

# The extent of inequalities in relation to maternal and newborn health at community level: a baseline study in Ntchisi District, Malawi

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## Abstract

This is a summary of findings from a social analysis studies carried out by CARE as a baseline study in implementing a community mobilization approach to improve maternal and newborn health (MNH).

The aim of the study was to find out the extent of the existing inequalities in relation to MNH. The study was conducted in three communities in Ntchisi district for a period of 8 months (October 2004 to May 2005). The findings revealed that there are social inequalities between women in accessing health services, information and support in maternal and neonatal health. Meaning that maternal health services

at community level may not serve everyone due to criteria that is applied locally to decide who benefits. The study also found that there is inadequate capacity and coordination at community level in maternal health support system leading to inequalities in accessing maternal and newborn health services.

The study concluded that communities can play an effective role in facilitating MNH services if they can have common understanding and ownership of MNH issues for them to be mobilized and to facilitate access to MNH services.

## Introduction

Care International in Malawi is implementing a three year pilot project in Ntchisi district, Models for Inclusive and Equitable Sexual and Reproductive Health (MINERSH), aimed at building community capacity to address inequalities in sexual and reproductive health with a focus on maternal and neonatal health (MNH). The overall goal of MINERSH project is to improve equity amongst households and individuals in relation to MNH care and support. Before implementing the project CARE wanted to understand the extent of inequalities at community level hence it conducted a baseline study for a period of 8 months from October 2004 to June 2005 in Ntchisi district. This was done to address the question of why in a very poor community where access to health services is very difficult, still some women and newborn babies are in better health than others. This paper outlines the study methodology, data management, findings with their discussion, summary of the inequalities and a conclusion is made.

## Methodology

A total number of 28 focus group discussions were conducted with traditional counselors, village health committees, older and young men and women. There were also key informant interviews (20) with village chiefs, health centre nurse, traditional counselors, faith based counselors, traditional birth attendants and health surveillance assistants. In addition, 115 women from three communities (group village headmen areas) were interviewed. A household questionnaire was administered to women who were 6+ months pregnant and those that had pregnancy within the last 12 months.

The research study area was Ntchisi district where MINERSH is piloting its interventions in 3 Group Village Headmen (GVH) areas of Mdimba, Kafulu and Mkhlapathumba), reaching an

estimated population of 4500.

The study used an inclusive sampling process for every woman who qualified to be interviewed in each of the selected villages. The respondents were those who were 6 months pregnant and above and all women who had pregnancy in the last 12 months. 115 women were interviewed in the 11 villages representing 54% of the total sample size for all the three communities. In total 216 people were interviewed including the key informants.

## Data management

For the quantitative research component close-ended questions comprised the survey instrument. EPI Info 2000 was used to create a user friendly data entry programme, and data were entered by a statistician.

For the qualitative research component, all discussions were written down in the vernacular Chichewa language. The notes were then transcribed and translated into English. From each transcript, text was identified and categorized in accordance to the main themes and sub-themes thereby allowing the text to be coded. After assigning the text to specific themes, the data was then compared across different groups of men, women and was also used as comparisons and contrasts to what other groups and individuals reported on specific issues.

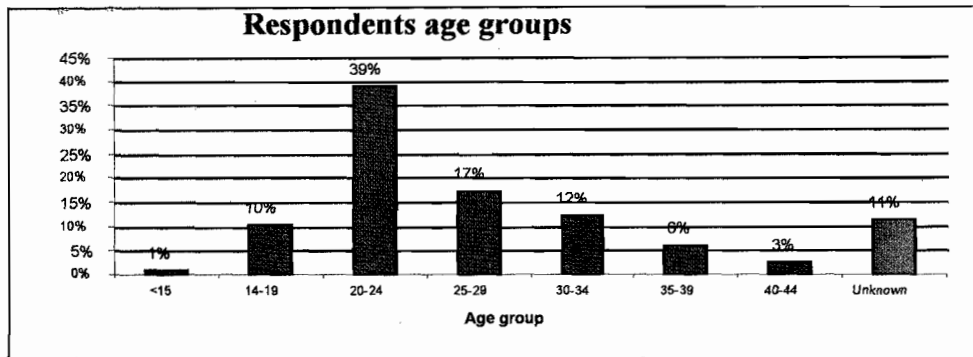
## Research Findings

The study revealed that there are social inequalities between women in accessing health services, information and support in maternal and neonatal health. The findings are presented first, followed by a sub-section discussing their implications.

Demographic characteristics of the respondents

The age of the respondents ranged from 14 to 44, and 13 did not know their age (Figure 1).

