Exploring the decision-making processes during childbirth in rural Sierra Leone

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Abstract

High rates of maternal mortality remain a persistent problem in Sierra Leone. Efforts to reduce these high rates have included initiatives to encourage more women to deliver at health facilities. Despite the introduction of free health care for pregnant women, many women still continue to deliver at home, with few having access to a skilled birth attendant. In addition, inequalities between rural and urban areas in accessing and utilising health facilities persist. Further insight into how and why women and their communities make decisions around childbirth will help guide future plans and initiatives in improving maternal health in Sierra Leone. This qualitative study explores the decision-making process during childbirth in rural Sierra Leone. It has particular focus on examining the thoughts and experiences of mothers living in rural areas, the perceived risks associated with pregnancy and delivery, and who and what influences the decision-making process. The study draws on 13 in-depth interviews, three group interviews, eight focus group discussions and informal interviews with rural Sierra Leonean women, their family members, traditional birth attendants, health workers and other key informers.

The results of this study demonstrate that the decision-making process during childbirth in rural Sierra Leone is dynamic and intricate, and needs to be understood within the broader social context that it takes place in. Decisions are rarely independently made and are usually socially negotiated. The amalgamation of past experiences, social expectations and relationships of those involved, as well as the perceived risks of the individual and their community influence how decisions are made. Preferences regarding where to give birth and with whom assisting, are weighed up against the complexity of enabling, supportive and inhibitory factors that are present within the health care systems and social context. Decisions are often pragmatic and rational, made within the constraints of poverty and other social determinants out of the direct control of the individuals involved. Final decisions can be ad hoc at times as new and unexpected circumstances or events occur.
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1.0 INTRODUCTION

“I really want the old woman to take me to the hospital to deliver, but when the other people told me to stay here, and wait for a time, that is why I stay. (...) I don’t have any understanding about delivering; they are the ones that have the experience. So anything that they tell me, I need to listen to them.”

These are the words of a young mother in one of the rural villages. She was 16 years old and this was her first pregnancy. At six months into her pregnancy she moved to the village where her parents lived. This was so her mother, who had experience with pregnancy and childbirth, could look after her. Her husband stayed behind in his village. Her labour pains started just after midnight on a Sunday morning. She told her aunts, who in turn told her mother. Her mother called for the traditional birth attendant (who she refers to as the old woman), who examined her. She was told it was not yet time to deliver and that she had to wait. She was told to bear up with the pain and that the baby would come at 2 o’clock in the afternoon. 2 o’clock and then 4 o’clock passed and she had still not delivered. She was tired. She wanted to go to the hospital, but the older women around her told her that it was not yet time, she just had to wait. Her mum was outside her room crying. She was worried for her only daughter because she had been in labour for a long time. Her father and brothers were also waiting outside. In the evening when the sun had set the older women sent her father to collect a man from another village. He was described as an old granddad that had experience in childbirth. He gave her tablets. Her uncle was worried and started to look for a motorbike to take her to the hospital. She finally gave birth on the Monday night before her uncle could find a motorbike.

This woman’s story was explored to try and understand the different individual, social, cultural and structural factors that influence the decision-making process for women in rural Sierra Leone during childbirth. Who was involved in the decisions and how much influence did they have on the situation? To what extent
did her own experience, understanding and knowledge of childbirth and the potential risks, play in the decision-making process? This thesis aims to explore these questions to gain a deeper understanding about the decision-making process during childbirth in rural Sierra Leone.

1.1 Structure of the thesis

This thesis is divided into five chapters.

Chapter one, including this introduction, begins by presenting essential information on the research setting, which is Sierra Leone. This is followed by an in-depth review of the literature, which includes: maternal mortality globally and in Sierra Leone; strategies to reduce maternal mortality; decision-making and health-seeking behaviour; the research aims and objectives; and finally a description of the theoretical frameworks that have been influential in this research project.

Chapter two presents the research design, including the methodology, discussion of the research sites, participants and recruitment strategies, as well as examining the methods chosen and how they were used. Data analysis, reflexivity and trustworthiness will then be discussed, followed by ethical considerations and dissemination of results.

Chapter three presents the research findings. It is divided into ten main themes and ten sub-themes.

Chapter four provides an in-depth discussion on the findings, relating them to theoretical frameworks and other empirical studies.

Chapter five is a presentation of the concluding remarks and future recommendations.
1.2 Background information

The Republic of Sierra Leone is situated on the west coast of Africa, bordering the North Atlantic Coast between Guinea and Liberia. It has a tropical climate with two distinct seasons. The rainy season starts in May and ends in October, the dry season starts in November and ends in April. Its surface area covers approximately 72,300 square kilometres (1, 2). The estimated population in 2012 was 5.9 million people, of which about 39% reside in urban areas. There are about 20 distinct language groups, reflecting its diversity of cultural traditions. The main religions are Islam (60%), Christianity (30%) and Indigenous beliefs (10%) (3).

Administratively the country is divided into four major areas, namely Northern, Southern, Eastern provinces, and the Western Area where the capital Freetown is located. The provinces are further divided into twelve districts, which in turn are subdivided into chiefdoms, governed by local paramount chiefs.

The country’s health service delivery system is pluralistic, where government, religious missions, local and international non-governmental organisations (NGOs) and the private sector all provide services. Health services are delivered through a network of health facilities consisting of 1,054 Peripheral Health Units (PHUs) that are composed of Community Health Centres (CHCs), Community Health Posts (CHPs) and 51 hospitals (20 government owned, and the rest
owned by private-for-profit, non-governmental and faith based organisations) (4).

