SCHOOL OF MEDICINE AND HEALTH SCIENCES

FACTORS CONTRIBUTING TO HOME DELIVERIES AMONG PREGNANT WOMEN IN UKWIMI: LUSANGANZI DISTRICT

BY

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DECLARATION

DISSERTATION CLEARANCE AND DECLARATION

I Stephen Manianga, do hereby declare that this dissertation is my own original work. It has been guided and marked by my supervisor in accordance with the guidelines for Bachelor of Science in Public Health at University of Lusaka. It has not been submitted elsewhere for a degree at this or another University.

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Supervisor

I, Aniset Kamanga guided, read this dissertation and approved it for presentation. I am satisfied that this is the origin work of the author under the name it is presented. I confirm that the work has been completed satisfactorily and ready for presentation.

Name of Supervisor Aniset Kamanga

Signature  **Date** 24 May 2023

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To my friends, thank you for always being there for me, for keeping me motivated and focused, and for providing a listening ear whenever I needed it.

DEDICATION

I hereby dedicate my dissertation to my beloved father, Mr. Christopher Manianga, and my late mother, Stella Zulu Manianga.

Dad, you have been a pillar of strength, support, and guidance throughout my academic journey. Your unwavering faith in me and your constant encouragement have been invaluable. You have taught me the importance of hard work, determination, and perseverance, and I am forever grateful for your love and support.

Mom, although you are no longer with us, your memory continues to inspire and motivate me. You were a loving and caring mother who always encouraged me to pursue my dreams. Your unwavering love and sacrifice have been the driving force behind my academic success. I will forever cherish the fond memories we shared together, and I know that you are watching over me from heaven.

ABSTRACT

Background: In developing countries, including Zambia, maternal mortality rates are a pressing public health issue. The primary causes of death are related to pregnancy and childbirth. Although approximately half of women give birth in a healthcare facility in Zambia, there is significant regional variation with the lowest rate being in rural and the highest rate being in urban areas.

Objective: To evaluate factors contributing to the high number of home deliveries among pregnant women from Ukwimi village in Lusangazi district.

Materials and methods: Analytical cross sectional study was used among the women with children less than 2 years prior to the study in 2023 in Lusangazi district. Structured questionnaire was used to collect the information. Data were analyze using STATA version 14.

Results: The minimum age of respondent were 15 years old and the maximum was 49 years old with the mean age of 28.9 (SD=8.2) years. The majority of participants 90 (23.7%) were mothers between the age of 20-24, 83 (21.9%) were mothers aged between 25- 29 years, 60 (15.8%) were mothers aged between 30-34, 60 (15.8%) were mothers aged between 35-39 years, 46 (12.1%) were mothers aged between 15-19 years, 22 (5.8%) were mothers aged between 45-49 years, 18 (4.7%) were mothers aged 40-44 years, and one did not know her actual age. The majority of respondents 223 (59.5%) attended primary school education, 74 (19.7%) never went to school, 56 (14.9%) attended secondary education and 22 (5.9%) attended university education.

Conclusion: Well trained and equipped health workers are known to be a vital protective factor against maternal and new born morbidity and mortality, as they provide maternal health care services.

Recommendations: Based on study findings, improving education for girls, to improve accessibility of health facilities and promote early booking of antenatal care clinics by women have been recommended.

CONTENTS

ACRONYM AND ABBREVIATION

AIDS……Acquired immune deficiency syndrome

ANC…….Antenatal care

HIV……..Human Immune deficiency virus

IMR……..infant mortality rate

MDGs……..Millennium development goals

MMR……....Maternal mortality rate

MOH…….Ministry of health

SMAG……Safe motherhood Action Plan

TBA……..……Traditional birth attendants

UN…….United Nations

UNICEF……..United nation international children emergency fund

WHO……World health organization

ZDHS…….Zambia demographic health survey

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CHAPTER ONE

1.0 INTRODUCTION

To have good maternal health, there is need to put in place proper and quality reproductive health services to ensure the safety of women transitioning to motherhood; failure to do so will result in thousands of women dying each year (WHO, 2011a). Maternal health refers to a woman's health during pregnancy, delivery and the postnatal period (WHO, 2011b). Maternal mortality is defined as the death of a woman while pregnant or within 42 days after the termination of a pregnancy, regardless of the site or duration of the pregnancy, from any cause related to the pregnancy or its management but not from accident or incidental causes (WHO, 2015). For the previous three decades, according to Kassebaum et al. (2014) Maternal mortality has received attention on a global scale, and efforts are still being made to increase accurate data generation to help pinpoint the scope of the issue. The rate of maternal death reduced by 44% globally between 2010 and 2014 compared to 1990. (Bohren et al.., 2015: Chou, Daelimons, Jolivet & Kinney, 2015; every woman every child, 2015; Say et al.., 2014).

Although some progress has been made toward lowering maternal mortality rates, the enormity of current global estimates has become more comprehensive when considered on a daily basis. On a daily basis, it is estimated that 800 women die from pregnancy-related complications, implying that one woman dies every minute (Kassebaum et al., 2014). Globally, 99% of maternal deaths occur in low-income and developing countries, with Sub-Saharan Africa and South-East Asia having the highest rates (83.8%) and other Latin American and Caribbean countries have the highest number maternal death.

According to Say et al. (2014) the causes of maternal health death are complex and numerous, including hemorrhage (27%), indirect causes (27%), hypertension (14%), and sepsis (11%), as well as other related direct causes (10%), abortion (9%), and embolism (3%). Pre-existing medical conditions, such as anemia, malaria, HIV-related complications, cardiac and cancer diseases, account for more than 70% of the indirect causes of maternal mortality (ZNPHI, 2018). However, because these factors differ across regions and countries within the country, addressing the main causes and factors that contribute to maternal mortality rates is difficult. In order to develop targeted interventions for specific causes, accurate data must be generated, which will lead to global causes of maternal death.

There are multiple causes of high maternal mortality rates worldwide, as well as factors contributing to maternal death; young girls under the age of 15 are at high risk of dying and those who give birth at home, which, when complications arise, cannot be managed. Other factors contributing to high maternal mortality rates include limited access to health care services and poverty, which is also linked to a higher rate of maternal death (WHO, 2015). Lack of knowledge, skills, and education among expectant mothers, traditional care-seeking practices, and beliefs regarding childbirth are the factors that are causing home deliveries in low-resource and developing countries, with 60% of home deliveries in Africa occurring in remote areas and being attended by traditional birth attendants—unskilled birth attendants.

The World Health Organization (WHO) defines traditional birth attendants (TBA) as the person who assists the mother during birth and learns her skills through apprenticeship that involves both observation and imitation & she is often highly regarded by the community that chose her to assist women in child birth. There is an increase in the number of maternal deaths because home delivery is always done in unsanitary conditions or environment not only that, birth attendants cannot manage complications when arise in the process of giving birth. Approximately 47% of maternal deaths worldwide occur in Sub-Saharan countries; it is estimated that 35% of women in developing countries do not attend antenatal care during pregnancy, 50% give birth outside health facilities, either at home or on their way to the health facility; and 70% do not receive postpartum care and Zambia is one of the countries with high maternal mortality in Sub-Saharan Africa (Mohan, 2005).

