by Agbede, Aja and Owolabi (2015) reviewed that 28% of the respondents who were asked to state their preferred placed of delivery still patronised unskilled birth attendants such as the Traditional Birth Attendants (TBA), church or religious centres and delivery at home (attended to by family or friend), abrogating the WHO recommended health

centre delivery. The study was conducted in a semi-urban area. Therefore, it lacks specific experiences to rural and remote women such as the Chipembe women in Zambia.

In a study in Kenya by Arero et al. (2021), 56.7% of pregnant women who were in the study delivered from health facilities and hospitals while 43.3% delivered from home. In a similar study in Eritrea by Gebregziabhera et al (2019), the enrolled mothers were asked as to the "ideal place of delivery" and 64.9% said at health facility, 29.1% said at home by skilled birth attendant while 6% opted for home delivery by a traditional birth attendant (TBA). In Ethiopia, (Belay and Sendo 2016), in their study, disclosed that out of the total respondents only 38.2 % of women gave birth in health facilities for their most recent birth while the rest (61.8 %) delivered at home. The study was cross-sectional and the target population was town mothers. Just like Agbede, Aja and Owolabi (2015)'s study, this study lacked specific experiences to rural and remote women such as the Chipembe women in Zambia.

Southern African Region

In Tanzanian study by Ngowi (2017), most women (78.6%) delivered at the health facilities while (21.4%) delivered at home/on the way to health facility. Reasons for delivering at home include: abrupt occurrence of labour pain in 52%; long distance to the health facilities 25.1%; transport unavailable 13.5%; lack of money to pay for transport 5.3% and unfriendly experience with the health care providers, 4.1%. Majority of respondents (62.8%) reported that both husband and wife decided on the place of delivery, (24.4%) reported making the decision on their own, 8.1% reported husbands making the decision and 4.8% reported the relatives made the decision. Regarding estimated distance to the nearby health facilities, 87% live within five kilometers while 13% live more than 5 km away. This was a cross-sectional study and thus it lacks in-depth analysis of the situation that phenomenological study design can review.

Local studies: Zambia

One study in Zambia by Gabrysch et al. (2011) published that out of the 3,692 births to rural mothers in the Demographic and Health Survey (DHS) 2007 with relevant distance information, 32.5% occurred in a health facility, 0.4% were home deliveries attended by a nurse or midwife, and 67.1% were neither in a facility nor attended professionally.

Gabrysch et al. (2011) further reported that bicycle ownership was fairly common in the area, but motorised transport was virtually absent, with less than 1% of births occurring to mothers whose

household owned a car or motorbike. Births in families that owned a bicycle were much more likely to have been in a facility (19 out of 31 in total). The study also showed that dry season births were somewhat more likely to have taken place in a facility compared to those in the rainy seasons. Proximity to delivery facilities was strongly associated with facility birth, as was higher level of obstetric emergency care available within 15 km (Gabrysch et al. 2011). The study was limited to two major factors that influence women's access to care: distance to health facility and level of service delivery. Hence, could not dig out certain experiences that are outside distance and level of care.

In a cross-sectional study by Scott et al (2018) in Zambia, nearly all respondents (98.9% overall) registered their intention to deliver at a health facility and the respondents who participated in the IDIs frequently discussed the value of delivering at a health facility, even among those who did not deliver at a facility themselves.

Muyunda (2019), in a local Zambian study, discovered no difference in choosing professional care over Traditional Birth Attendants (TBAs) for both HIV positive and HIV negative women.

Scott et al (2018) disclosed that although less than 1% of women self-reported that they intended to deliver at home, just over 18% of women in this sample delivered either at home (15.3%) or on the way to a health facility (3.2%). Insufficient time, transportation challenges, and cost barriers were cited as reasons for delivering at home or on the way to a facility (Scott et al 2018). Qualitatively, the costs associated with reaching the facility, obtaining the necessary supplies to deliver at a facility, and distance or transportation challenges may have contributed to the reasons some women delivered at home.

The Scott et al. (2018) study was cross-sectional and was limited to home delivery. Hence, like many others, it is too specific to review more issues around choice of place of delivery among pregnant women.

Tembo and Mambwe (2022) concluded in their study in Lundazi, Zambia, that the husband, mother in-law, the mother and grandmother to the pregnant woman and the wider community were strongly influenced a pregnant woman's choice of delivery place. Married women did not exercise their right to autonomy. This study was a mixed study design, combining cross-sectional

study with a qualitative descriptive approach. Thus, it could not dig deeper into participant's experiences beyond what the cross-sectiona study design was looking for.

2.1 Theoretical review

Using the three delays model, Kifle et al. (2018), categorized factors that influence women's decisions-making process. In light of the first delay (predisposing factors), several variables were found to be independent predictors of the choice of delivery place. These variables reflect the socio-cultural context in which women live and how these factors affect their preferences in access to and use of health services.

In the perspective of the second delay, both economic and physical accessibility to health facilities were found to have significant influence on women's preference of delivery place. Many studies have noted that women from poor households are less likely to use delivery services as institutional delivery causes financial hardship and challenges families to pay even for nominal fees, transport fees, and compensating the gap left at home to care for children. Some studies have also reported that poor women tend to face violation in their dignity and experience abusive treatment from the health personnel during facility deliveries (Kifle et al. 2018).