The life expectancy at birth is 48.9 years for women and 47.5 years for men. The fertility rate is 4.7 live births per woman with the infant mortality rate at 103.5 per 1000 live births (1). The major diseases include: malaria, dengue fever, yellow fever, tuberculosis, pneumonia, viral diarrheal diseases, schistosomiasis\(^1\), rabies and Lassa fever\(^2\) (3).

1.3 Maternal mortality and health seeking behaviour: A literature review

Over the last 25 years there have been global efforts to improve maternal health, from the “Safe Motherhood Initiative” launched in Nairobi in 1987 (5) to the fifth Millennium Development Goal (MDG) “Improving Maternal Health” in 2000. The fifth MDG had one target of ‘reducing maternal mortality by three quarters between 1990 and 2015’, with the indicators being: reducing maternal mortality ratio; and increasing the number of births attended by skilled health personnel. A second target of achieving universal access to reproductive health by 2015 was added in 2005 (6).

Maternal death is defined, in the International statistical classification of diseases and related health problems, 10\(^{th}\) revision (ICD-10), as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnant, from any case related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes”\(^{7}\)(p4). Maternal mortality ratio (MMR) is defined as the “number of maternal deaths during a given period per 100,000 live births during the same time period”\(^{8}\)(p1190).

Maternal mortality remains an international public health problem. A systematic analysis of the global burden of disease estimated that 292,982 maternal deaths

\(^{1}\) Schistosomiasis, also known as bilharzia, is a type of infection caused by parasitic worms that

\(^{2}\) Lassa fever is an acute viral haemorrhagic illness (http://www.who.int/csr/disease/lassafever/en/)
occurred in 2013 (9). This huge loss of life directly impacts upon child mortality as the health of both neonate and older children is closely related to that of the mother (10, 11). Globally, maternal mortality has improved with the annual rate of change in the MMR at -0.3% from 1990-2003, and -2.7% from 2003-2013 (9). Although MMR reduced globally, it increased in much of sub-Saharan Africa in the 1990s, with West and Central Africa making particularly slow progress (9). Maternal deaths in developing countries are thought to account for 99% of all maternal deaths globally (7), with 56% of these occurring in Sub-Saharan Africa (7, 12).

The MMR for Sierra Leone remains high at 622.6 per 100,000 live births (9), compared to the global MMR of 209.1 per 100,000 live births (9). The lifetime risk of maternal death is 1 in 23 in Sierra Leone (7). The WHO Report for Trends in maternal mortality from 1990-2010 states that there is “insufficient progress” towards improving maternal health in Sierra Leone (7)(p43).

1.3.1 Causes of maternal death

It is estimated that potentially life-threatening complications occur in 10-15% of all women at some point during pregnancy, childbirth or the post-partum period (11). In the majority of cases these complications will be unexpected and unpredictable (5), with most occurring during labour, delivery and 24 hours post-partum (8, 13).

The main medical causes of maternal deaths are: haemorrhage^3, sepsis^4, eclampsia^5, ruptured uterus as a result of obstructed labour and complications of

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^3 Obstetric haemorrhage is the most commonly documented cause of maternal death. This can take the form of antepartum bleeding (e.g. as a result of placenta praevia or placental abruption), intrapartum bleeding (e.g. as a result of rupture of the uterus) or post-partum hemorrhage (e.g. as a result of atony of the uterus, associated with disseminated vascular coagulopathy, or trauma to the genital tract). (van den Broek NR. Maternal and Newborn Health. 2013:135-40)

^4 Puerperal sepsis is a temperature rise above 38.5 degrees Celsius maintained over 24 hours or recurring during the period from the end of the first to the end of the tenth day after childbirth or after abortion. Failure to recognize and manage puerperal sepsis early on will lead to septic shock and coagulopathy (van den Broek NR. Maternal and Newborn Health. 2013:135-40).

^5 Eclampsia is the onset of fits in a woman whose pregnancy is usually complicated by pre-eclampsia. The fits may occur in pregnancy after 20 weeks gestation, in labour, or during the first
abortion (11). Women who do not die due to these complications, will often be left with life-long ill health or disability (10, 14). Globally, the five main complications account for at least 80% of all maternal deaths. They are well understood and can be readily treated with existing effective, and relatively inexpensive, medical and surgical interventions (11). However, the most vulnerable women (typically poor women from rural areas) often have limited access to these important life-saving services (15, 16).

1.3.2 Strategies to improve maternal health
Internationally it has been agreed that increasing the proportion of women delivering with skilled attendance will improve maternal health by reducing mortality and morbidity during childbirth. A skilled attendant has been defined as “an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns” (17)[p1]. It should be noted that in Sierra Leone ‘maternal and child health aide’ (MCH Aide) are also regarded as skilled attendants (18).

‘Skilled birth attendance’, the process by which a woman is provided with adequate care during labour, delivery and the early post-partum period, consists of both the skilled attendant and an enabling environment. This includes adequate supplies and equipment, transport and effective communicating systems. It also includes political will, policy and sociocultural influences, education and training of skilled attendants (13).

In addition to ‘Provision of Skilled Birth Attendance’, as one of the indicators for MDG 5, another key strategy that has been introduced to reduce maternal mortality and morbidity is the ‘Availability of Essential (or Emergency) Obstetric...
Care’ (EOC) alongside neonatal care (EmONC) (11). EOC is a package of clinical interventions needed to prevent deaths from the main direct obstetric complications. It is divided into two levels of care: basic (BEOC) and comprehensive (CEOC). BEOC facilities are typically health centres without the need for an operating room. They are able to provide six main functions: parenteral antibiotics, parenteral oxytocic, parenteral anticonvulsants, manual removal of placenta, assisted vaginal delivery and removal of retained products of conception. A CEOC facility, which requires an operating theatre and usually functions in district hospitals, offers two additional services: blood transfusion and caesarean section (19).

