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Decision-Making that Determines Choice of Delivery Location Among Pregnant Women in Lundazi District- Zambia

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ABSTRACT

Deciding where to give birth is the woman's entitlement. The choice of a delivery location has serious implications that border on the health and life of the mother and her foetus. This study explored critical players who influence pregnant women significantly about the choice of the birth place in Lundazi district-Zambia. Six Focus Group Discussions involving 30 Antenatal mothers and 30 members of Small Motherhood Action Groups (SMAGs) were conducted between March and April, 2019. This study found that pregnant women in Lundazi district were greatly influenced by their husbands, mother in-laws, biological mothers, grandmothers, neighbours, elderly women and the community when deciding the choice of a delivery location. Women with little or no education had a higher chance of depending on the significant others to decide where they could deliver. In some instances, this weighty decision was made when labour began. Women should be autonomous when deciding what is best for their reproductive health needs for them to achieve a positive pregnancy experience and outcome. But socio-cultural practices reduce their autonomy. A well-informed society can be supportive of a woman when deciding to choose a delivery location where she can be safe, supported and assisted by skilled staff.

Key words: *Antenatal, decision, birthplace, choice*

1.0 Background

Decision-making is an unavoidable voluntary duty required in the fulfilment of fundamental needs at individual and corporate level. The decision about the delivery location is critical in pregnancy. It is an utterly important aspect of women's experience of childbirth (Grigg & Kensington, 2015). The delivery location acts as a relic reminding the woman where her maternity pilgrimage ended. But most importantly it is a source of motivation for positive pregnancy experience. Decision about delivery location can be a source of ill-fate in case of maternal or foetal complications during or after the birthing process.

Grigg and Kensington (2015) put it more succinctly that birthplace decision-making can have far-reaching implications for women. Therefore, the process should be done carefully weighing all the options and risks from every stand point. But usually the process is complex and has powerful socio-cultural implications in some cultures (Kildea, 2006; Kornelsen et al., 2010). When a pregnant woman makes an individual informed decision about her delivery location, it means a play out of autonomy, control, dignity, decency and responsibility. But decision-making about the choice of a birthplace occurs in, and is strongly influenced by the social, cultural and political context within which women and families live (Grigg& Kensington, 2015). Scholars however, trace the ability for a woman to make a decision independently on the delivery location to the time of gender identity formation in babies as they interact with society (Triratnawati&Izdiha, 2018). Through social interaction, distinguishable behavioural tendencies emerge that position men and women differently within their households and communities (Nugroho, 2011).

Societies where men hold economic power, women have less bargaining power (Charter, 2004) and this affects their ability to choose the birthplace for their babies. Similarly, societies where mother in-laws exercise much authority and power, in such societies, the ability of a woman to choose a place to deliver her baby is severely attenuated. Delivery in a health facility is associated with benefits related to presence of skilled staff, life-saving equipment and hygienic conditions that help reduce the risk of maternal and neonatal complications and deaths (Campbell & Graham, 2006). But societies where the social position of a woman is lower, it is not uncommon for in-laws, husbands, mothers and the wider society to have different knowledge about pregnancy (Triratnawati&Izdiha, 2018) and where the pregnant woman should deliver from. Scholars note that the decision on the delivery location has consistently been associated with maternal and neonatal outcomes (Kifle et al., 2018) meaning it can reduce the risks to the woman and her baby during delivery or put the woman and her baby at risk of developing complications and eventually die if help delays.

Lundazi district of Zambia, logged a total of 64 maternal deaths between 2016 and 2018 (Provincial Integrated Meeting, 26th September, 2019). During one of the Maternal Death Surveillance Review, it was reported that one pregnant woman died because her husband could not allow her to go and

deliver from a health facility. The objective of this study was to find out about the decision-making process that determines the choice of the delivery location of pregnant women in Lundazi district- Zambia.

Methods

The study utilized a cross-sectional study design with a qualitative descriptive approach. The study was conducted between March and April in 2019. In line with Krueger (1994)'s prescription of ten people for a range of perspectives, each Focus Group Discussion session performed in this study, comprised 10 participants. This study held 6 Focus Group Discussion sessions. To ensure credibility and dependability the study used antenatal mothers and Small Motherhood Action Groups(SMAGs) "obtain the broadest range of information and perspectives on the subject of study" (Kuzel, 1992:37). The role of Small Motherhood Action Group members is to raise awareness about pregnancy and birth-related complications and to reduce critical delays in decision-making at a household level about seeking life-saving maternal healthcare in health facilities (Ensor et al., 2014).