Figure 1. Distribution of respondents by age group (n=216)

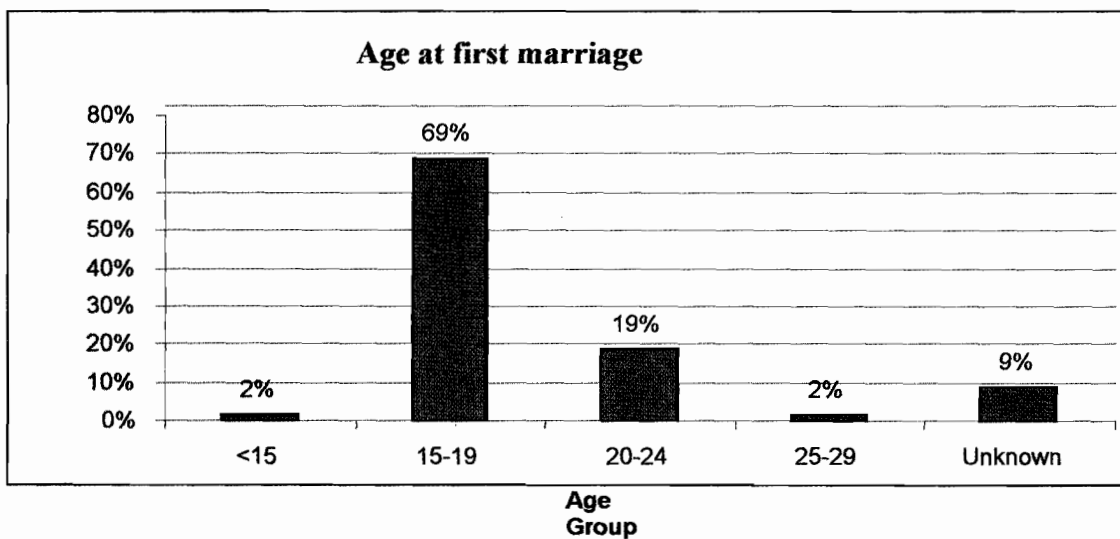


### Marital status

According to the findings, a majority of married women were between ages 15 to 19, 114 out of 115 interviewed women were

married at the time of the survey of which 18 (15.8% of the sample size) were in a polygamous marriage and live in a patrilineal family system.

Figure 2 - Age of women at first marriage



### Education

Most of the respondents had attended school up to primary level, (51.8%) respondents reported an ability to read vernacular language while 19.3% had difficulty and 28.9% could not read.

### Economic activities of respondents

The findings indicated that 75% of the respondents were living below the poverty line (taking poverty as living on less than a dollar per day according to the World Bank 1993). Out of 115 women interviewed, 110 (95.7%) rely on farming while 4 (3.5%) are involved in small scale enterprise and 87.8% of the respondents spouses were largely involved in farming while 7% were involved in small scale businesses. 99.1% of the households in the survey had houses with grass thatched roofs while 93% had houses with mud walls. Only 50% of the households had granaries with maize. This reflects an overall impression of poverty and similar poverty levels in the communities.

### Discussion

The findings showed that 15.8% of the respondents were in a polygamous marriage, with women as young as 20 years old. As wives in patrilineal society, their value is the ability to have children, contributing to maternal morbidity and mortality related to high parity (Beischer, 1992), since with every marriage a woman feels obliged to produce children for the new husband in

such a family system. Meaning that women in polygamous marriages are more prone to maternal morbidity and mortality as they may not want to use family planning services in order to give more births to please their husbands and maintain their value as women. In addition, considering the economic status of the communities, women in polygamous marriage may have inadequate material support as resources are shared between several wives.

The type of dwelling and the possessions of the households in which the respondents were drawn from indicate that most families are poor. According to literature, poor macroeconomic environment and poverty limit ones access to health services (Republic of Malawi, 2004). This entails that poverty is one of the underlying factors limiting access to health services in the study area, as the health centers are at most three to four hours away from the community, entailing the cost of transport. Although 51% of respondents had attended school, none had gone beyond primary education; therefore the respondents can be categorized as having had low level of education. Level of education has a strong correlation with seeking and accessing health care, and education beyond primary has a significant impact. With education, women are less likely to engage in harmful practices; beliefs in supernatural causes of illness or death are reduced and accessible and functional health facilities are more likely to be used resulting in safer pregnancy and childbirth (Harrissons, 1997).

## Key players in maternal and newborn care and their roles

### Men

Men were ranked highly (59%) during pregnancy and delivery as persons who are supportive, as breadwinners they assist their wives by seeking transport during emergency related to pregnancy and delivery. Often an oxcart is sought or a message is sent to the health centre for an ambulance by the husband. Although men support and care for pregnant wives, culturally it was not acceptable to let men know about pregnancy issues, such information was restricted to women.