Studies conducted in Ghana, south-east Madagascar and Zambia found that pregnant women in rural communities do not typically decide where to give birth; rather, the husband and relatives make this decision. Most women wait for their husbands to give them permission before going to give birth at a hospital or clinic (Sajedinejad et al.., 2015).

There have been global strategies implemented to reduce the number of maternal deaths, such as education initiatives, improved access to care for childbearing women, and quality improvement of programs that aid in maternal mortality rate reduction (Bauserman et al.., 2015; Dettric, Firth & Soto, 2013; Ramaaswamy, Kallan, Srofenyo, & Owen, 2016). Zulfigar et al. (2013) outlined key evidence-based interventions that should be implemented and scaled up with health systems include improving maternal nutrition during pregnancy, emergency obstetric care and postpartum

care (including stillbirth and preterm birth prevention, emergency neonatal resuscitation and immediate new born care) and detecting maternal new infections.

According to (ZDHS, 2018), describe that the number of institutional deliveries that occur in Zambia declined from 51 percent in 1992 to 44 percent in 2001-2002 before increasing to 48 percent in 2007 and 84 percent in 2018, similar to the birth attendants done by skilled personnel in Zambia declined from 50 percent in 1992 to 42 percent in 2001-2002, thereafter, the percentage increased from 47 percent in 2007 to 80 percent in 2018.

However, according to MOH (2021), at national level, the coverage of institutional deliveries dropped from 80.5 percent in 2019 to 73.9 percent in 2020, subsequently recording decline in deliveries attended by skilled personnel from 74.5 percent to 65.9 percent during the same period. In every 4 women who made at least one antenatal visit, one of them did not return to deliver at health facility, about 6 in every 10 deliveries attended by skilled staff where under supervision midwives or Obstetricians.

Furthermore, government of republic of Zambia came up with strategies that have been put in place to reduce maternal death such as building maternity waiting room to allow mothers to go and wait from the health facility this happen most in rural areas where most of home deliveries take place, sensitizing pregnant women the importance of institutional delivery and the dangers of home delivery despite government introducing all the activities some pregnant women still give birth at home.

Therefore, there is a link between maternal mortality rate, home deliveries, delay in recognizing danger signs in pregnancy, and delay in seeking health care services (SDC, 2007).

1.1 STATEMENT OF THE PROBLEM

A substantial number of women who give birth at home are not captured in the prevention of mother-to-child transmission (PMTCT) (Adinan et al., 2019).

Lack of institutional delivery can have a number of effects, including increased rates of morbidity and maternal mortality. Home deliveries can result in the transfer of HIV/AIDS to the newborn baby, family members, or traditional birth attendants who perform deliveries without the required tools (Kasede et al., 2021). Home delivery is only feasible when there are no complications during labor; otherwise, were there is complications a mother must be immediately referred to a nearby medical facility. In most cases, by the time complications arise, it is already too late, the mother and the baby dies or if the mother survive suffers from severe disabilities. However, less studies have focused on individual factors that lead to home delivers in rural areas.

In Zambia according to ministry of health 2017-2020 (MoH) annual health statistical report shows that the number of maternal death has remained high since 2015 at average of 14-16 maternal death every week. Furthermore, report shows that deaths occurring at home because of home delivery were low across the provinces. However, they were some indications that most of the provinces may have been underreporting community death or home delivery death at community level (MOH, 2021).

Therefore this study is going to help to find out factors that hinder institutional deliveries and knowing these factors will help to improve institutional delivery in Ukwimi vilaage which is located in Eastern province Lusangazi district.

1.2 JUSTIFICATION

Different factor affect deliveries in health facilities, it is very vital to establish or narrow gaps which exist among region and to improve quality services delivery to pregnant mothers and reduce maternal mortality, morbidity and disabilities that come as the results of complications related to pregnancy and childbirth. The gap which exists among regions in health facilities services delivery being low in remote areas compared to urban areas including Zambia.

Therefore, for significant improvement in health service delivery in health facilities, there is need to find factors considered to contribute to home delivery among pregnant mothers in rural areas, mostly residents of Ukwimi Village in eastern Province. There has been a lack of study in this area. The aim of this study was to find useful information that hinders pregnant mothers or women from giving birth in health facilities despite the high number of women attending antenatal clinics.

The information is going to be useful to the community and decision-makers in Lusanganzi District, and at the regional level, it will be useful for the implementation of policies and planning and also for making various interventions related to the research findings to reduce maternal mortality and be able to achieve the Millennium Development Goals by 2030 that no woman or mother should die of maternal or pregnancy-related death.

1.3 OBJECTIVES

1.3.1 Main objective

To evaluate factors contributing to the high number of home deliveries among pregnant women from Ukwimi village in Lusangazi district

1.4.2 Specific objectives

1. To establish effect of long distance on home deliveries among pregnant women from Ukwimi village in Lusangazi district
2. To determine the proportion of women attended antenatal clinic who delivered at home in Ukwimi village in Lusangazi district
3. To determine the effects of household income on home deliveries among pregnant women from Ukwimi village in Lusangazi District

1.5 Research questions

1. What are the effects of long distance on home deliveries among pregnant women from Ukwimi village in Lusangazi district?
2. What is the proportion of women attented antenatal clinic who delivered at home in Ukwimi village in Lusangazi district?
3. What is the effects of household income on home deliveries among pregnant women from Ukwimi village in Lusangazi District?

CHAPTER TWO

2.0 LITERATURE REVIEW

The second chapter of this proposal is a review of the literature, which will evaluate factors related to home deliveries as well as some factors that encourage expectant mother living in rural areas. It will also present theoretical and conceptual frameworks, which will highlight variables and present the researcher's overall view of the study.

2.2 Global maternal mortality rate

Kimario et al. (2020).The third Sustainable Development Goal of the United Nations aims to reduce maternal mortality rate by 2030 to less than 70 per 10,000 live births globally and 216 per 10,000 live births in developing countries. Despite various interventions, such as the implementation of international safe motherhood 358,000 women worldwide die from pregnancy-related causes each year, with obstetric complications killing 99% of women in Sub-Saharan Africa and Asia (WHO, 2010).

In 2005, the adjusted Maternal Mortality Ratio (MMR) for sub-Saharan Africa was 900 deaths per 100,000 live births (WHO, 2007). According to the Millennium Development Goals, between 1990 and 2015, the mortality ratio was supposed to be reduced by 75 percent which most of developing countries did not manage to achieve including Zambia (UN, 2007). The majority of African nations continue lag behind in achieving the MDGs, with the burden of disease and poverty cited as the problem. Only few nations, like Rwanda, have succeeded in achieving the Millennium Development Goal on maternal mortality.

2.3 Causes of maternal mortality rate

The major causes of maternal death in low-resource and developing countries are complex and numerous, with Sub-Saharan Africa and South Asia being the most affected regions. Say et al. (2014) maternal deaths are caused by hemorrhage (27%), indirect causes (27%), hypertension (14%), sepsis (11%), and other related direct causes (10%), abortion (9%), and embolism (3%). Cameron, Suarez, and Cornwell (2019) conducted similar studies on factors that contribute to maternal deaths. Anemia, malaria, HIV-related complications, cardiac diseases, and cancer account for more than 70% of maternal deaths (ZNPHI, 2018).