In variables that capture the third delay of seeking care (women's perceived need and benefits of delivering in health facilities), several factors were found to have independent predictive power on the choice of delivery place. Exposure to information on television, radio, and in the print media can increase knowledge and awareness of new ideas, social changes, and can affect an individual's perceptions and behavior, including those about health matters. As such, the utilisation of the mass media to influence women's knowledge about delivery risks, availability of services and promoting the benefits of health facility delivery has been employed as a major strategy in many countries (Kifle et al. 2018).

2.2 Conceptual framework

The conceptual framework for this study was constructed based on the three delays model of maternal healthcare utilisation developed by Thaddeus and Maine and later expanded by Gabrysch and Campbell to conceptually distinguish emergency care-seeking and preventive care-seeking behavior. According to Thaddeus and Maine's (1994) model, reasons expectant mothers may or may not seek skilled care at childbirth were captured in some thematic areas, including the sociocultural factors, accessibility to health facilities, care environment and resources, and availability of skilled attendants.

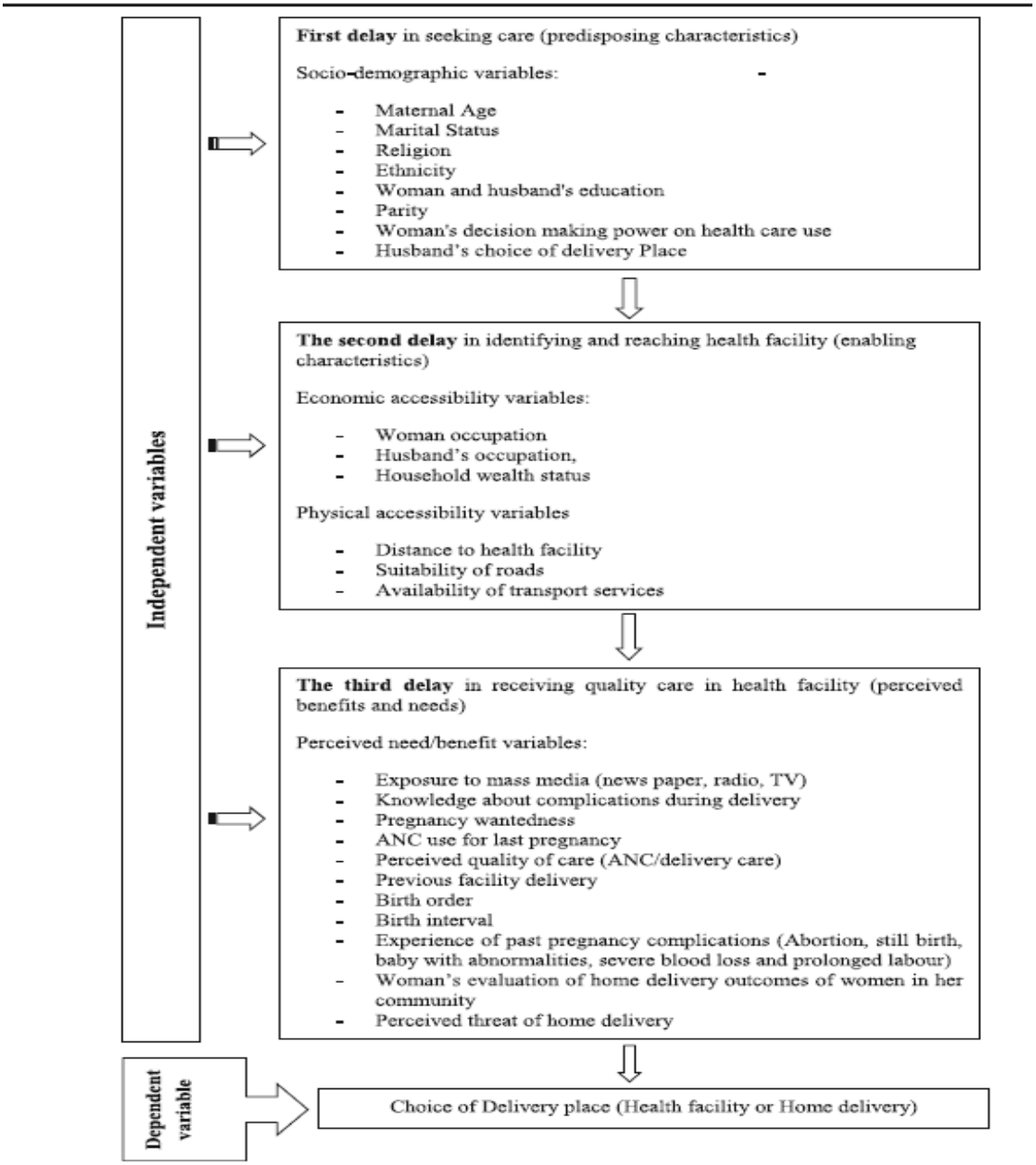
“The adapted conceptual framework captures factors associated with the choice of delivery place in terms of the first delay in seeking care (predisposing characteristics), the second delay in identifying and reaching health facility (enabling characteristics), and the third delay in receiving quality care in health facility (perceived benefits and needs)” (Kifle 2018).