Data for the study was collected by means of Focus Group Discussions moderated by the Assistant Researcher in local *Tumbuka* language. Each Focus Group Discussion session was conducted in a well ventilated room taking 60minutes. Participants were given a thorough explanation about the purpose of the study, matters on confidentiality, consent, and audio recording. Upon obtaining consent from the participants, the researcher went on to collect demographic data from the participants. Questions from the Focus Group Discussion guide were read in English by the researcher and translated into *Tumbuka* by the Assistant Researcher. Participants' responses were translated from *Tumbuka* into English with the help of the Assistant Researcher. The Sony audio-recorded information was replayed at the end of the session for clarifications and additions from participants. The responses were written down and later typed and stored as a Microsoft copy. At the end of each session, participants were served with refreshments.

Results

A total of 60 participants categorized as 30 expectant mothers and 30 Community Health Volunteers participated in the study. The youngest participant was 18 and the oldest was 40 years for pregnant women; 30 and 64years for Community Health Volunteers. All participants were peasant farmers. Except for 10 who reported to have completed High School and 15 who completed junior secondary level education, the rest failed to complete primary education.

Question. Explain to me who influences the decision about the delivery location?

The purpose of this question was to gain deeper understanding of who influenced the choice of the delivery location for a pregnant woman in Lundazi district- Zambia. Participants explained that in the village, pregnant women had no freedom to choose the birthplace of her baby. First in the rank was her husband, followed by her mother in-law. Down the hierarchy ladder, came her own mother, grandmother, neighbours, friends, Traditional Birth Attendants, the head man and the stranger. Health workers and the woman herself stood at the bottom. As reported by one Another participant from the same Focus Group Discussion responded:

In the village, it is not a woman alone who makes a decision on where to deliver from. Her husbands, in-laws, her granny, elderly women including a stranger have greater influence. They decide whether she should deliver from home or at a health facility (Focus Group Discussion 1, Female SMAG Member).

Among antenatal mothers there was a mixture of answers over the role of a husband in deciding the delivery location. Some reported that the woman needed to consult her husband. The level of education of the 'yeah' group was low. This group reported that a husband is a 'father of the house' therefore; he had the final word over the delivery location. The group insisted that it was inappropriate for a woman to ignore her husband on matters bordering birthing location. They insisted that a woman was under obligation to leave all critical decisions to her husband as a sign of loyalty and submission as observed from an antenatal mother's report.

The husband is the decision maker about the delivery location

It's the husband who should decide where the wife should deliver from. When the husband pays the bride price, then he automatically earns the privilege of deciding the birthplace of his children. (Focus Group Discussion 1, Antenatal Mother, 36years, reached Grade two).

The other pregnant woman aged 36 years with educational history of reaching Grade four reported;

Every woman is taught to be loyal to her husband. In submission, she has to allow her husband make decisions even on where her wife should deliver (Focus Group Discussion 3, Antenatal Mother, and 36years, reached Grade four).

Pregnant women with relatively higher educational levels posited a radically different opinion. They reported that women in their own capacity guided by advice from Health Care Workers had the legitimacy to decide the birthplace. A 24year old woman, expecting her third child reported:

*For sure the husband should have a word about where I should deliver from but whatever he may say the final decision should be the woman guided by the counsel from nurses and doctors should decide. If he tells me just deliver from home I need to refuse. It will be me who will be put in danger and not him. If I die my baby and the family is the one that will lose out. He will continue with his life and even marry a week after I am burried (*Focus Group Discussion 1, Antenatal Mother, 24years, reached Grade nine).

The mother and the grandmother of the pregnant woman is the decision maker

During the second Focus Group Discussion with antenatal mothers, more interesting responses were gleaned. The responses exalted the social position of the pregnant woman's mother and her grandmother as people with the word of authority about the woman's delivery location. Reported the first time mother:

For me when the time comes to deliver, my mother will decide where I should deliver from. (Focus Group Discussion 2, Antenatal Mother 18years, reached Grade 7). When asked why her mother, she said; *my mother is experienced. If she delivered me then she can be trusted to have her grandchild*.

Other pregnant women reported that the grandmother to the pregnant woman had the privilege to decide where the woman could deliver. Reported one mother:

If it means judging people by means of experience then the grandmother is the right person to decide where a woman should deliver from. My grandmother tells me that during her time deliveries were not as complicated as they have become in recent times. So every woman should deliver from the clinic (Focus Group Discussion 2, Antenatal mother 25years, reached Grade 5).

Experiences observed by members of Community Health Volunteers (SMAGs)

Focus Group Discussion with members of the Small Motherhood Action Group yielded additional information about how the choice of a delivery location and consequences.

In my neighbourhood a pregnant woman died because her husband refused that she goes to deliver from a clinic. He told mkaziwam'ngóno (second wife) *that if the first wife delivered all her children through home delivery who was she to decide of choosing to deliver from the clinic? In obedience, the second wife changed her mind and had a home delivery but during the childbirth process she developed the bleeding complication and died at home* (Focus Group Discussion 1, Male Participant, SMAG Member Form 3).