1.3.3 Delivery at health facilities
Within the literature, reference to skilled attendance is often tantamount to delivery in a health facility (20), also described as ‘institutional delivery’. A paper from the Lancet Series on Maternal Health in 2006 recommended promoting routine delivery at a health facility in order to ensure all women have skilled attendance at birth (14). These health facilities should assist with healthy births, and include basic emergency obstetric care as well as having access to well-functioning referral level care (2, 10, 18).

Often governmental and international surveys use ‘delivery in a health facility’ or ‘institutional delivery’ as an indicator towards improving maternal health (21-23). In Sierra Leone the government advocated institutional births in 2009 (24) as a strategy to reduce maternal mortality (25). The authors of the 2008 ‘Needs Assessment for Emergency Obstetric and Neonatal Care’ in Sierra Leone’ also recommended increasing institutional deliveries, amongst other measures, as a way to reduce maternal mortality (26).

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7 Oxytocics are drugs that stimulate contraction of the myometrium (the smooth muscle tissue of the uterus). They are used to induce labour, to prevent or control postpartum or post abortion haemorrhage. They can also be used alone or with other drugs to induce abortion (http://www.ncbi.nlm.nih.gov/mesh?term=Oxytocics).
8 Anti-convulsants are used to depress abnormal nerve impulses in the central nervous system and delivered via injection (van den Broek NR. Maternal and Newborn Health. 2013:135-40.)
In 2008 the estimates for institutional deliveries in Sierra Leone was very low; at 24.6% (2). Qualitative studies, conducted alongside the ‘Needs Assessment’, investigated why women in Sierra Leone chose traditional birth attendants (TBAs) over health facilities for maternal and newborn care services (27), and identified barriers to the uptake of EmONC (28). These barriers included: poor quality and disrespectful care; continuous shortages of equipment and supplies; lack of public utilities; and geographical inaccessibility including transport challenges. These findings are consistent with similar studies in different contexts (29-34).

It should be noted at this point that there is some debate about whether delivery in a hospital is the best location or not, for routine, non-complicated deliveries. Johansen et al. (35) discuss how obstetricians have increasingly taken over responsibility for normal births in their paper on medicalization of childbirth⁹. The authors suggest that this medicalization of childbirth has perhaps gone too far, especially in high-resource countries. A Cochrane review (36) in 2009 showed that in high and moderate-income countries childbirth occurs in hospitals for the majority of women. Alongside this have been increasing rates of routine medical interventions (37), some of which are deemed to be unnecessary for non-complicated labours, such as use of intravenous infusions and oxytocin (35). With increasing interventions during labour, so too have assisted delivery rates and caesarean sections increased (35). Both unnecessary medical interventions and increased rates of assisted delivery and caesarean sections may lead to more complications (36). Further, any admission into hospital can increase iatrogenic risks as well as hospital-acquired infections (38).

Furthermore, attending a health facility or hospital to deliver usually results in other non-medical disadvantages such as loss of income, time and the burden of additional costs (20, 29, 33, 39-44).

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⁹ Medicalization refers to the extension of biomedicine into areas of life that previously were considered social rather than medical, e.g. childbirth (Pool R, Geissler W. Medical Anthropology. Raine NBaR, editor. Maidenhead: Open University Press; 2005.)
The Cochrane review (36) on planned hospital birth versus planned home birth summarised that although there are increasingly better observational studies suggesting that planned hospital birth is no safer than planned home birth, there is no strong evidence from randomised trials to favour one over the other. A systematic review by Knight et al. (45) emphasised that many health facilities in low resource settings, such as Sierra Leone, remain persistently under-resourced and are actually unable to handle serious obstetric complications successfully. Therefore suggesting that to impose sanctions to ensure women attend a health facility to deliver may not actually be the best strategy for some settings and for some communities.

It must be acknowledged that conclusions from these studies and reviews refer to home delivery for low risk pregnancies, with an experienced midwife and importantly with collaborative medical backup. This includes robust referral and transport systems. Hospital delivery is still considered the best option for high-risk pregnant women (35-37, 45). Ensuring skilled attendance at home and the back up of timely transportation to a functioning hospital is often unrealistic in low-resource settings such as rural Sierra Leone.

### 1.3.4 Free Health Care in Sierra Leone

Recent studies conducted in Sierra Leone identified prohibitive costs to be one of the main barriers for women accessing maternal health care and utilising facilities during childbirth (27, 28, 46). In 2010, in response to these findings, the government of Sierra Leone introduced the Free Health Care Initiative (FHCI) for pregnant women, breastfeeding mothers and children under the age of 5 (47), as well as the establishment of a rural midwifery school, and the increase in enrolment into existing midwifery schools (26).

In addition to FHCI, another local-level initiative has been introduced in the form of ‘bylaws’ (46). It is not known how these laws originated, but they are found throughout the country. The laws are described as a way to stimulate ‘facility care’, and are put in place by local authorities (typically chiefs). Women are
required to attend antenatal care and give birth at a facility. If they do not, the woman, their husband and/or occasionally TBA, will be fined. If women give birth too quickly or late at night and therefore do not reach the health facility in time, they will not be fined if they attend the health facility the next day. In their study in 2010, Hershderfer et al. (46) found that these laws would, at times, be defied. The true role that these laws play in the decision-making process of where a woman delivers remains unknown.