The variables used to conceptualize the first delay were socio demographic factors such as maternal age, marital status, religion, ethnicity, parity, woman’s decision-making power on healthcare use, husband’s choice of delivery place, and woman and husband’s education. These predisposing factors are socio-cultural characteristics of individuals that exist prior to their illness that affect individual’s access to and use of health services.

The second delay, often explained as logistical aspects of obtaining care, was framed as economic accessibility (woman and husband’s occupation, household wealth status, and cost for transport) and physical accessibility (distance to health facility, suitability of roads, and availability of transport services).

The third delay, defined as a functional and health problems factor that generate the need for health care services, was represented by exposure to mass media, knowledge about complications during delivery, pregnancy wantedness, ANC use for last pregnancy, perceived quality of care (ANC/delivery care), previous facility delivery, birth order, birth interval, experience of past pregnancy complications, respondents’ evaluation of delivery outcomes of women in her community, and perceived threat of home delivery. Figure 1 is a diagrammatic expression of the conceptual framework showing different factors that can influence the choice of place of delivery.

The conceptual framework of the study is shown on Fig. 1.



Conceptual framework for the determinants of choice of delivery place

Adapted from Kifle et al. 2018.

CHAPTER THREE

This chapter discusses study methods, study designs, sample size and sampling procedures employed in this study, and ethical considerations. It also discusses the data collection, data storage, data analysis, and reporting.

3.0 Methodology

Data collection: a questionnaire was designed to gather responses "themes" on matters of choice of place of delivery, wishes and desires. Data analysis followed the theme analysis methods.

3.1 Study Approach

Qualitative study

3.2 Study design

Phenomenological study

3.3 Study population/Target population

Parous women and currently breastfeeding women in Chipembe catchment area. Chipembe community was divided into four major zones ¬ East, West, North and South zones. At least a participant was selected per zone. Village furthest from the clinic and those closest were also considered.

3.4 Sample size, sampling procedures

Sample size was determined by data saturation. Sampling went on until a point at which no new shared themes or ideas emerged. Data saturation is a point during interviews when no new themes were being added to the study.

3.5 Data collection methods

Questionnaire interview: A questionnaire was designed to suit the in-depth interview.

Recording: Some interviews were recorded using my phone for later reference.

Writing themes down on a theme table

3.6 Data analysis

Thematic analysis: This is where written responses and interview recordings had been analysed while noting common issues the participants reviewed.

Tables: The table had rows and columns so that themes could be summarised in it.

3.7 Ethical considerations

The study adhered to the principle of beneficence, benevolence, and voluntary participation, anonymity of respondents, confidentiality of all information collected and ownership of

information. Approval for the study was sought from the University of Lusaka ethics committee (UNILUSREC), informed consent from participants and from DHO was obtained.

CHAPTER FOUR

4.0 Results

To recapitulate, this study focused on factors that influenced pregnant women when a choosing place of delivery. The study was guided by the three-delay model and answered three research questions: How an expectant mother chose a place of delivery; what factors beyond a pregnant woman's control affected her decisions; and finally, how sufficient there were available alternatives for places of delivery. Therefore, this chapter presents interview findings from 11 participants. It also includes indented direct speeches of the actual responses from individual participants. These responses are headed by Italicised themes.

How did a pregnant woman choose a place of delivery?

11 participants were interviewed and 10 of them had at least a delivery at Chipembe. Even the one mother who has never had a delivery at Chipembe desired to deliver from this Clinic but could not as she was a first timer. Chipembe was the most desired and patronised place of delivery by expectant mothers in the community. However, some mothers had no choice but to deliver from another facility or from home for different reasons.

Most expectant mothers who had a delivery away from Chipembe clinic delivered from the Nyimba District Hospital under instructions from the Chipembe care providers. A few went to other health facilities such as Minga Mission Hospital and Kafue General Hospital for various reasons. A considerable number of multiparous women had at least a home delivery.

The first-time mothers and multiparous policy

The care provider instructed first timers and multiparous women with more than 4 past pregnancies to go to Nyimba District Hospital or pick a preferred hospital with skilled manpower and medical technology to handle complications.

One mother said,

> "I did not choose Nyimba District Hospital. A nurse here told me to go to Nyimba District Hospital when my expected date of delivery (EDD) nears. So I went to Nyimba and on the same day I delivered. I spent the night there. The next day I was discharged. If it were not for that instruction, I would have delivered from Chipembe"

Another one said,

> "I had 10 pregnancies before I decide that I needed no more. Some babies did not make it. The previous male Midwife referred me to Nyimba District Hospital on 3 pregnancies. The first one was a breech. So, they had to refer me to the hospital as an emergency. The other two were pregnancy number 9 and 10 in that order, which met the multigravida and prime policy that was introduced here around 2015. The policy became serious after 2015. That's how come I delivered my last two babies from Nyimba District Hospital."

Distance to the clinic

Most women thought Chipembe was an ideal place to deliver from because it was near. Even those who wished to deliver from another facility were discouraged by distance.

> "Chipembe is near. It is just a walk away. If I choose a clinic far from home, I would need transport. Our roads are bad and taxis are expensive." Said a multiparous mother.