When women visit ANC clinics for delivery or postpartum care, the majorities of issues that arise during this time are controllable and may be addressed during pregnancy, preventing unintended pregnancies by providing them with family planning. Since maternal deaths cannot be predicted, family planning can also help reduce them by roughly 25%; however, only 44% of married and unmarried women between the ages of 15 and 49 in rural areas use family planning, which is a low rate (ZDHS, 2018). However, by having births at health facilities with trained birth attendants and in conducive or acceptable environments, as well as by increasing the frequency of antenatal care visits, these difficulties and maternal mortality can be managed or reduced (Gabrysch & Compbell, 2019).

Slow progress in reducing maternal mortality in low-resource countries can be attributed to a lack of health services as well as poor utilization of those that are available (UNFPA, 1994). According to WHO (2015) poverty and limited access to care are also associated with a greater contribution to maternal deaths, which contributes to slow progress in reduction and makes it difficult for most developing countries to meet the third sustainable development goal. Similar World Bank (2018) data showed that Zambia is a low middle-income country with 58% of the population living below the international poverty line of US$1.90 per day. This shows that it's difficult for a country like Zambia to reduce maternal mortality by less than 70/100,000 live births because of poverty, which slows progress regarding the reduction of maternal health.

2.4 Effects of long distance on pregnant women to deliver at health facility

Transportation to and from the health facility and home is one barrier that makes pregnant women not able to attend ANC services in remote areas, as well as not deliver at a health facility but end up giving birth at home in an environment where there is no proper sanitation and equipment, which can expose both the mother and the baby to infections that can come or rise due to the poor sanitation and equipment used. In rural areas, most of the health facilities are not within proximity of less than 8 kilometers as per standard from World Health Organization recommendations. As a result, pregnant women give birth at home because they do not have enough money to use when going to the facility. This simply means that the longer the distance, the less likely women are to attend ANC services as well as giving birth at home.

Scott et al. (2018), some of the factors that have been often mentioned in earlier literatures as affecting women's choice of where to give birth include the actual distance to the medical institution, transportation difficulties and cost. The majority of women who are already experiencing labor pains or showing indications of labor choose to give birth at home out of fear that they will give birth on the way to the health institution because of the distance. Furthermore, Banke-Thomas et al. (2022) did a retrospective study in Lagos, Nigeria, using closer-to-reality distance and travel estimates to examine the effects of distance on emergency obstetrical care (EmOc). Shared that most of the deaths were occurring among pregnant women who traveled less than or equal to 10 kilometers and arrived at the health facility in 30 minutes. However, according to his findings, out of 4181 pregnant women with obstetric emergencies, 182 (4.4%) resulted in maternal death, and among those who died, 60.3% traveled less than 10 km directly from home and 61.9% arrived at the hospital in 30 minutes. Furthermore, in his findings, all women who traveled 10–15 km were significantly associated with maternal death.

However, Karra et al. (2017) argues that these are simply assumptions that the further pregnant women are from a health facility, the less likely they are to use ANC services. However, it was stated in his argument that the existing literature has two potential flaws: first, the distances typically contain measurement error, and second, the studies have small sample sizes and low detecting power.

2.5 Effect on lack of facility delivery package among pregnant women

Due to financial constraints, pregnant women may choose to deliver at home, and if a health facility does not provide these delivery packages, women will avoid institutional deliveries. Sharmal et al. (2018) and Myint et al. (2018) conducted similar studies in Pikistan and Mynmar, respectively, and included all related expenses on health care services received during delivery care, such as hospital costs, investigation costs, drug costs, consultation fees, food, living costs, transportation, and other related costs. Calculating the out-of-pocket expenses that a pregnant woman should incur in order to give birth at a health facility. However, given that the majority of people in developing nations—including Zambia—live below the international poverty threshold of US$1.90, we can presume that a lack of facility delivery packages can influence the choice of where to give birth (World Bank, 2018). Additionally, studies carried out in Kenya revealed that pregnant women

frequently choose to use high-quality facilities and services when offered financial and delivery packages (Cohen, 2017).

So if women are provided with financial assistance it will reduce the likelihood of women giving birth and health facility.

2.6 Health effects on women who deliver at home

Kumar et al. (2017) outlined the dangers and complications that can leave a woman with disabilities when she has given birth at home, where those complications cannot be managed without skilled birth attendants. Complications include uterine rapture, fetal heart tone, bladder rupture, fetal demise, and undetectable fetal moments. Furthermore, Grunebaum et al. (2019), who conducted a similar study, found that sudden, severe fetal compromise during labor or delivery can happen to even low-risk patients. Pregnant women who happen to have low risk are not exceptional to complications since complications can arise at any time during labor.

2.7 Regional perspective

Understanding the causes and contextual factors surrounding the maternal deaths that occur each year in Africa is critical for health programming. West Africa has the highest rate of maternal mortality in the world, with 679 MMR deaths per 100,000 live births in 2015 (WHO, 2015).

Despite the adoption of MDG 5, the majority of Sub-Saharan African countries fall short of the target. The majority of women in the region are still dying as a result of maternal deaths. According to the World Health Organization, timely access to effective emergency obstetric interventions can prevent 88-98% of maternal deaths (Gunarwardena et al., 2018).

Sub-Saharan Africa failed to meet the Millennium Development Goals (MDGs) deadline of 2015, and goal 5 ("improve maternal health") remains unmet in comparison to many of the other goals. Its first goal, "reducing maternal mortality by 75%," was not met by the deadline, with only 50% of the reduction achieved according to 2013 data. According to the MDG report, the maternal mortality rate has decreased from 400 deaths per 100,000 live births worldwide in 1990 to 210 deaths per 100,000 live births worldwide in 2010. This was a significant reduction, but it was insufficient to meet the 75% reduction target. The Sub-Saharan region has made the least reduction of the several regions reviewed by the MDGs, with a 41% reduction, compared to regions such as

eastern Asia, with a 69% reduction (the highest of all regions), and southern Asia, with a 64% reduction (United Nations Millennium Development Goals Indicators, 2013).

Overview of local perspective

ZDHS (2018), describe that the number of institutional deliveries, deliveries that occur in Zambia declined from 51 percent in 1992 to 44 percent in 2001-2002 before increasing to 48 percent in 2007 and 84 percent in 2018, similar to the birth attendants done by skilled personnel in Zambia declined from 50 percent in 1992 to 42 percent in 2001-2002, thereafter, the percentage increased from 47 percent in 2007 to 80 percent in 2018.

However, according to MOH (2021a), at national level, the coverage of institutional deliveries dropped from 80.5 percent in 2019 to 73.9 percent in 2020, subsequently recording decline in deliveries attended by skilled personnel from 74.5 percent to 65.9 percent during the same period. In every 4 women who made at least one antenatal visit, one of them did not return to deliver at health facility, about 6 in every 10 deliveries attended by skilled staff where under supervision midwives or Obstetricians.

MOH (2021b), outlined that maternal death remained high since 2015 at average of 14-16 maternal death in every week. The proportion of death occurring at home was generally low across provinces but there were indications that most provinces may have been underreporting community death. This shows there gap on collection of data on maternal death in rural areas, hence government should strengthen communication of maternal death.