Since 2008 the percentage of institutional deliveries have been gradually increasing in Sierra Leone (18, 25, 48), although it should be noted that these statistics differ between reports (18, 25). With the introduction of FHCI institutional deliveries have continued to increase at a more rapid rate, reaching 54% in 2010 (25) and a less rapid increase of 54.4% in 2013 (48). These estimates remain lower than the target of 90% of births being in a health facility by 2015 (25). Encouragingly, the most recent Demographic Health Survey (DHS) for Sierra Leone also includes delivery by a skilled provider amongst it results. This survey suggests that ‘institutional delivery’ is not the only indicator for delivery and maternal health considered by the Government. The percentage for delivery by skilled provider is slightly higher than that for institutional deliveries, at 59.7% compared to 54.4% (48). It must be noted that all these recent results from the 2013 DHS are for women who had a live birth in the last five years. Therefore, women who lost their child before or during delivery would not have been included in this data, likely skewering the results.

A study conducted in late 2010 in Bo, a Southern Province of Sierra Leone, also showed an increased utilisation of healthcare facilities to deliver since the introduction of FHCI (49). These results are specific to urban areas and cannot be transferred to rural areas. In addition, they cannot be extrapolated to the rest of the country, as Bo is a unique district in a number of ways. It had higher rates of institutional deliveries prior to the introduction of FHCI, and a Médecins San Frontières (MSF) hospital, present since 2003, introduced a comprehensive emergency obstetric and neonatal care facility with an emergency ambulance transfer service in 2008 (50).
The 2013 Sierra Leone DHS (48) found that utilisation of health facilities to deliver differed between urban and rural areas: 68.1% in urban areas and 49.7% in rural areas (48). These inequalities persisted for delivery with a skilled attendant, at 78.9% delivering with a skilled attendant in urban areas and 53.2% in rural areas. These results correlate with findings from a global literature review in 2009, which found large variations in provision of skilled attendance during birth between rural and urban areas in Sub-Saharan Africa (51). In addition a report published by Amnesty International in 2011 showed that despite statistics indicating that facility-deliveries have increased, many women continue to have limited or no access to essential care during pregnancy and birth in Sierra Leone. Amnesty International recommended effective monitoring and accountability systems to be instigated (52).

1.3.5 Health-seeking behaviour and decision-making processes

Other countries that have implemented free or reduced costs have also found that this alone does not ensure access to maternal healthcare for all (29, 53, 54). Studies have highlighted the importance of context-specific research when exploring reasons behind utilisation or non-utilisation of health facilities during childbirth (29, 53, 54). Health-seeking behaviour is often conceptualised as a sequence of actions taken in an attempt to rectify ill-health (55). It is a creative process and is not simply the result of beliefs acting within the restraints of a specific culture or system (56). However, focusing on the end-point of health seeking behaviour will often result in the complex nature of the ‘process’ involved in getting to that end-point being ignored (55). Decision-making processes and health-seeking behaviour are closely linked, with much movement and amalgamation between the two (57). Recognition of ill-health, identification and comparison of different options and information, formation of preferences and arrival at a decision result in different forms of behaviour. The outcomes of the behaviour and therefore the decisions made in getting there are evaluated; sometimes resulting in different actions being taken, sometimes not; all of which subsequently affects future-decision making (55). Decision-making is not a
rational, linear process leading to a one-off episode of health-seeking behaviour, but a flexible and on-going process occurring within a dynamic social context (55). Researchers have increasingly considered the experiences, perceptions, preferences and perceived potential risks of the 'service-user' during pregnancy and delivery to gain a deeper understanding of both decision-making processes and health-seeking behaviour within specific contexts (30, 31, 39, 58, 59).

Within Sierra Leone antenatal care coverage is high; at a estimated 97.1% (48) suggesting that whilst access to antenatal care appears to be readily accepted and accessed, delivery in health facilities and hospitals is not so freely utilised. Studies conducted before the introduction of FHCI in Sierra Leone identified a number of factors that can influence decision-making with regards to utilisation of TBAs or health facilities and women’s health seeking behaviour during pregnancy and childbirth (27, 28, 46). Barriers to accessing care at health facilities included prohibitive and unreliable costs, geographic inaccessibility, distance, lack of transport and long waiting times. Furthermore, bad reputation of the health facilities linked to perceived incompetence and impatience of staff, lack of equipment, supplies and human resources, over-crowding and lack of utilities such as electricity and water were also factors influencing the decision-making process (27, 28, 46).

Previous positive experiences with the TBAs, their perceived expertise and experiences, as well as their ability to provide continuum of care from childbirth through to newborn care all act as motivating factors for women to access care from the TBAs within the village (27, 28, 46). In addition, the leadership role of the TBA within the community and their status within the secret societies in Sierra Leone, as well as their perceived competence in treating supernatural phenomena, all impact upon health-seeking behaviour (27, 46).

A study conducted six months after the introduction of the FHCI in the Northern Bombali area of Sierra Leone, on the impact of the FHCI on child health, identified a number of barriers that still remained for communities in accessing health care. These included direct costs when accessing health facilities, lack of
drug availability and limited staff, long distances and poor road conditions, and mothers being too busy working and farming. In addition, beliefs about the causes of an illness, for example seizures perceived to be caused by a spirit implies that care will be sought from a sorcerer rather than at the health clinic (4). A more recent study by Scott et al. (60) explored parents’ healthcare seeking strategies for children in Sierra Leone. This study moved beyond barriers to care seeking and explored the more complex decision-making and active negotiations undertaken by parents during this process. The utilisation of different options available to them secured the best perceived treatment for their children within their financial, social and geographical context (60). The authors reported that social networks, as well as collaboration within and across families, could affect how parents decide upon the best care for their sick child. These influences can contribute towards, or hinder, the utilisation of resources necessary to access care, for example, provision of carers to cover the mother’s own domestic duties whilst she sought different health care for her child (60). Although these last two studies were looking at decision-making and care seeking specifically for children, many of the concepts and issues raised by the authors will be useful and pertinent when considering the decision-making process during childbirth in rural Sierra Leone.