> "I would have loved to have Nchanga North Hospital as my place of choice but it is provinces away!" said another mother.

HIV positive status

One participant said she chose Chipembe as a place of delivery because of her HIV positive status. She said that she believes that health care providers would help prevent Mother-to-Child Transmission. So, she had three deliveries from Chipembe Clinic and one delivery from Nyimba Dstrict Hospital due to Anaemia, and no home delivery."

> "I am a multipourous woman with 4 past pregnancies. The first one was a stillbirth. I delivered from Chipembe Clinic. The second one was delivered from Nyimba District Hospital because I had low blood. The last two were delivered from Chipembe Clinic. I can never deliver from home because doing so would put my innocent children at risk of HIV infection."

Anaemia

Anaemia had an influence on 4 pregnant women's choice of delivery place. These participants mentioned at least low blood as the reason for referral to the Nyimba District Hospital. Some of them were diagnosed with low blood during antenatal care while others developed acute anaemia during delivery due to prolonged birth and bleeding.

History of abortion.

One woman was told to deliver from a hospital because she had a past history of abortion. She did not choose Nyimba District Hopsital. Instead, she went to Minga Mission Hospital. She said Minga Mission Hopsital had previously treated her better than did Nyimba District Hospital.

> "I delivered this baby and his elder brother from Minga Hospital. I preferred Minga to Nyimba District Hospital because of the good patient care they give me. It was not really up to me whether or not to deliver from Chipembe. The reason was that my first two pregnancies did not last. I miscarried. So, I delivered both my first born and his now baby brother from Minga Mission Hospital."

Financial/Economic status

Most mothers cited financial constraints to delivering from a far health facility.

> "Choosing a clinic requires that you consider your financial status at home. You cannot just pick a clinic very far. What will you and your mother eat while you wait to deliver. So, it is best to choose a clinic nearer."

Not aware about the right to choose

Some women did not know they could choose where to delivery from. They believed their catchment area clinic was their only choice.

> "I did not know I could choose. Chipembe is the only one I have ever known. In times of complications, Nyimba District Hospital is where we're referred. But, to be honest, even if we were to choose another clinic, which one would it be because all other clinics are either smaller than Chipembe or are too far from home."

Home delivery

Three of the 11 participants had at least a home delivery. Each on had a slightly different reason for delivering at home.

No delivery room at the local clinic

For example, one woman (39) said,

> "I delivered my second pregnancy from home because there was no delivery room in the Chipembe. There was no maternity ward with a delivery room at the Chipembe during that time. So, we delivered from our homes."

Staff attitude

One participant expressed the displeasure at how a former midwife at Chipembe scolded her during delivery. However, she did not state whether it affected her future choices for places of delivery.

Financially incapacitated

Another one (30) said,

> "I had to delivery from home because I had no money to pay for transport to the clinic from home when labour started. Besides, facility delivery was still optional at the time. So, it was much affordable and convenient for me to deliver from home."

Lack of knowledge

The third participant, 46-year-old, said,

> "I have been to a delivery room 4 times. I had my first two pregnancies delivered from home. Home delivery was normal during our time. We did not know the importance or benefits of facility delivery. But, they began to teach us about facility delivery and its benefits. After the health education, I connected and related my bad experiences to home delivery. I bled a lot. One time, on my second pregnancy delivery day, I fainted. I bled for an extended period of time. A few days later I recovered. So, health education made me realise how dangerous home delivery is. My mother and the Traditional Birth Attendant (TBA) did not know what really happened to me and so they could not help me in any way. I'm lack I survived. From the time I learnt of facility delivery, I went to Chipembe for delivery. So I delivered my last two children from Chipembe."

My best friend was a care provider at the clinic

A 28-year-old woman said,

> "I chose Chipembe for a place of delivery because my best friend was a Clinical Officer General there at the time. So, I knew she was going to take good care of me."

Gifts

Some mothers were motivated by gifts Chipembe gave for every facility delivery. A participant (30) said,

> "I had my first delivery from home. That time home delivery was not a big deal. But, I bled too much until they brought me to the clinic for help. On my second pregnancy, I

> learnt that they were giving a mosquito net, a baby bathing tub, and some clothes for the baby. Those gifts made many of us come to delivery from the facility. On my subsequent deliveries I got used to facility delivery. So I went to Chipembe even though they no longer gave gifts."

Fear of complications at home

Most participants did not choose home as a place delivery because of fear of birth complication. For instance, a 46-year old changed her preference from home to facility when she experienced prolonged bleeding during her second pregnancy. This finding is in consistency with findings in a study by Dhakal et al. (2017) where some pregnant women dreaded birth complications associated with home delivery.

Travelled out of the district.

A 26-year-old participant from Yeleseba village delivered from Kafue General Hospital because she was visiting when labour came.

> "I had travelled to Kafue that year. Labour found me there. So, I delivered from the Kafue General Hospital. If I were in my village, I would have delivered from Chipembe."

On the question: what issues does your place of delivery have and what would you suggest be improved. Most women responded negative. A few pointed out some issues such as delivery place being too small to accommodate multiple women at the same time; delivery place being too close to the lobby and OPD, hence no privacy; clinic not providing sleeping space for mothers after delivery, and Health care worker attitude be bad

A 20-year-old first timer said this about Nyimba Distict Hospital,

> "They do not have enough delivery space. Also beds for babies are not enough. Three babies shared a bed. I had nowhere to lie or sleep after delivery. I stool the whole night. They should consider this issue in future."