2.8 Causes of maternal mortality rate

Thaddeus and Maine (1994) used three delay models to outline factors that contribute to maternal death: a woman's decision to seek care (first delay), her ability to reach care (second delay), and her ability to receive adequate maternal health services (third delay). These factors can lead to maternal death, and if they are not addressed, Zambia will struggle to meet its third sustainable development goal of 70/100000 live births by 2030. However, the Ministry of Health (MOH) (2021) cited the major causes of maternal death in Zambia, which included obstetric hemorrhage (33%), non-obstetric complications (22%), and hypertension (15%), which were responsible for one-third of all maternal deaths.

2.9 Effects of long distance on pregnant women to deliver at health facility

According to Moyo et al. (2019), access to maternal health services, particularly facility childbirth, remains challenging mainly in rural Zambia, and this leads to delays in seeking care due to the distance from home to the health facility. Different literature has been consistent in the findings, which vividly show that delayed referral to clinics is one of the causes of maternal death in Zambia (Amare et al., 2019). This happens when, due to a long distance or bad state of the road, it takes time for a woman to reach the clinic to be attended by a skilled birth attendant, which can leave a woman with either disabilities or cost both her and her baby their lives because of the distance. Distance is associated with an increased number of maternal and neonatal deaths.

2.0.1 Effect of a lack of facilities on the delivery package among pregnant women

Kaiser et al. (2019) outlined that Zambian women who delivered a baby within the previous year were reported to have spent money on deliveries, suppliers, transport, baby clothes, diagnostic tests, and medications, among others. Approximately 98 percent of women reported spending money on clothes or blankets; over 80 percent purchased supplies such as disinfectant or cord clamps; and about a third, 36 percent, paid for transportation. Removal of the delivery package has led to women stopping going to deliver at the clinic in most of the rural areas because most of the women cannot afford to pay for transport or to buy needed items such as gloves and disinfectant. During ANC, women are told to come with the delivery package, and those who do not manage to do so do not go to the health facility because of a fear of being embarrassed and tend to deliver at home even where they are aware of complications that arise during labor (Scott et al., 2018). Despite the abolishment of user fees, pregnant women still spent more on the things they needed at the clinic. According to Sialubanje et al. (2014, 2015; Chama-Chiliba & Koch, 2016), the cost of deliveries at health facilities in Zambia goes beyond user fees, which were removed.

2.0.2 Health effects on women and the baby who delivered at home

It is dangerous for both the baby and the mother to give birth at home. Almost all infant deaths occur as a result of home deliveries, and neonatal deaths can occur as a result of umbilical cord infection caused by premature birth. Giving birth at home can harm a woman's health by causing seizures, which can lead to death; excessive bleeding; and the transmission of HIV and AIDS if

the person caring for the pregnant woman is injured. The same period can also infect the baby because home births are performed in an unsanitary environment without adequate protective equipment (Multharayappa K. and Prabhuswamy P., 2003).

Konje et al. (2020) outlined that unskilled workers can pose a risk of increasing maternal mortality or morbidity for both newborns and their mothers, as well as exposing them to unanticipated danger, mostly if their health is compromised. This can be a link for infection transmission; hence, there is a need for more interventions to strengthen institutional deliveries in remote areas to reduce neonatal and maternal deaths.

Summary of literature review

Results of many studies indicated that there are numerous reasons that can cause pregnant women to give birth at home. The research also showed that location, travel time, the state of the road system, and distance all contribute to delays in receiving medical care. Financial capability, a failure to recognize pregnancy-related complications, a failure to seek medical help promptly, and a lack of prior experience are all factors in delayed care. Lack of referral systems or poor referral systems, unmotivated and undertrained staff, and subpar facilities all contribute to delays in receiving adequate services.

2.0.3 Theoretical framework

The theoretical framework of this study is going to be based on an educational approach model.

Educational Approach Model

This approach will empower people to make informed decisions about their health and well-being by providing them with the necessary skills, knowledge, and information.

This educational strategy

- This approach will not persuade or motivate change in any direction, but it will always have an outcome that will lead people to make the best choice.
- This approach will increase people's knowledge, which will lead to changes in behavior and the adoption of good practices.
- This approach will compel people to speak up or make informed decisions.

The method was used to increase knowledge and information include lecturers, counseling, posters, TV and radio programs, and pamphlets. Drama, role play, and demonstrations can help to improve skills.

Evaluation is done by measuring the knowledge gained, which will be accomplished by:

- Questionnaires\interviews
- Test feedback and evaluation

The assessing of the skills acquisition can be through

- Role play
- Personal feedback
- Observational in natural settings

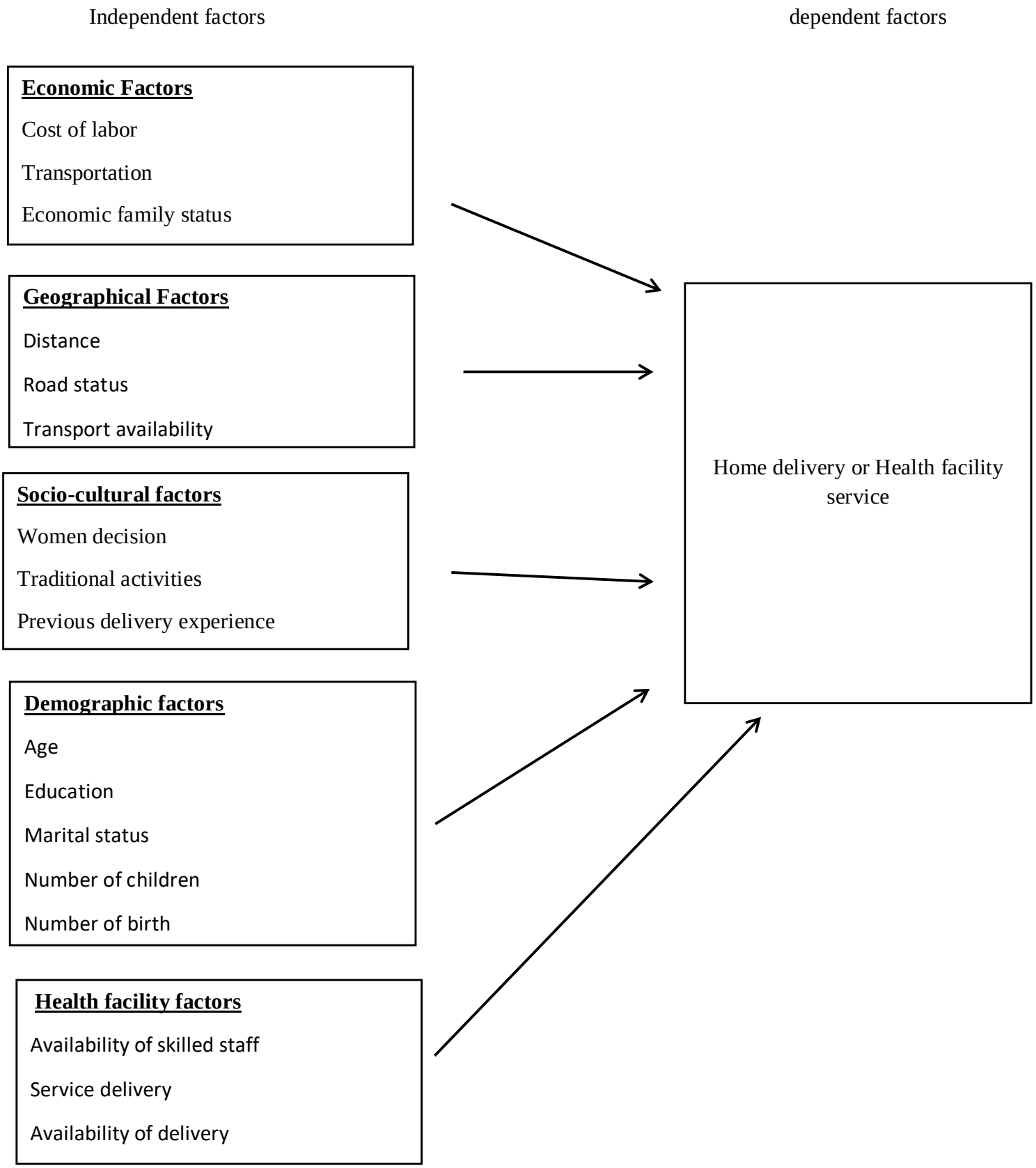
This approach relates to my study in such a way that there will be knowledge acquisition among pregnant women, which is going to result in their making informed decisions on where to give birth or deliver from because of the knowledge that they will have about the dangers of home birth and the importance of institutional deliveries.