### Traditional Birth Attendants (TBAs)

TBAs were the most used source of care and treatment during pregnancy, delivery, and newborn care by women in all the three GVHs. Their roles include giving advice, delivering babies and providing traditional medicine during pregnancy, delivery, and after delivery to both the mother and her newborn. The number of women attending antenatal care at health facilities higher than those who finally delivered at the health facility.

The standard cost of delivering a baby at a TBA is MK300; TBAs also accept other forms of payment instead of money. The cost of delivering at a health centre is high because of long distances and number of days women stay in the hospital.

### Counselors

The study found out that there are two kinds of counselors in the communities, church counselor and traditional counselor. These are women and men selected by a church or community to take the role of counseling within their own church and community on issues of pregnancy, delivery and newborn care. The counseling is provided to girls, boys, newly married couples, as well as women who have just delivered their first born child.

### Elderly women

Elderly women referred to as *nchembere* in Chichewa, are very influential in the provision of maternal and newborn care. Elderly women who have experience in child delivery and have delivered children play a key role related to childbirth and newborn care. They provide advice, conduct deliveries and support pregnant woman, as well as a woman with a newborn.

The elderly women do not charge for their services but the woman, who has used the elderly woman's service, usually gives her MK50 (compared to the MK300 given to TBAs) or some other gifts to express their gratitude for the services rendered.

### Parents

Due to patrilineal family system, the mother-in-law of a pregnant woman is responsible for caring for the pregnant woman. Her responsibilities include escorting her daughter-in-law to a health facility or to a TBA for antenatal care, and to accompany her for the delivery; she also does most of the household chores for her daughter-in-law. If a daughter-in-law is not in good terms with the mother-in-law, all this support is inaccessible.

### The chief

Chiefs get involved in matters relating to MNH when an unmarried girl gets pregnant out of wedlock. As a way of addressing the situation of premarital pregnancy which is not tolerated by the community, the chief authorizes an initiation rite known as Chimbwinda. During the initiation rite, the girl is reprimanded for her behavior of having sex before marriage, which is seen as 'unbecoming' in the eyes of many community members. In

addition, when a woman or baby dies, chiefs are involved to mobilize people for burial ceremony.

### Community-based health workers

A variety of community based health workers exist including Health Surveillance Assistants (HSAs), Growth Monitoring Volunteers (GMVs), Village Health Committee (VHC) members and a few villages have peer educators. They encourage pregnant women to seek antenatal care, family planning and give health talks about appropriate care during pregnancy and child care.

### Discussion

From the findings, it is clear that care and support around MNH is likely to be provided to women or households who have no limitations of accessing that support. However, girls who get pregnant before marriage, women not in good terms with their mother-in-law, women who will not go to the counselors to seek assistance and other groups of people will continue to be excluded from being supported when pregnant, during delivery and during post partum period.

Cultural norms play a role in determining who accesses information, care and support. Whoever violates the society norms is denied of support, information and care by the community and individuals.

The chief has authority to organize the community to work together or support each other in funerals and weddings but not in MNH issues. This clearly shows that Maternal and neonatal care issues are considered as individual/household's responsibility, thereby limiting the extent to which the community can be involved and support. From the findings, the only organized support outside one's family is from counselors. However, the counselors often counsel couples who are newly married or when they are expecting their first child, thereby leaving out mothers who need support even after having their first child, and unmarried mothers. Experience has shown that success of health services often depends on community support and involvement to reduce maternal mortality (Maine, 1993). Probably the question could then be: what kind of support and involvement?

### Community birth support plans

In all the study communities, none had a village emergency plan or transport plan to assist pregnant women or women with their newborns to seek timely medical help. However, the community provides support if the mother/baby dies by attending the funeral and burying the child. There is no transport assistance from the community, the husband is responsible to get transport which he has to pay for (usually it is an ox cart or bicycle).

On the other hand, communities do get organized and support each other on non-MNH issues like funerals, weddings, initiation ceremonies and village celebrations. In such situations, each households is asked to contribute a small some of money and food items for the activities and the village headman mobilizes people to organize such functions.

### Discussion

There is arguably, therefore no community ownership of MNH issues as discussed earlier on; they are regarded as individual household matters. If these communities manage to organize themselves in times of funerals and weddings, they could take up an effective role in MNH if there were a common understanding and ownership of MNH in the community (Graham, 2004). The most effective role for the community would be to

facilitate access to medical care among women who develop obstetric complication. This can take a number of forms including identifying women with obstetric complications, facilitating the decision to seek medical care, assisting with transportation to the appropriate medical facility and helping to pay the cost of care (Maine, 1993).