A 39-year-old mother from Alidon village said this about Chipembe,

> "Chipembe is a good place of delivery. But it I too close to the lobby and OPD. When you are shouting, everyone outside can hear you. Sometimes, you want to walk naked but there are people right near the door. Another issue, the former male midwife used to lash a lot. Nonetheless, Chipembe should be empowered with those things that the hospital has

in order for us to receive care conveniently from Chipembe regardless of the condition or situation."

Religious beliefs, traditions, customs and values

None of the participants' decision was influenced by religious beliefs, customs, traditions etc. in choosing a place of delivery. The participants were free to decide where deliver from.

Family, husband or in-laws influence your decision-making?

All participants were not influenced by their respective husbands, boyfriends, parents, family, in-laws etc. in decision-making.

The 46-year-old's response,

> "Family do not tell us what to do. Tradition: It is no longer those olden days when tradition was strictly followed. These days, we are enlightened and we prefer following what health care providers say."

What factors beyond a pregnant woman's control when choosing a place of delivery?

Most women cited poor road network, birth complications such as breech labour, Anaemia, the Gravida 1 and Gravida 5 policy, past history of abortion and Labour coming at unexpected time for away from Chipembe delivery.

Those who delivered from home said they did not feel compelled to deliver from the facility, or did not think facility delivery was necessary.

Were there sufficient alternatives for places of delivery?

Most women think the alternatives were limited. A few think one choice is enough. Another few did not know they could choose. So they did not think about sufficiency of alternatives.

CHAPTER FIVE

5.0 Discussion and limitations

This chapter is a commentary of the result chapter in relation to the reviewed literature on "Factors that influence a pregnant woman's choice of place of delivery." It digests answers to all the three research questions: how a pregnant woman chooses a place of delivery; whether or not there are influential factors beyond her control; and whether or not she has enough alternative choices. By comparing the findings with the reviewed literature, similarities and differences will be discussed while pointing out areas that need further investigation. Finally, limitations that I have experienced throughout this study shall elucidated.

5.1 Key Findings

Place of delivery

In this study, 5 places of delivery were mentioned by participants, viz. Chipembe Mission Rural Health Centre (Chipembe), Nyimba District Hopsital, Minga Mission Hospital, Kafue General Hospital, and Home.

10 out of 11 (91%) of the participants have at least had a delivery at Chipembe; followed by 6 of 11 (55%) who had a delivery at Nyimba District Hospital; then 3 of the 11 (27%) participants who had at least a home delivery; and finally, 2 out of 11 (18%) of the participants who had at least a delivery outside the Nyimba District. This is in consistency with the 2017 Tanzanian study '*Women's determinant factors for preferred place of delivery in Dodoma region, Tanzania: a cross sectional study*' by Ngowi, who reported a high proportion (78.6%) of home deliveries and a much lower proportion (21.5%) of the participants having delivered from home. It is also in consistency with the findings in a local Zambian study '*Factors affecting home delivery among women living in remote areas of rural Zambia: a cross-sectional, mixed-methods analysis*' by Scott et al. (2018) in which a small proportion (18%) of women in their sample delivered either at home (15.3%) or on the way to a health facility (3.2%).

Influential factors

A considerable number of participants expressed their lack of knowledge on the right to choose a place of delivery. Another lot said that there were limited options. For instance, a 39-year-old participant said, "I did not know I could choose. Chipembe is the only one I have ever known. In times of complications, Nyimba District Hospital is where we're referred." This is similar to a Coxon (2017) study, *What influences birth place preferences, choices and decision-making amongst healthy women with straightforward pregnancies in the UK? A qualitative evidence synthesis using a 'best fit' framework approach* finding, which disclosed that UK women often

did not feel they had a choice of place of birth, or believed their choice was limited to deciding between two or more hospitals.

All participant women in this study expressed positive attitude towards facility delivery, with Chipembe being the most preferred place of delivery. This finding is similar to a Ghana study by Mahama (2019) in which high proportion (81%) of the women indicated their willingness to facility delivery.

Husband, boyfriend, in-laws and family

There was no influence from parents, husband, siblings, in-laws and relatives in a woman's choosing of place of delivery. This finding contradicts with three studies: the (2019) Ghana study '*Factors That Influence Place of Delivery Choice Among Expectant Mothers in Ghana*' by Mahama; the Nepal study by Dakal et al. (2017) '*Factors Affecting the Place of Delivery among Mothers Residing in Jhorahat VDC*; and the local Zambian study in Lundazi by Tembo and Mambwe (2022) '*Decision-Making that Determines Choice of Delivery Location Among Pregnant Women in Lundazi District- Zambia'* all of which reported some level of power and influence the woman's relatives, husbands, in-laws and parents have on the choice of place of delivery.

The finding is in consistency with findings by Dhakal et al. (2017) which found no association between choice of place delivery and age, religion, family type, and occupation of mother.