In summary, maternal mortality ratios (MMR) remain high in Sierra Leone (9). Efforts have been made to reduce MMR through increasing the number of women delivering at a health facility, for example, through the introduction of the FHCI in 2010 (47). Despite this, utilisation remains lower than hoped, with marked inequalities between rural and urban settings (48). There is a lack of understanding about the health seeking behaviour of women during childbirth in Sierra Leone. In particular, further qualitative studies are needed to explore the often complex decision-making processes made by women and their communities. Understanding who and what influences the process, including the impact of perceived potential risks related to different options, will all contribute to a “thicker” understanding of the decision-making process (55). In particular, there is a need to explore where and with whom women in rural areas prefer to deliver. In addition, since the introduction of FHCI in Sierra Leone there has been
a lack of qualitative studies looking into why utilisation of health facilities during childbirth remain low now that prohibitive costs have, in theory, been removed. Furthermore, it is unknown how much of a role the local ‘bylaws’ have in encouraging utilisation of health facilities during childbirth, and how they may affect the decision-making process.

1.4 Research Aims
This research aims to explore the decision-making process during childbirth, including whom and what influences the process. It also aims to explore how women and the local community perceive the potential risk of pregnancy and delivery, especially in rural areas. It is hoped that information gained through this project will help guide future plans and initiatives in improving maternal health in Sierra Leone.

1.4.1 Objective:
To explore the decision-making processes during childbirth in rural Sierra Leone.

Specific Objectives:

- To examine the thoughts and experiences that mothers living in rural areas have around childbirth and place of delivery.
- To explore how women and the local community perceive the potential risk of pregnancy and delivery.
- To explore who and what influences the decision-making processes of where to deliver.
- To explore the influence of the ‘Free Health Care Initiative’ on women’s perceived access to maternal health care.
- To explore the influence of ‘bylaws’ on utilisation of health facilities during childbirth.
1.5 **Theoretical Frameworks**

There are a number of theoretical frameworks that have been influential during the planning, implementation and analysis of this research project. The next section will give a brief introduction to each of these frameworks and how they have affected the research project and final report.

1.5.1 **3-delays framework**

The 3 delays framework is one of the most commonly used frameworks when discussing maternal mortality within the literature. It is based on the fact that between 75-80% of all maternal deaths are due to complications which could be successfully treated if medical treatment was sought and received in a timely manner. ‘Delay’ is therefore seen as the main factor involved in contributing to maternal deaths (57).

This study was initially inspired by this framework, which divides the delay in accessing timely medical treatment into three phases (57). Phase 1 delay is described as the ‘delay in deciding to seek care on the part of the individual, the family or both’. Phase 2 delay is the ‘delay in reaching an adequate health care facility’ and phase 3 is ‘delay in receiving care at the facility’.

Gabrysch and Campbell (20) adapted this framework in 2009 as they felt that the original framework implicitly looked at home births with complications. They expanded the framework to include preventative facility delivery for uncomplicated childbirth, so that the three phases were conceptually separated into two pathways: preventive care seeking and emergency care seeking.

In a review of the literature on maternal mortality in Sierra Leone a lack of knowledge around the decision-making process during childbirth was found. Exploring how decisions are made, and by whom, will contribute towards understanding the different aspects involved particularly during ‘phase 1’ in the 3-delays framework, for both preventative and emergency care-seeking behaviour.
1.5.2 Medical systems

Arthur Kleinman, a physician and anthropologist, describes medical systems as being socially and culturally constructed (61). He states that these systems include people’s beliefs and patterns of behaviour, and that these are governed by cultural and social rules (56). In his book “Patients and Healers in the Context of Culture” he divides the health care system into three overlapping sectors: the popular sector, consisting of individual, family and community beliefs and activities; the professional sector, which is the organised and institutional parts of health care; and thirdly the folk sector, consisting of sacred or secular types of folk medicine (61).

Kleinman also discusses how medical systems are forms of social realities, which is where social norms and roles are defined and performed. These social norms affect, amongst other things, how individual’s behave, how they perceive the world and how they communicate with those around them (61). He argues that social realities differ between locations, different social groups, professions, education, socioeconomic status, and sometimes within one family and between individuals (61). Kleinman uses the term ‘clinical reality’ to describe health beliefs, expectations, norms and different therapeutic activities that influence interpretations of illness and peoples care seeking behaviour. Each health care sector, as described above, can interpret and form clinical realities in different ways, and these clinical realities will be seen and used differently by social groups, families and individuals (61). One might say that the social reality is part of this reality that expresses all types of clinical phenomenon and activities. However, this part of the reality is also partly constructed by the clinical reality.

Kleinman's concept of the three health sectors is useful when trying to understand how society deals with health and illness, but it should not be used in a static and systematic way. It has been suggested that researchers should focus on studying what people actually do when they are unwell, rather than just the health systems (56). In reality, people’s behaviour changes so that they may use
a number of different models and systems either simultaneously and overlapping, or different systems at different times, depending on circumstances or changing rationalities.

Medical pluralism is another concept closely related to the idea of health care systems (56). It describes how there are a number of different actors or healers operating within the same health care system or society. Each of these actors can provide different explanations and treatment for ill health, and enable members of that society to choose between the different options available, depending upon the situation that they are in (56). Again, the use of the different actors available tends not to be static, using one over the other, or one after the other. The use is rather simultaneous and overlapping, which has been described as medical syncretism (56).