Furthermore, this approach is going to help women of childbearing age be empowered with all necessary skills and knowledge acquisition to overcome or get rid of all beliefs and misconceptions in order to promote service utilization and the health of the pregnant women. When women of childbearing age acquire knowledge and information on the dangers and possible risks of life-threatening conditions such as hemorrhage, post-partum, uterine rapture, cephalopelvic disproportion, and neonatal asphyxia.

2.0.4 The conceptual framework

This study is going to assume economic factors (cost during and after labor, transportation to and fro, time spent, and economic family status), geographical factors (total distance to health facility**,** status of the roads**,** transport availability), and socio-cultural factors (women's decision, traditional activities, previous delivery experiences). Demographic factors (age, education, marital status, number of children, and number of births) environmental factors (availability of skilled workers, service delivery**,** availability of delivery suppliers, and equipment).

Research variables are going to be mentioned in the conceptual framework below Figure 1.



Source: compiled by researcher, 2023

CHAPTER THREE

3.0 METHODOLOGY

This chapter provides an overview of the method that researcher was using to obtain or gather data in order to archive research objectives. The study site, study design, sampling methods, data collection and data analysis, data presentation, and ethical considerations were covered in the methodology.

3.1 STUDY APPROACH

The researcher employed a quantitative approach in which information was gathered from existing SMAG in each village because they have data on pregnant mothers who deliver within their catchment area or village.

3.2 STUDY DESIGN

This research used analytical cross section study to collect information aimed at addressing the objective of the study.

3.3 STUDY POPULATION

The study population were women of childbearing age of (15-49 years) living in the villages that were selected.

3.3.1 Inclusion criteria

All women of childbearing age 15-49 years, were eligible for the study, which included women who gave birth within one year during the time of study only.

3.3.2 Exclusion criteria

All women under 15 years, those above 49 years and those without a history of delivery were excluded.

3.4 SAMPLING PROCEDURES

Since the targeted area of study was wide, the multistage cluster sampling technique was used in this research to select sample units from sample population in the following order;

3.4.1 First stage

Since the sampling frame have 4 wards, 2 wards will be selected randomly from 4 wards.

3.4.2 Second stage

After selecting two wards randomly, two villages from each ward will be selected randomly

3.4.3 Third stage

From each village which was selected all household with women who have children or delivered less than 1 year were eligible for the study.

3.4.4 Sample size

The sample size for this study was calculated using the single population proportion formula; the level of significance was set at 95% (Z-Score) = 1.96).

The following formula was used:

$$n = \frac{(Z)^2 P ((1-p)}{d^2}$$

Where P is a proportional estimate,

Z = 95% confidence level of certainty critical value $(1.96)^2$

The margin of error between the sample and the population is denoted by d^2.

The required sample size is $n = n^0$, so the sample size will be $\frac{(1.96)^2 x (0.5). (0.5).}{(0.05)^2}$

n= 384

3.3.5 Independent variables

Economic factors (cost during and after labor, transportation to and fro, time spent, and economic family status), geographical factors (total distance to health facility**,** status of the roads**,** transport availability), and socio-cultural factors (women's decision, traditional activities, previous delivery

experiences). Demographic factors (age, education, marital status, number of children, and number of births) environmental factors (availability of skilled workers, service delivery**,** availability of delivery suppliers, and equipment).

3.3.6 Dependable variables

Preference for delivery location: home or health care facility

3.5 DATA COLLECTION

Using the questionnaire, eligible childbearing women were asked to fill in the questionnaire from house to house by well-trained data collectors (an organized team), and the data collection process was supervised. To supervise the data collectors, an organized team members were recruited. The data collectors were trained for three consecutive days, and the data collectors were fluent in both Chewa and Nsenga. The orientation covered the following topics: how to record, how to approach, how to deal with harsh conditions during the process, and the purpose and scope of the study.

3.6 DATA ANALYSIS

The data was checked for uniformity, consistency and accuracy. The data analysis and interpretation of data was done using computer software (STATA). Data were entered into STATA for analyzing. Chi-Square was used to determine association between independent variables and outcomes.

3.7 ETHICAL CLEARANCE

The study was approved by the University of Lusaka's research ethical committee and the Lusangazi District Health Office. Furthermore, full consent was obtained from all participants who took part in this study. In this research participants' warfare was protected by maintaining confidentiality, and all steps were taken in an open and honest manner. The importance of voluntary participation in the study was emphasized. Participants had option to withdraw or not participate in the study if they so desire.

CHAPTER FOUR

4.0 RESULTS

The study was conducted in Lusangazi District were four villages where selected randomly. The total number of 380 women with children less than 2 years old were recruited and participated in this study.

The minimum age of respondent were 15 years old and the maximum was 49 years old with the mean age of 28.9 (SD=8.2) years. The majority of participants 90 (23.7%) were mothers between the age of 20-24, 83 (21.9%) were mothers aged between 25- 29 years, 60 (15.8%) were mothers aged between 30-34, 60 (15.8%) were mothers aged between 35-39 years, 46 (12.1%) were mothers aged between 15-19 years, 22 (5.8%) were mothers aged between 45-49 years, 18 (4.7%) were mothers aged 40-44 years, and one did not know her actual age. The majority of respondents 223 (59.5%) attended primary school education, 74 (19.7%) never went to school, 56 (14.9%) attended secondary education and 22 (5.9%) attended university education.