Distance to a health facility

Distance was regarded as a factor in decision-making when choosing a delivery place. Chipembe is the most patronised place of delivery because of its proximity. This finding is consistent with findings by Ngowi (2017) in Tanzania in which long distance influenced 25.1% of the participants' home delivery amon those who stayed more than 5km from the Health centre and 87% of facility delivery among those who stayed less than 5km away from the facility. It is also in consistency with Gabrysch et al. (2011)'s study on 'The Influence of Distance and Level of Care on Delivery Place in Rural Zambia: A Study of Linked National Data in a Geographic Information System.' 'in which proximity to health centre was associated with facility delivery.

Fear of complications at home

Most participants did not choose home as a place delivery because of fear of birth complication. For instance, a 46-year old changed her preference from home to facility when she experienced prolonged bleeding during her second pregnancy. This finding is in consistency with findings in a study by Dhakal et al. (2017) where some pregnant women dreaded birth complications associated with home delivery

Financial/economic factors

All the participants showed a negative attitude toward choosing a distant place of delivery due to financial challenges. This is consistency with the Tanzanian study by Ngowi (2017) in which some opted for home delivery due to financial incapacitation.

Anaemia

Anaemia had an influence on 4 pregnant women's choice of delivery place. These participants mentioned at least low blood as the reason for referral to the Nyimba District Hospital. Some of them were diagnosed with low blood during antenatal care while others developed acute anaemia during delivery due to prolonged birth and bleeding. There is not study which associated anaemia to choice of place of delivery. Therefore, more investigations need to be done on this particular factor.

HIV positive status

One participant said she chose Chipembe as a place of delivery because of her HIV positive status. She said that she believes that health care providers would help prevent Mother-to-Child Transmission. So, she had three deliveries from Chipembe Clinic and one delivery from Nyimba Dstrict Hospital due to Anaemia, and no home delivery. This study contradicts with findings by Muzyanda et al.'s study in of 2019 in which the proportion of those who sought professional care as opposed to Traditional Birth Attendants was the same in both HIV positive women and HIV negative women. Therefore, more investigations need to be conducted for more comprehensive understanding on this factor.

Staff attitude

Only one participant expressed the displeasure at how a former midwife at Chipembe scolded her during delivery. However, she did not state whether it affected her future choices for places of delivery. Nevertheless, this result agrees with Gangtaba (2021) study in Ghana in which about 25% of the participants chose home delivery due to staff disrespect.

5.2 Study limitations

1. Translating the questionnaire from English to a local language was difficult. Hence, some key information could not be gathered.

2. Due to language barrier, some responses had to be couched out of the participants, which created a bias.

3. Some participants did not feel enough to say anything negative about staff attitude especially when I met them at the health centre.

4. Most participants were suspicious with the line of questioning in the interview despite the assurance that all information gathered would stay confidential.

CHAPTER SIX

6.0 Conclusion and Recommendations

6.1 Conclusion

Findings of this study can be categorized according to the Three-Delay Model. First delay, which list factors that delay women to access health care services include lack of knowledge about their right to choose, lack of knowledge about the benefits of facility delivery or risks of home delivery, parity, that is either being prime gravida or multigravida, with multigravida, etc. The Second-Delay includes distance to the health centre, poor roads, lack of money to pay for a taxi etc. The Third-Delay includes delay by health practitioners to identify complications and refer to higher level of care, failure by practitioners to educate pregnant women before had about the risks of certain pregnancies, bad staff attitude towards pregnant women in labour and many more.

6.2 Recommendations

Local solutions:

1. Community leaders to organise local resources such as burnt bricks, wildlife-broken trees and local artisans such as bricklayers and carpenters to fix broken roads
2. Community leadership and religious leaders to cooperate with local health centre staff in promoting health-seeking behaviour among pregnant women.
3. Health centre staff to adhere to the professional conduct as enshrined in the HPCZ charter.
4. Health centre management to find ways of improving the management of the facility, patients and the community such as having frequent community engagements to hear how they feel about the performance of the facility.
5. The SDA Church to get stop interfering directly in the management of the clinic for the smooth running of the facility.
6. The Church should find an amicable way of airing their grievances than aggression towards staff.
7. Staff to learn to respect their jobs by being in the right place and doing the right jobs while on duty.
8. Community to avoid abusing health care workers as there can never be comprehensive and focused care provisions when the provider’s feelings are hurt.
9. Community to utilise the suggestion box as often as they feel while the facility must check the suggestion box frequently and read suggestions with open minds.
10. Community to come up with local rules and purity measures against home delivery, late registration for ANC and failure to meet all ANC visits.

11. The Church, Community leaders and political leaders to lobby for upgrading of the Chipembe Mission RHC to a Hospital through CDF as it is a high-volume facility but far from the hospital.

Long-term solutions:

1. The government and the community must improve rural road networks leading to health facilities in a sustainable manner.
2. Government must expedite the decentralisation of primary health care services in rural areas so as to reduce travel time and distance to the nearest health facility.
3. Government and the community should join hands in promoting safe motherhood among women and adolescent girls in rural areas.
4. The Ministry of Health must consider bringing more specialised equipment and manpower distribute them in several locations in Nyimba District to combat maternal and neonatal deaths.
5. The Continued Professional Development (CPD) must be properly regulated so that it serves the right purpose improving knowledge and skill among health practitioners.
6. The Ministry of Health to consider bringing a backup ambulance to Nyimba District to increase efficiency in times of emergencies.
7. Government to expand Blood Donation Services so that Donations can be done locally in the district.
8. Early detection of anaemia is important in managing gestational anaemia. Therefore, laboratory requirements must be made available at all times.