In addition to Sierra Leone's pluralistic professional health care system as reported at the beginning of this chapter, there are a number of additional potential health care providers or actors within the popular and folk sectors. These include sorcerers, traders with access to biomedical medicine and TBAs. Sorcerers have abilities to treat supernatural phenomena, such as convulsions caused by demons, or to diagnose if a problem is due to witchcraft or immoral behaviour. TBAs are no longer officially integrated into the professional health sector nor are they recognised by the Government as skilled attendants, and are therefore considered part of the folk sector in this study (46, 62, 63). TBAs in the rural setting of Sierra Leone have either received some form of training in the past from the government or NGOs, or are untrained (46). Patients in Sierra Leone tend to use the different health systems and health providers in a syncretic way, moving between the different sectors as their perceived needs dictate (59).
1.5.3 Explanatory models

Kleinman (61) uses ‘explanatory models’ to describe how individuals explain and understand illness and disease\(^{10}\), and justify the treatment that they seek. These models help to explain questions regarding aetiology, pathophysiology, course and consequences of illness, and appropriate treatment choices (61). Health practitioners, and people within a patient’s network will also hold their own explanatory models, meaning that it is not just the individual’s own model that can impact upon their health-seeking behaviour (56).

Explanatory models are often vague, open to change, and can lack distinction between ideas and experiences (61). They are therefore, not static concepts, but can change and adapt depending on different experiences and situations. It is important not to assume that an individual refers to only one explanation for an episode of ill health, rather they may give a number of different rationalities as to the cause and potential course of treatment for the same problem. The consideration of social meanings being attributed to behavioural and biological signs is another important aspect to contemplate which is often ignored in the explanatory model approach (56).

It is hoped that this study will gain a deeper understanding of the explanatory models that the different people involved during childbirth in rural Sierra Leone hold. This will help to explain and understand the decision-making processes during childbirth, including who influences which aspects and what explanations are given for different health-seeking behaviour.

1.5.4 Risk

The concept of risk is widely used to explain abnormalities, misfortune and frightening events. It assumes human choice, responsibility and blame, and that therefore, something can be done to prevent or reduce the potential harm (64).

\(^{10}\) “Disease refers to a malfunctioning of biological and/or psychological processes. Illness refers to the psychosocial experience and meaning of perceived disease” (Kleinman A. Patients and Healers in the Context of Culture - an Exploration of the Borderland between Anthropology, Medicine, and Psychiatry. Berkeley: University of California Press, Ltd.; 1981. p72)
Risk is understood and negotiated in the social and cultural context in which it is situated and the use and value of risk subsequently needs to be judged within its own, specific culture (65). The discourse and knowledge around risk is apt to change over time just as the sociocultural context in which it is set also changes (64).

In her book “Purity and Danger”, Mary Douglas (65) discusses how the laws of nature are often utilised to affirm moral beliefs communities may have about particular behaviours. If a particular misbehaviour is deemed threatening to the harmony of a community then it will be associated with negative consequences. In turn these moral beliefs may become risks for certain diseases or conditions. For example one type of disease is caused by adultery, another by incest (65). In this way, risk can be understood as the cultural response to misbehaviour: the consequence of breaking a taboo or committing a sin (65).

The meaning of risk differs from place to place, and is constructed by the different actors involved. How these actors perceive, place significance on, and understand risks will vary from setting to setting, depending also upon how these different actors interact with each other. When considering the role of risk during decision-making processes it is important to consider the collective rather than just the individualistic assessment of risk, taking into account everyday experiences, common requirements and expectations (64, 65).

With all of these concepts in mind, it was deemed important to understand the risks that are considered and that potentially affect the decision-making processes during childbirth in rural Sierra Leone.

1.5.5 Feminist Theory

Feminist theory is another theory that has been influential during this research project. Feminist theory is very diverse with an ever evolving set of ideas (66, 67). All branches of feminist theory typically have four main concerns that they attempt to tackle: 1) to explain how and why gender inequality began; 2)
explain why it still continues; 3) to introduce effective strategies to improve inequality or ensure full equality for both genders; and 4) to imagine a world where gender inequality no longer exists (66). There are a number of different branches of feminist theory as well as many feminist theorists. I shall not attempt to cover all aspects or views surrounding this huge and diverse discourse, but shall discuss those that have been influential in my thinking, and thus affected the creation of this thesis.

Liberal feminism typically explains women's oppression through the cultural restrictions that constrain women from participating or competing in the public world, for example, law, politics and medicine (67). Liberal feminists argue that society holds the false belief that women are intellectually and physically less capable than men. This can perhaps be compared to Simone de Beauvoir's first principle on women's situation in the world: that man is the absolute, whereas woman is the other (68). As described by Toril Moi, who has studied de Beauvoir in detail, with this status of other comes a situation that is unjust and oppressive. De Beauvoir's second principle is that freedom, not happiness, is the way to measure the situation of woman. In particular, freedom should not be abstract, but should allow women to have equal access to education, health, equal pay and fair working conditions to make use of their rights (68).

Within the context of Sierra Leone, although a number of actions and policies have been implemented to improve gender equality in the country (69), inequality still remains. For example, fewer girls remain in education compared to boys. Under-age marriage remains commonplace despite the law prohibiting marriage before the age of 18 years (69, 70). Abortion remains illegal and gender based violence is typically viewed as a social problem rather than a criminal act (69), both of which can detrimentally affect the health of women in Sierra Leone. In addition, de Beauvoir describes how freedom comes with responsibility, that perhaps women need to acknowledge that they may consent to their own oppression, or help to oppress other women (68). This can be related to Sierra Leone, where female genital mutilation, seen by many as a violation of women's human rights, is essentially conducted by women on women (71).
Another branch of feminist theory is radical feminism, which finds that the patriarchal system that oppresses women is so flawed that it cannot be reformed and thus needs to be eliminated (67). The family is deemed to be a central part of society’s power structure, and therefore, patriarchy within the family, which can oppress women in their own homes and lives, in turn transcends across to power on a political level (72). Sierra Leone is a patriarchal system, whereby men are the head of the household and responsible for main decision-making (46, 73). Radical feminists find that oppressive gender identities and modes of behaviour are learned from an early age within the family. This also links with de Beauvoir’s third principle around women’s situation in the world: in that women are not born but made (68). Thereby, being born female, immediately sets your position in society and some argue that it equates to them being born into a specific class or caste (72). Radical feminists argue that when women are married the assumption is that they will conduct the majority of the unpaid domestic chores and undertake the majority of childcare. Both of these roles limit women’s opportunities in work outside of the home, thereby keeping the power over assets and money, firmly in men’s control. This economic dependence along with limited education opportunities and exclusion from public positions often results in a lack of voice during decision-making processes both in the home and on a wider scale (72).