4.1 Demographic characteristics, and health care delivery

Despite giving birth in health facility depends on demographic factors, such as occupation of respondents and the spouse, age of participants, education and income. In this study it was not statistically significant between giving birth at health facility and factors. However, occupation of respondents were fairly associated with giving birth at health facility with P- value= 0.03. Furthermore, more than 80% of respondents whose occupation were farming give birth in health facilities compared to those occupations who were house wife, government employee and self-employment. The P- values for age of participants were (P-value= 0.589), P-value for level of education were (P-value =0.855), P-value for income on monthly basis were (P-value= 0.484) and the P-value for spouse occupation were (P-value= 0.070) respectively (**Table: 1)**

Table 1: demographic characteristics, and healthcare delivery (n=380)

Characteristics	HF delivery (%)	home delivery	χ^2 (P-value)
Age of participants			
15-19	41(12.2%)	5(11.4%)	
20-24	83(24.7%)	7(15.9%)	
25-29	71(21.3%)	12(27.5%)	
30-34	51(15.2%)	9(20.5%)	(0.589)
35-39	56(16.7%)	4(9.1%)	
40-44	15(4.5%)	3(6%)	
45-49	22(5.8%)	4(9.1%)	
0	1(0.3%)	0(0%)	
Education respondents			
Primary	198(59.6%)	24(58.4%)	
Secondary	51(15.4%)	5(11.6%)	(0.855)
University	19(19.3%)	3(7%)	
Never been to school	64(19.3%)	10(23.3%)	
Occupation of Respondents			
House wife	18(5.4%)	7(15.9%)	

Farmer	287(85.4%)	31(70.5%)	(0.033)
Government employee	12(3.6%)	3(6.8%)	
Self-employment	19(5.7%)	3(6.8%)	
Spouse occupation			
Government employee	9(2.7%)	39(6.8%)	
Farmer	288(85.7%)	31(70.5%)	(0.070)
Self-employment	29(8.6%)	7(15.9%)	
Pastor	10(3%)	3(6.8%)	

4.2 Health factors and place of delivery

On time taken to reach the health facilities the majority of respondents were 205(53.95) spent more than an hour to reach health facilities, which means they lived more than 5kilometres and about 175(46.05) spent less than an hour to reach health facilities, that means they lived less than 5kilometres. The *P*-value for both deliveries is (0.379), they is no association between delivery at home and distance to the health facilities (**table 2**)

Table: 2 distance from health facilities and delivery at home (380)

Variables	HF delivery	home delivery	P-value
Distance			
Less than 5km	152(45.24)	23 (52.27)	(**0.379**)
More than 5km	184(54.76)	21 (47.73)	
Total	**336**	**44**	**38**

4.3 Utilization of reproductive health services

Among 380 participant, 327(86.1%) attended ANC services more than four times during the period of pregnancies, 50 (13.2%) women attended ANC services three times during the period of their pregnancies, 1(0.2%) woman attended ANC services only once during her period of pregnancy and 2(0.5%)) did not attend any ANC services during their period of pregnancy and the reason given were the distance from the health facility were the contributing factor why they did not attend any ANC services. (**Table 3**)

Table: 3Antenetal count attendance (n=380)

Number of visits	frequency (N)	percentage (%)
None	2	0.5
Two times	1	0.2
Three times	50	13.2
Above four times	327	86.1
Total	**380**	**100**

Despite attending antenatal clinics, the number of 44(11.58%) women delivered at home while the majority 334(87.89%) women had deliveries conducted by skilled personnel at health facilities and two delivery occurred on the way to a health facility 2(.053%). However, the majority of people gave birth in health facilities with the help of skilled health personnel (**Table 4).**

Table 4: distribution of respondent by place of delivery (n=380)

Place of delivery	**frequency (N)**	**percentage (%)**
Health facility	334	87.89
Home	44	11.58
On the way	2	0.53
Total	**380**	**100**

44 (11.58%) of participants who delivered without the help skilled health personnel expressed their intentions of giving birth at health facilities with the exception of two women who delivered at home.

The majority respondent 25(56.82%) the reason given for not delivering in health facilities was due to sudden onset of labor and 9(20.45%) was due to the distance to the health facilities. The other reasons given were lack of transport 8(18.18) and 2(4.55) women it was due to cultural beliefs. (**Table: 5).**

Table 5: Reason for home delivery among women who intended to delivery at health facilities (n=44)

Reason	Frequency (N)	percentage (%)
Lack of transport	8	18.18
Sudden onset of labor	25	56.82
Long distance to the health facilities	9	20.45
Culture	2	4.55
Total	**44**	**100**

4.4 Monthly income status and delivered at home

Monthly income were classified as follows; K100-200, K300-700, K 800-1000 and above K5000. There were no association between place of delivery and monthly income status of household. However, 29(10.58%) of respondents who can afford referral cost to another health facility delivered at home compared to 245(89.42%) who cannot afford referral cost delivered at health facility, the difference was not statistically significant.

Table: 6 Monthly income and delivered at home (n=380)

Characteristics	Health Delivery (%)	Home delivery (%)	X^2 (P-value)
Monthly income			
100-200	272 (74.52)	30(68.18)	
300-700	40 (11.90)	7 (15.91)	0.487
800-1000	12(3.57)	3 (6.82)	
Above 5000	12(3.57)	4 (9.09)	

Table 7: Factors associated with home delivery

Variables	HF delivery	home delivery	P-value
Distance			
Less than 5km	152	23	(**0.379**)
More than 5k	184	21	
Satisfaction			
Not satisfied	12	9	(0.000)
Satisfied	323	28	
Referral cost			
Cannot manage	245	29	(**0.330)**
Yes can manage	91	15	

Transport			
Personal	4	3	
Public	54	9	(0.000)
Ambulance	274	28	
Others	3	4	
Delivery decision			
Self-decision	4	1	
Husband	22	8	(0.021)
Jointly	296	30	
Relatives	14	3	
Antenatal count			
Two times	0	1	
Three times	41	9	(0.005)
More than 4 times	294	33	
Income			
100-200	272	30	
300-700	40	7	**(0.487)**
800-1000	12	3	
More than k5000	12	4	

Spouse occupation			
Government employee	9	3	
Famer	288	31	**(0.070)**
Self-employment	29	7	
Pastor	10	3	
Respondent occupation			
House wife	18	7	
Farmer	287	32	**(0.033)**
Government employee	12	3	
Self-employment	19	3	
Level of education			
Never been to school	64	10	
Secondary level	51	5	**(0.855)**
Primary level	198	25	
University level	19	3	
Age of respondents			
15-19	41	5	
20-24	83	7	
25-29	71	12	

30-34	60	9	**(0.589)**
35-39	56	4	
40-44	15	3	
45-49	9	4	

The variables which were found to be statistically significant after doing Chi-square were satisfaction, transport and antenatal count showed to have strong association both with *P*-value less than 0.005 which means they is strong association between these variables; satisfaction, transport ,antenatal and the place of delivery. However, some variables such as distance, referral cost, delivery decision, income, spouse occupation, respondent's occupation and age of the respondents had *P*-value greater than 0.005 which means they were not statistically significant which shows they is no association between these variables and the place of delivery.(**Table 7)**

CHAPTER FIVE

5.0 DISCUSSION

The study looked at factors contributing to home deliveries, in this study included women attending antenatal clinic and delivery at home. The study further looked at the factors that negatively affect the delivery in health facilities among pregnant women with children less than 2 years, the factors included Geographical factors, socio-cultural factors, demographic factors and health facility factors.

Several studies have shown that socio demographic factors such as education, income, spouse occupation influences women's decision to give birth at home. Most studies founds that younger women, less educated women, women in rural areas are like to give birth at home (Olaitan et al, 2017). Similar study were done in India by Patel et al, 2021 which showed same findings on social demographic factors to be the most contributing factors for people to give birth at home. According to Shankwaya S (2008), a study conducted in Zambia revealed that a majority of women (55%) who give birth in health facilities are young, with 65% of them being first-time mothers. This aligns with the findings discussed above.