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Appendices

Questionnaire

PART 1: CONSENT REQUEST AND ELIGIBILITY FOR INTERVIEW

1. Having read and understood the consent form, do you give consent to this interview?

2. How many times have you delivered a baby? (healthy and/or stillbirths)

3. Where did you deliver each of your babies from?

   Place 1_____

   Place 2_____

   Place 3_____

   Place 4_____

   Place 6_____

   Place 7_____

4. Were these the places of your choice? (YES or NO)

5. How was your experience in this place of delivery?

PART 2: CHOOSING A PLACE OF DELIVERY

1. Why did you choose each of these places?

2. Where would you have loved to deliver from each of those times and why?

3. In what way does each of the following influence your decision in choosing a place of delivery? Mother, Father, siblings, Husband, Grandparents, Cousins, Nieces, Uncles, In-laws etc.

4. How do your religious beliefs, traditions, customs and values influence your decisions?

5. What other things influence your decisions?

PART 3: FACTORS NOT WITHIN HER CONTROL

1. Are there things beyond your control that influenced your choice of place(s) of delivery? If Yes, mention them

2. What would you suggest be done to reduce effects of those factors?

PART 4: SUFFICIENCY OF AVAILABLE ALTERNATIVES

1. How many choices did you have for places of delivery?

2. Were your alternatives enough for you or did you wish for more options?

3. If you were to choose places of delivery today, how many choices would you have and how sufficient are they?

4. What would you say about your right to choose a place of delivery in this community?

5. What would you suggest be changed or improved upon to satisfy your right to choose a place of delivery?

PART 5: STORY OF LABOUR EXPERIENCE

Tell me a story of one of your labour experiences and how you found yourself in a particular delivery room.

Consent Form

Consent Form for Personal Data Collection

1. I have read/been explained to and fully understand the information in this research project proposal. I confirm that I was provided with the opportunity to take into consideration the information, ask all the questions I wanted, and I have had them answered satisfactorily.
2. I am fully aware of what is expected from me. I understand that I will be asked a set of questions, which I am supposed to answer as honestly as possible.
3. My decision to participate in this study is fully voluntary. I also understand that I am free to leave at any time without providing any reason. I understand that my withdrawal will not affect my legal rights
4. I understand that I can withdraw my permission to use my data within a week after it has been collected. I understand that in this case, my data will be deleted and will not be used for this research.
5. I understand that the data provided by me during the data collection process may be looked at by the researcher, their supervisors, and the UNILUS Research Committee members. I give permission for those individuals to have access to my data.
6. I understand that my participation will not be associated with any kind of risk or benefit.
7. I understand that my data will be treated with care and confidentiality. I also understand that it will not be given to any third party and will be disposed of after 6 months from the study completion date.
8. I understand that regardless of the type of data provided by me during this study, my identity and the identity of individuals I speak to about will remain anonymous.
   AND NOW:

I hereby declare that the personal data I provide is done so on a voluntary basis and I understand that the data will be used by the student who is carrying out a Maternal and Child Health research Project (**ASSESSMENT OF FACTORS INFLUENCING A PREGNANT WOMAN'S CHOICE OF PLACE OF DELIVERY IN CHIPEMBE: A PHENOMENOLOGICAL STUDY**

Year: 2023) of (School Name: University of Lusaka).

I hereby agree to release my personal data for the following purposes:

• for processing the Maternal and Child Health research in the abovementioned project;

• for identifying the needs relevant to the abovementioned project;

• for reporting or making presentations subject to the requirements of the abovementioned project, the school, or other participating or sponsoring organisation(s) involved;

• for educational research and analysis in an anonymous format in which no identifying information can be found.

I understand I have the right to access and correct all personal data in accordance with the provisions of the Laws of Zambia.

Full Name: _____ Signature: _____ Date: _____

If unmarried participant is below 18 years of age or mentally incapacitated

Name of Guardian/ Committee: _____

Signature: _____ Date: _____

Contact method (email or phone): _____

Ethical review

SCHOOL OF MEDICINE AND HEALTH SCIENCES LEOPARDS HILL CAMPUS
Plot No. 37413, Off Alick Nkhata Mass Media. P. O Box 36711, Lusaka.
Phone: +260211258505, 258409 Fax +260211233409; Cell +260976075850,961917862,
E-mail:unilus@zamnet.zm,ictar@zamnet.zm

SCHOOL OF MEDICINE AND HEALTH SCIENCES RESEARCH ETHICS COMMITTEE

Ref no: IORG0010092-2023/056

Date: 15th DECEMBER, 2022

RICHARD VICTOR KALE - BSPH19218681

Re: RESEARCH TITLE: ASSESSMENT OF FACTORS INFLUENCING A PREGNANT WOMAN'S CHOICE OF PLACE OF DELIVERY IN CHIPEMBE: A PHENOMENOLOGICAL STUDY

The above research was submitted to the research ethics committee for review. The study has no major ethical problems and is approved subject to the following:

1. The study cannot be changed without express permission of the UNILUS Research ethics committee
2. Approval from the Lusaka District health Management or equivalent health authorities should be sought.
3. The study tools should be added.
4. An informed consent form should be attached and filled by all study participants (If dealing with primary data)
5. The risks and benefits should be included in the consent form.
6. Ensure before commencement that approval is sought from ZNHRA

Congratulations and the committee wishes you success in your work.