Critique to this negative viewpoint of the patriarchal family includes the failure to explore changes in marriage over time and between classes. This analysis of patriarchy is based on a now dated ‘white western family’. It should also be noted at this point that many discussions around feminist theory usually centre on this specific type of woman: white, western, middle-class. Feminists such as Chandra Talpade Mohanty (74) have criticised western feminism for its inclination to gloss over the differences between ‘Southern women’. This then leaves the question; do these discussions apply to the poor women in rural Sierra Leone? It is beyond the scope of this thesis to truly investigate this interesting discourse, but as feminist theorist Susan Okin has argued, women across the world have a lot in common and are usually greatly affected by similar issues.
such as laws and customs around marriages, divorce, and family life on the whole (67). What is important, is that concepts such as sexual division of labour, reproduction, marriage and patriarchy are considered within their local sociocultural setting (74).

Issues such as inequality in division of labour and earnings, have been discussed in the context of West Africa, showing that women typically earn less and work harder than men in the same situation (75, 76). Furthermore, gender biases in property and inheritance laws and in other channels of acquiring assets also leave women at greater risk of poverty (72). These occurrences along with gender biases present in both societies and governments partly explain another branch of feminist theory: feminisation of poverty. This phenomenon describes how a disproportionate percentage of the world’s poor are women (77). The combination of gender inequality and poverty means that poorer women often experience reduced access to health care services, in turn putting them at increased risk of poor health. This is a vicious circle as poor health further limits their employment opportunities and ability to earn money, thereby reducing their autonomy in decision-making in the home. This includes the decision to access health care or not, which further increases their risk of ill health.

1.5.6 Pre-disposing, enabling and supportive factors

Another theoretical influence during this study has been behavioural sociologist Marshall Becker’s work on models and theories seeking to explain individual’s adherence to medical treatment (78). Although this project was not looking specifically at adherence to treatment, the combination of predisposing factors with enabling and supportive factors, influencing patient’s decisions in treatment choices, was deemed useful when understanding some of the findings from this study.

According to Becker, pre-disposing factors can consist of health beliefs and attitudes, including willingness to seek and accept specific medical assistance, and perceived susceptibility and severity of a condition. These pre-disposing
factors, in isolation, are seldom responsible for the use of a specific health care service, but can motivate patients towards one type of health care service over another. In order for patients to actually use any type of health care they require enabling factors. Enabling factors are related to availability and accessibility of specific health services; use of time, the possibility to combine attendance with work, money needed to pay for transport and poor treatment by health workers (78). Supportive factors can include social pressure or social support, often found in the family or wider community. These social pressures or support can produce beliefs about a certain course of action, or motivate an individual to act in a particular way in order to conform to the wider social group. Therefore, an individual’s family or friends can encourage them to choose one form of healthcare over another, and their opinions and beliefs should be considered when exploring decision-making processes. The combination of different predisposing, supportive and enabling factors can serve as barriers or facilitators for individuals and communities in their movement between different parts of treatment options (78). It should be noted that a critique of this model is that individuals are often portrayed as highly rational decision-makers. However, individuals may not always behave in a “rational manner” when seeking health care, and decisions may not always be consciously made. Further, people’s rationalities may change during the health seeking process, as a response or adaptation to a variety of enabling and supportive factors (55).
2.0 RESEARCH DESIGN

This chapter will describe the research design starting with the methodology, discussion of the research site, participants and recruitment strategies, before examining the methods chosen and how they were used. Data analysis, reflexivity and trustworthiness will then be discussed, followed by ethical considerations and dissemination of results.

2.1 Methodology

Qualitative methodology enable a researcher to explore and describe the social reality of participants and gain a deeper understanding of their situation within a specific context (79). The methodology can be used to explore experiences, understand why a particular course of action was taken, explore how people perceive, interpret and respond to different risks, and the meanings they attribute to them within a specific setting. Qualitative methodology can also be used to contextualise health beliefs, preferences and health-seeking behaviours, gain new knowledge and understand more complex realities (79). This study explores the decision-making process during childbirth in Sierra Leone. One of the theories that have inspired me whilst planning my research methodology is that of constructivism (80). It suggests that knowledge and truth are constructed or interpreted through the perspectives of human beings (30), and that humans construct their own social realities in relation to one another (80). With this in mind, I believe that to explore women’s perceptions and experiences of pregnancy, perceived potential risks as well as what or who influences decision-making processes during childbirth, are best described and explained by the women themselves (30). Decision-making processes are typically made up of multiple dimensions, involving the individual, family and wider community (55, 60). Drawing on people’s experiences, thoughts, preferences, and perceptions of risk during pregnancy, as well as their perceptions of accessibility to health care, will help to explore this multi-faceted phenomenon further. A qualitative study design was, therefore considered to be most appropriate for this research project.
2.2 Methods
The specific methods that were used were: focus group discussions (FGDs); group interviews; individual in-depth interviews (IDIs); and informal discussions with key informants. The triangulation of information through using different methods, sites and participants was intentionally selected, so as to increase the understanding of the complex interactions and phenomena surrounding decision-making around where to deliver during childbirth.