In this study a high percentage of first-time mothers gave birth in health facilities (87.39%) compared to those who gave birth at home (11.58%), they were no significant difference between the two. The study also found that there was no correlation between maternal age and giving birth at home, which was consistent with a similar study conducted in Uganda where factors such as age, distance and education did not have a significant impact on delivery location when compared to the father's occupation. The level of education a mother receives plays a significant role in the health outcomes of both the mother and child. Many studies have demonstrated that a higher level of maternal education is linked to improved health outcomes. This relationship has been consistently observed in different research over time. According to various studies, maternal mortality risk decreases with higher levels of maternal education. Kifle et al. (2017) conducted a study in Ethiopia that revealed women without formal education had a greater likelihood of dying during pregnancy or childbirth compared to those with secondary education or higher. Similarly, Ahmed et al. (2014) conducted a study in Bangladesh that found women who lack formal education are at greater risk of maternal mortality than those with higher levels of education.

Child health outcomes are positively impacted by maternal education, as evidenced by a study conducted by Garenne et al. in 2017. The results of the study indicate that children born to mothers with higher levels of education have a decreased likelihood of under nutrition and stunting. Maternal education is also linked to increased utilization of maternal and child health services, including antenatal care and immunization, as shown in a study carried out in India by Bhalotra and Rawlings in 2013. In this study, 94.3% of the women with primary, primary and university education delivered in health facilities compared to 19.3% of those who have never been to school.

Women who work and earn an income may save money to use for a health facility delivery. However, the relationship between maternal employment and place of delivery has been explored in several studies, with mixed findings. Some studies have found that women who work are more likely to deliver in a health facility, while others have found no significant association between maternal employment and place of delivery.

One study conducted in Nigeria by Ezegwui et al. (2014) found that women who worked were more likely to deliver in a health facility compared to those who not working. The study found that women who were employed were more likely to have access to information on maternal health, which increased their likelihood of seeking care during pregnancy and childbirth. Similarly, a study conducted in Nepal by Kc et al. (2016) found that women who worked in the formal sector were more likely to deliver in a health facility compared to those who worked in the informal sector. In this study, there was no significant statistical difference between women's occupation and their choice to give birth in a health facility. On the other hand, similar study conducted in Ghana by Asuming et al. (2018) found no significant association between maternal employment and place of delivery. The study found that other factors such as age, education, and wealth were stronger predictors of place of delivery than maternal employment.

5.1 Health factors and place of delivery

Pregnant mothers in rural areas often consider distance as a decisive factor in selecting a delivery location, as health facilities are not frequently available. Even if a health facility is properly staffed and well-equipped, it becomes pointless if the pregnant women cannot access it easily due to the long walking distance involved. Numerous studies have shown that the proximity to healthcare

facilities greatly affects the probability of women giving birth in a health facility. The scarcity of healthcare facilities in many rural and isolated regions makes it difficult to obtain maternal and newborn health services, causing difficulties such as longer travel times, more costly transportation, and a shortage of available medical professionals.

Doctor et al. (2015) conducted a study in Nigeria and discovered that women who stays over 5 km away from the nearest healthcare facility were significantly less probable to give birth in a health facility. Similarly, Mpembeni et al. (2007) conducted research in Tanzania indicating that proximity to health facilities was a predictor of facility delivery. According to their findings, women living more than 5 km away from a health care facility were less likely to have facility deliveries opposed to those living closer. Furthermore, according to Tesfaye et al. (2018), a study conducted in Ethiopia indicated that women living beyond 10 km of a healthcare facility are at a greater risk of not delivering in a health facility. Moreover, the research found that women residing closer to health facilities tend to receive more antenatal care, which suggests that the geographical distance to healthcare facilities affects the usage of other maternal health services as well.

However, in this study the results shows that they is no association between distance and delivering in health facilities, 184(54.70) women who lived more than 5 kilometers delivered in health facilities compared to 23(52.72) who lived more than 5Km who delivered at home. The proportion of women to give birth in health facilities is coupled with some rules set by headmen to say if a woman give birth at home should be punished, this has attributed to women to be giving birth in health facilities because of the fear to pay money when getting under five card as well as paying goat to the head men.

The place of delivery among pregnant women can also be influenced by various health factors such as the condition of the mother's health, complications related to pregnancy, and the accessibility of emergency obstetric care. Yalew et al. (2019) conducted research in Ethiopia and discovered that pregnant women who encountered pregnancy-related problems had a higher chance of delivering at a healthcare center. The findings also revealed that receiving antenatal care may boost the probability of delivering at a health facility, implying that timely detection and treatment of complications during antenatal care could increase the likelihood of giving birth in such facilities.

Similarly, a study conducted in Tanzania by Mosha et al. (2018) found that women who experienced pregnancy-related complications were more likely to deliver in a health facility. The study also found that the availability of emergency obstetric care, including access to cesarean section, was a significant predictor of place of delivery.

5.2 Monthly income status and delivered at home

The occupations of both a husband and wife play a crucial role in determining the family's financial capacity for childbirth. Husband with financial stability may provide the wife with better delivery facilities due to Financials stability. Gabrysch & Campbell (2009), high-status occupations are linked with increased financial resources that can be utilized for skilled delivery care expenses.

Several studies have investigated the relationship between monthly income status and delivering at home among pregnant women. The findings from these studies suggest that lower monthly income status is associated with an increased likelihood of delivering at home. The place of delivery among pregnant women is largely influenced by socioeconomic factors, according to a study conducted in India by Chaturvedi et al. (2016). Results showed that women from lower income groups, rural areas, and those with low levels of education were more likely to deliver at home. These findings imply that addressing economic disparities could potentially increase access to healthcare facilities for pregnant women. Similarly, a study conducted in Ethiopia by Teshome and Hailu (2016) found that women with higher monthly incomes were more likely to deliver in health facilities. The study also found that the distance to the nearest health facility was a significant predictor of place of delivery, with women living closer to health facilities being more likely to deliver in health facilities.

Another study carried out in Nepal revealed that place of delivery was strongly linked to monthly income status. According to Paudel et al. (2018), those who had a higher monthly income were more likely to give birth in health facilities, whereas women with lower incomes were not. On top of that, the research demonstrated that pregnant women who had received antenatal care were also more prone to deliver their babies in healthcare settings.

However in this study they were no association between monthly incomes and place of delivery most women with low income who resides in typical remote area 88.4% delivered in health

facilities, most women in Lusangazi district their monthly income is within K100-200 monthly but majority of women do give birth in health facilities the most contributing factors is the penalty fee which were introduced to those giving birth at home.

5.3 limitations of study

The study may have been affected by recall bias, as some participants had difficulty remembering certain details about their antenatal clinic visits. To obtain accurate information, MCH cards were utilized. Additionally, there is a possibility of inaccurate data being reported by health workers administered the questionnaire in the field area. It is difficult to determine the extent of these biases with certainty.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

Well trained and equipped health workers are known to be a vital protective factor against maternal and new born morbidity and mortality, as they provide maternal health care services. In Lusangazi district the proportion of women who attended antenatal clinic at least more than three times was higher (86.1%) and the delivery in health facilities were high with 87.89% compared to the studies done in Lundazi and Nyimba district with lower percentage of women who delivered in health facilities in 2014-2015.