During the third Focus Group Discussion with members of SMAG, one female participant narrated the following:

In my village I insisted to the pregnant woman and her grandmother to go to the clinic and deliver from there. When she and her grandmother arrived at the clinic, they were told that that the woman's delivery should be at a hospital and not a clinic because it was her first pregnancy. When the grandmother heard about delivering from the hospital she made a decision to sneak out with her pregnant granddaughter. When the ambulance arrived to pick the granddaughter, the two had run away. The grandmother decided that her granddaughter should deliver from home because at the hospital she would be taken to theatre where they would cut her and cause infertility. Sadly, when they reached home, things took a twisted turn. Her delivery was characterized by complications. So she died. I heard the following day of her death (Focus Group Discussion 3, Female participant SMAG Member Grade seven*).*

When asked when exactly is the decision made about the choice of the delivery place for a woman, responses from antenatal mothers and SMAG members varied widely as observed from the response from this antenatal mother.

Timing of the decision

The moment labour starts then the husband has to decide whether to take you to the hospital or whether you should deliver from home ((Focus Group Discussion 1, Antenatal Mother,36 years, reached Grade 2).

The other antenatal mother during the same Focus Group Discussion countered:

Health workers educate us that the decision about where a mother should deliver from should be made the moment a woman realizes that she is pregnant. Making a decision at the last minute is dangerous(Focus Group Discussion 1, Antenatal Mother, 28years, reached G12).

Responses from SMAG members were as follows:

The trend in the village is to wait for labour pains. The decision to take the woman to the clinic or to allow her deliver at home is usually made under panic. No wonder many of the women deliver on their way to the clinic (Focus Group Discussion 2, Female participant SMAG Member).

Another SMAG member remarked:

If a woman has a supportive family, she is assisted to follow instructions given at the clinic. She is taken to the clinic early at the clinic for close monitoring(Focus Group Discussion 2,Male participant SMAG Member).

Discussion

The choice of the delivery location is embedded in the antenatal care package. Pregnant women are educated both as a group and as individuals on the best option with regard to the birth place for their babies. The health facility is hailed as the only available option for women to give birth because it is safe, clean and provides a supportive environment characterized by presence of skilled staff, life-saving equipment, drugs and other supplies. Studies

have indicated that despite the appealing messages by health workers to pregnant women to choose a health facility as a birth place for their babies, sometimes advice is not accepted, invitation ignored, warnings never heeded and open doors forever closed with resultant fateful maternal and foetalcomplications and deaths. The objective of this study was to find out about decision making about where a woman in Lundazi district-Zambia gives birth. This study found that the husband, mother in-law, the mother and grandmother to the pregnant woman and the wider community are very influential in deciding the woman's delivery location. These findings are similar to those of Triratnawati and Izdiha (2018). In their study titled *Family Intervention in the problem of Maternal Death: A case study of pregnant women in Mbojo, Bima, West Nusa Tenggara*Triratnawati and Izdiha (2018) found that the husband, biological mother, mother in-law significantly influenced how the pregnant woman access health care services(p270) including where the woman should give birth. This study found that pregnant women with low or no education at all had less freedom to decide for themselves the delivery location. They were dangerously dependent on their husband. Bound by the customary laws and traditions, some felt incapable of deciding to go to the hospital. They felt obliged to wait for the husband for fear of disrespecting him as noted from the narration from one of the SMAG member.

In my neighbourhood, a woman felt labour pains but failed to request to be taken to the clinic. She insisted that she would wait for her husband who was away to return and decide what should happen. The husband took long to return and by the time he was arriving at home, his wife was lying in a pool of blood. Luckily he acted fast and rushed her to the hospital where they gave her three units of blood ((Focus Group Discussion 3,Male participant SMAG Member Grade 11)

This study's findings corroborate with the findings of other studies. First, Mwaniki et al., (2012) observe that the level of education attainment empowers and broadens a woman's range of choices giving her the ability to be in control of her reproductive health needs including where to give birth. A study conducted in Ghana by Smith et al., (2013) found that women with low level of education were likely to be influenced to deliver from home while those with higher level of education had greater chances of delivering in a health facility. Moyer et al., (2013) argue that women who depend on men for economic survival may require to seek permission from their husband on where to deliver because their husbands are high up in the social strata.

Conclusion

Women should be autonomous when deciding what is best for their reproductive health needs. This should be done to enable them achieve a positive pregnancy experience and outcome. But socio-cultural practices reduce their autonomy. Husbands, mother in-laws, their own biological mothers, grandmothers, neighbours, and the wider community greatly influence women's decision to choose where to give birth. A well-informed society can be supportive of a woman when deciding to choose a delivery location where she can be safe, supported and assisted by skilled staff.

Recommendation

This study recommends that Health Care Workers should provide consistent attitude-changing awareness community meetings. Additionally, Health Care Workers should work closely with communities in strengthening male involvement.

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