Prof Kasonde Bowa
MSc(Glasgow),M.Med(UNZA),FRCS(Glasgow),FACS,FCS,DPH(LSTMH),MPH(UCL)
Chairman- UNILUS REC
Professor of Urology and Consultant Urologist
Executive Dean
University of Lusaka and University Teaching Hospital School of Medicine and Health Sciences.

Request letter

SCHOOL OF MEDICINE AND HEALTH SCIENCES LEOPARDS HILL CAMPUS

Plot No. 37413, Off Alick Nkhata Mass Media. P. O Box 36711, Lusaka.
Phone: +260211258505, 258409 Fax +260211233409; Cell +260976075850,961917862,
E-mail:unilus@zamnet.zm,ictar@zamnet.zm

Date: 15th DECEMBER, 2022

……

……..

……..

PERMISSION FOR **RICHARD VICTOR KALE - BSPH19218681 TO** CONDUCT A RESEARCH STUDY AT YOUR FACILITY/ INSTITUTION/ORGANIZATION

Reference is made to the above subject matter

The University of Lusaka, School of Medicine and Health Sciences here by requests for permission for **RICHARD VICTOR KALE** Public Health Student to conduct research at your facility/ institution/ organization, entitled**; ASSESSMENT OF FACTORS INFLUENCING A PREGNANT WOMAN'S CHOICE OF PLACE OF DELIVERY IN CHIPEMBE: A PHENOMENOLOGICAL STUDY.** The research is in partial fulfillment of the requirements for the degree of Bachelor of Science Public Health. This is purely for academic purposes and information gained in such a way will not be used in the public domain without prior authorization from the institutions/ organizations involved.

The research topic has been cleared by the University of Lusaka, School of Medicine and Health Sciences Research Ethics Committee as per the attached copy. Data collection is expected to be done from **1st January, 2023 to 31st March, 2023**.

The University of Lusaka avails itself of this opportunity to review to your office the assurances of its highest considerations and looks forward to your timely and favorable response.

Prof Kasonde Bowa
MSc(Glasgow),M.Med(UNZA),FRCS(Glasgow),FACS,FCS,DPH(LSTMH),MPH(UCL)
Chairman- UNILUS REC
Professor of Urology and Consultant Urologist
Executive Dean University of Lusaka and University Teaching Hospital School of Medicine and Health Sciences.

Ethical clearance

NATIONAL HEALTH RESEARCH AUTHORITY
Lot No. 18961/M, off Kasama Road, Chalala, P.O. Box 30075, LUSAKA
Tell: +260211 250309 | Email**:** znhrasec@nhra.org.zm | www.nhra.org.zm

Ref No: NHRA00010/8/02/2023 Date: 8th February, 2023

The Principal Investigator, Richard Victor Kale, University of Lusaka, **Lusaka, Zambia.**

Dear Mr. Kale,

Re: Request for Ethical Clearance and Authority to Conduct Research

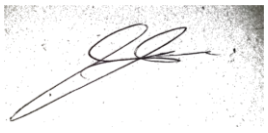
The National Health Research Authority is in receipt of your request for ethical clearance and authority to conduct research titled **"Assessment of Factors Influencing a Pregnant Woman's Choice of Place of Delivery in Chipembe: A Phenomenological Study."**

I wish to inform you that following submission of your request to the Authority, our review of the same and in view of the ethical clearance, this study has been **approved** on condition that:

1. The relevant Provincial and District Medical Officers where the study is being conducted are fully appraised;
2. Progress updates are provided to NHRA bi-annually from the date of commencement of the study;
3. The final study report is cleared by the NHRA before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the NHRA, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, University leadership, and all key respondents.

Yours faithfully,

NATIONAL HEALTH RESEARCH AUTHORITY



Prof. Victor Chalwe,
ACTING DIRECTOR/CHIEF EXECUTIVE OFFICER

Work plan

KEY RESULT AREA	PRINCIPAL RESPONSIBILITIES	TARGET	SCHEDULE OF ACTIVITIES
Fundraising	Finding sources of funds	By 31 December, 2022.	➢ Approaching potential donors with the proposal ➢ Convincing potential funders for support
Data collection	Selecting of participants	February, 2023	➢ Selecting participants ➢ Administering the questionnaire ➢ Observing them during face-to-face interview ➢ Collecting all the necessary information
Data analysis	Decoding and presenting data	31st March 2023	➢ Thematic analysis ➢ Other forms of analysis
Reporting and presentations	Report submission	17th May, 2023	➢ Findings reporting ➢ Discussions ➢ Recommendations ➢ Conclusion ➢ Power point presentation to stakeholders

Budget Summary

ITEM	**ZMW**
REC clearance fee	500
Stationary	500
Transport	1000
Contingence funds	200
Grand Total	**2,200**