The results shows that they is no association between women education, age, transport, distance, antenatal count visit with home delivery.

Maternal health services need continuously sensitization to the community so that the number of pregnant mother who deliver at health facility can increase for us to attain millennium goals by 2030.

6.2 RECOMMENDATIONS

Based on study's findings, the following recommendation have been put forward:

- The Government should strongly encourage the improvement of education for girls beyond primary school since it has an impact on their decision about where to give birth.
- To improve accessibility of health facilities in rural areas should be strengthened by increasing both the number of facilities and transportation options.
- To promote early booking of antenatal care clinic and completion of more than four visits at the community level, as this provides women with sufficient information for safe delivery and encourages them to deliver in a health facility.
- A qualitative study approach involving in-depth interviews or focus group discussions with health providers should be conducted to gain a deeper understanding of the factors that affect delivery in health facilities.
- Next researcher should use multivariate analysis to determine the relationships among large sets of data, it's particularly effective in reducing biasness.

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APPENDIX

Data collection tool

1. How older are you?
2. Do you have the ability to write and read? Yes/ no
3. If yes, what level of education attended?
    A. Secondary education
    B. Primary education
    C. University level
4. What do you do?
    A. house wife
    B. farmer
    C. government employee
    D. Self-employment
5. What is the occupation of your husband?
    A. Employed by government
    B. Farmer
    C. Self-employment
    D. Pastor
6. What is your monthly income?
    A. K100 -k200
    B. K300- k 700
    C. K800- 1000
    D. Above k5000
7. How many children do you have?
8. Have you ever gone to an antenatal clinic during your previous pregnancy? Yes/no
9. If yes, how many times did you go during your last pregnancy??
    A. Once
    B. Two times
    C. Three times
    D. Four times
10. If not, why?

A. I didn't have any health issues/complications
B. it was far from my house to the hospital
C. the expense of transportation was high
D. Poor conduct by health professionals

11. Where did you have your most recent child delivered??
A. At home
B. Health facility
C. Traditional birth attendant house
D. D. On the way to the hospital

12. Was the place you intended to deliver from?
A. No
B. Yes

13. Where did you intend to deliver if not from health facility?
A. At home
B. Heath facility
C. Traditional birth attendants home

14. What were the factors that led you to deliver to the location you did?
A. lack of transportation
B. Sudden/ abrupt onset of labor
C. poor behavior of health workers
D. Culture

15. What mode of transportation is used when a pregnant woman is referred to a district hospital??
A. Personal transport
B. Public transportation
C. ambulance
D. walking

16. Can you afford the cost of transportation if you are sent to another medical facility??
A. no
B. yes

17. If yes, how will you raise the necessary funds to travel to the needed medical facility??

A. Sell live stocks
B. Borrowing money
C. Refusal referrals
D. Doing piece works

18. How far is the health facility on average from your home??
    A. Less than 5 km
    B. More than 5km
19. Are you satisfied with the care you received at the hospital? Yes/no
20. If no, what aspects of your facility's services make you unhappy??
    A. No drugs
    B. Bad behavior of health workers
    C. Lack of privacy
    D. Presence of male nurses during labor
21. What makes a woman not to deliver nearby health facility?
    A. Sudden onset of labor
    B. Bad behavior of health workers
    C. Presence of TBAs
    D. Distance to the facility

22. Who made decision of place of delivery?
    A. Self
    B. Husband
    C. Jointly
    D. Relatives
23. What suggestions do you have for improving health care in your facility??
    A. Increasing the number of health professionals
    B. Improving drug accessibility
    C. Health professionals should respect women's privacy
    D. Improving transportation, such as ambulances

WORK PLAN

Study Gantt chart

Activities	2022 Aug	2022 Sep	2022 Oct	2022 Nov	2023 Feb	2023 Mar	2023 April	2023 May
Proposal writing								
Proposal review								
Proposal presentation								
Proposal submission								
Data Collection								
Data review								
Dissertation writing								
Dissertation submission								

BUDGET

The following is going to be the budget for this study.

S/N	BUDGET ITEMS	UNIT	RATE PER(K)	COST(K)
1	(Ream of A4 plain papers,	1	60	60
3	Pack of pens	2	30	60
4	Printing services			500
5	Refreshments/ food(5assistants)			300
6	Research assistant allowances	5	5*50	250
7	Transport expenses			500
8	Data bundle	3	50	150
9	Final report binding			200
	TOTAL			**2,020**

CONSENT FORM

Dear participant,

I am Stephen Manianga and am a student at the University of Lusaka pursuing a Bachelor of Science in Public Health and health sciences. My program requires me to conduct a research project as part of the fulfillment of my degree program. To evaluate factors contributing to home delivery in Ukwimi Village, Lusangazi district.

I wish to let you know that you have been selected to be a participant in this study, and I wish to emphasize that participation is voluntary; you can withdraw from participation at any stage you want to do so. The question you will be asked is concerning factors contributing to home delivery. The information that you're going to share with me remains highly confidential and is intended to be used for academic purposes only.

Consent granted (please tick)

Yes

No

Signing of participant.....

Signing of researcher assistance……

Date of signed consent……..

Authorization letter, from NHRA, UNILUSREC

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: NHRA00004/1/02/2023 **Date: 1st February, 2023**

The Principal Investigator,
Stephen Manianga,
University of Lusaka,
Lusaka, Zambia.

Dear Mr. Manianga,

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 **"Factors Contributing to Home Deliveries among Pregnant Women in Ukwimi: Lusanganzi District."**

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. Godfrey Biemba,
DIRECTOR/CHIEF EXECUTIVE OFFICER

Incharge Ukwimi & Referral Hospital

SCHOOL OF MEDICINE AND HEALTH SCIENCES LEOPARDS HILL CAMPUS

Plot No. 37413, Off Alick Nkhata Mass Media. P. O Box 36711, Lusaka
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E-mail:unilus@zamnet.zm,ictar@zamnet.zm

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
LUSANGAZI DISTRICT HEALTH OFFICE
14 FEB 2023
DISTRICT HEALTH DIRECTOR
P. O. BOX 560302,
LUSANGAZI

Date: 15th DECEMBER, 2022

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PERMISSION FOR **STEPHEN MANIANGA - BSPH19216529** TO CONDUCT 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 **STEPHEN MANIANGA** Public Health Student to conduct research at your facility/ institution/ organization, entitled; **FACTORS CONTRIBUTING TO HOME DELIVERIES AMONG PREGNANT WOMEN IN UKWIMI: LUSANGANZI DISTRICT.** 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.

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SCHOOL OF MEDICINE AND HEALTH SCIENCES RESEARCH ETHICS COMMITTEE

Ref no: IORG0010092-2023/067

Date: 15th DECEMBER, 2022

STEPHEN MANIANGA - BSPH19216529

Re: RESEARCH TITLE: FACTORS CONTRIBUTING TO HOME DELIVERIES AMONG PREGNANT WOMEN IN UKWIMI: LUSANGANZI DISTRICT

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.