### Referral of difficult deliveries

TBAs mentioned that they are advised by HSAs and nurses not to conduct deliveries for women with certain conditions who then have to be referred to the health facility. However, TBAs reported that there are some women who are reluctant to deliver at a health facility and end up seeking the TBAs services when they are already in labour because they know that the TBA cannot send them to the health facility at this stage.

The research findings demonstrate that physically, the health facilities are inaccessible due to long distance to the health facility coupled with narrow roads which are in a poor condition making it difficult for vehicles access.

### Discussion

Comparatively, TBAs and elderly women are accessed the most by most women for delivery than the health centres. Firstly, these TBAs and elderly women live within the community and have an added advantage of perceived knowledge of indigenous treatment therapies related to pregnancy, management of deliv-

ery and danger signs for both the mother and the newborn. Despite free services offered by government health facilities, women incur costs to buy materials such as paraffin, firewood, food and transport fees, which translate into actual expenses of up to MK 2000. This makes more women to deliver at a TBA despite their services costing up to MK350. Payment for TBA's services is flexible as one may exchange a service with a commodity instead of money or money can be paid by installments. Although TBAs continue to be first choice of healthcare provider for many women, there is little that TBAs can do to prevent maternal deaths (National Statistics Office, 2002). If they are to make significant contribution to maternal health, they need more appropriate training and supervision, and realistic ways to refer women with obstetric complications (Maine, 1993). On the other hand, evidence emerging in 1990s showed that training TBAs has little impact on maternal mortality, rather the most cost-effective measure is provide access to obstetric care (Mann et al, 2005). But in this context access to obstetric care will still be challenged by opportunity costs incurred by pregnant women seeking services from a health facility.

### Care and support related to maternal and newborn

According to the findings, support was found to be withheld from women for different reasons. The table below summarizes the situations where and when support and/or care is not provided in relation to maternal and newborn care.

**Table 8: Situations where support is likely to be withheld**

Situations where support is withheld
One is unable to make or find money
One does not go to the health facility to get information
One has bad manners or unsociable behavior (do not relate well with others, do not assist others),
A female is impregnated out of wedlock
A wife of a man who excessively drinks alcohol uses lewd language
A wife or woman who is disobedient to her husband or to the chief

### Discussion

The findings demonstrate that almost everyone supports someone when there is a funeral unlike supporting others on issues relating to health, particularly maternal health. It was found that the notion of reciprocity play a big role in community support to individuals. People who do not help others are not supported and those who do not participate in communal development initiatives are excluded from the community support circles.

### Summary of identified inequalities

People's conception of what is fair is characterized by existing social norms in the community. Various concepts, including reciprocity, determine whether an individual is to be supported by the community apart from their own relatives. This reciprocity can be resource dependent; hence the real poor cannot participate as they lack the resources with which to reciprocate the care and support given to them.

Another concept affecting equity in provision of care and support is morality - being 'worthy' of being helped. This includes respect for elders' advice; dependability; ones attempt to do something about ones situation before others provide their help. Another underlying cause of inequality is that there is a lack of community ownership in MNH-related issues since they are considered personal or household matters. This can explain why

the poor, single pregnant women, women who have poor relationships with relatives or community members, are left out of getting care and support. Thus a behavior change approach is required to enable communities to change attitudes towards MNH issues.

Pregnancy is an end result of sex which the community attaches moral values to, such that social norms arising from cultural norms dictate sanctions applied when one gets pregnant out of wedlock. Hence often single women who are pregnant are unfairly treated. They are made to undergo a 'shaming' ritual of Chimwindi and despite this restorative ritual, the single mother is not supported. It is evident therefore, that interventions aimed at increasing fairness have to deal with engaging the community in discussing what is fair, who decides what is fair and how it should be established that fairness has been done and is seen to have been done.

In such patriarchal communities male dominance is the order of the day, therefore, terms regulating fairness are defined by males, and thereby inherently introducing some bias. In addition, women's low level education and position in patriarchal communities suggest that they are not aware of their right and neither can they access information on available health services. This situation is complicated by poverty in the community as a whole and distance to a health facility.

The study also demonstrates that the community is capable of organizing support to benefit the entire community as long as there is common understanding of why the entire community needs to be involved and if the entire community places a high value upon the issue on which support is being rallied for. Therefore, it is possible to work with the communities through a plan that can involve the entire village to support each pregnant woman and mother of a newborn baby to ensure that no one is left unsupported.

### Conclusion

Even if health facilities were available and accessible, it is likely that still there will be some women who will not meet their basic MNH needs due to social, cultural factors affecting their access to care. On the other hand communities can play an effective role in facilitating MNH services. However, communities need to have common understanding and ownership of MNH issues for them to be mobilized and get organized to facilitate access to MNH services. This is what MINESRH project would like to achieve in the study area.

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