2.3 The study sites and participants

2.3.1 Study sites
The study was conducted in Tonkolili District, Northern Province of Sierra Leone. According to the 2013 Demographic Health Survey (DHS), the Northern Province has the lowest percentage of deliveries in a health facility (37.1%) compared to the other provinces (48). Tonkolili District was purposively selected as the Multiple Indicator Cluster Survey from 2010 showed that this district had the lowest percentage of women who gave birth with a skilled attendant (30.7%) and the lowest percentage of women who gave birth in a health facility (24.3%) (18). However, the more recent results from the 2013 DHS, which were published in 2014, show that Tonkolili District no longer has the lowest percentage of women who delivered with a skilled attendant or who gave birth in a health facility (18). But it remains amongst the lowest three or four districts within the country. The government are encouraging health facility births in an attempt to improve maternal health (24, 25). Since the percentage of women utilising health facilities or delivering with a skilled attendant in Tonkolili district are amongst the lowest in the country, the discourse around pregnancy, childbirth and place of delivery was deemed to be of particular importance in this area.

Tonkolili is subdivided into 11 chiefdoms with two hospitals that serve the whole area (81). The main hospital, Magburka District Hospital, is a governmental hospital, and Masanga Hospital, an NGO-supported governmental hospital (82). One of the 11 Tonkolili chiefdoms is Kholife Rolla Chiefdom, which
is further divided into 5 sections. Of these 5 sections, one is La-lenken section, which is comprised of 25 villages. Masanga village, where Masanga Hospital is situated, is one of these villages. Masanga Hospital operates as both a hospital and a Primary Health Unit (PHU) – where antenatal, post-natal and care for children under the age of five occurs. It is staffed 24 hours, 7 days a week, and it therefore often receives emergency referral cases from Magburaka Government Hospital. It provides comprehensive emergency obstetric and newborn care, and is one of the bases for the country’s new surgical training programme. This is a programme, in partnership with the government, where Community Health Officers are taught surgical skills to handle some of the most common surgical and obstetric emergency cases, including caesarean sections.

Upon arrival in the field I met with other local researchers and health workers who worked in and around Masanga and La-lenken section. I spent time travelling around all villages in the La-lenken section, meeting the village chiefs and learning the layout of the section with the main roads and bush paths. In addition, this time allowed me to gain a greater understanding of life in the villages such as typical housing and living situations, types of work available and accessibility to Masanga Hospital. This was done in order to become familiar with the village infrastructure and have informal conversations with community members to assist with contextualising data collected (46). Time was also spent at Masanga Hospital, particularly at the PHU, Maternal and Emergency Wards.

Two villages were purposively chosen as they were both rural villages, whose community used Masanga Hospital for their main institutional health needs, but differed to ensure variation (80) with regards to: geographical site (e.g. distance from Masanga, accessibility and potential transport links); and socio-demographic variables of their communities (e.g. population size, main occupations).

Mabereh Gbonkoh is a small village and according to key persons in the community, it has a population of fewer than 200 people (estimates as the last census in 2004 did not show population size for individual villages)(81). It is
closer to Masanga Hospital than the other chosen village, with 2 main ways of accessing the hospital. The narrow bush road, which takes about half an hour at a moderate walking pace, has 3 rivers to wade through (higher water levels during rainy season, and more like streams during dry season). The other option is along the ‘main roads’ on a motorbike, a more convoluted route, which takes about 45 minutes with no big rivers to cross but very poorly maintained roads. The main source of income in this village is subsistence farming. There is a Seven-Day Adventist Church, and the population are a mixture of Christians and Muslims. There is not a school, so the children walk daily along the bush road to attend the school in Masanga.

The second village chosen, Makamba, is a larger village with a population of over 500. This estimation was gained through key persons in the community, as the exact population size was unknown. It is further from Masanga Hospital with one main route, along which you can either walk or take a motorbike. Very occasionally a car was seen driving this route but would often became stuck along the way. It takes about 45 minutes on a motorbike, and since there is no bush road short cut, walking takes considerably longer. There are four rivers and a number of small streams to cross between the village and the hospital. Two of the bridges are temporary and crudely built, so that occasionally passengers have to get off the motorbike to walk across safely. The rivers are often flooded during rainy season and people have to wade up to their necks at times to get across. There is one primary school in Makamba and one mosque. Again the religious beliefs are divided between Christianity and Islam. The main sources of income are subsistence farming and gold mining at local gold mines.

Once the villages had been chosen I formally met with the section chief and village chiefs to request permission to complete the research project at these sites. My research assistant and I accessed each site either by walking along the bush road or by riding a motorbike. These journeys enabled me to gain a better understanding of the challenges community members face when travelling around and to and from the hospital. Walking along the bush road particularly enabled us to plan and prepare for upcoming interviews, discuss topics and
issues that had arisen during the interviews, and share ideas about the process as a whole.

2.3.2 Research assistant

A research assistant was needed for all parts of the research, from assisting me to gain access to the various research sites in a culturally appropriate way; assisting in recruitment of participants; interpreting during the interviews and discussions; discussing the cultural context behind the participant's experiences and descriptions; and participating in the preliminary analysis. Prior to arriving in the field it was understood that pregnancy and childbirth in Sierra Leone are women's business. Therefore, it was deemed very important to work with a female research assistant, especially for interviews with women in the rural villages. Due to the location of the research site and the limited research budget it was not possible to find an educated female who had previous experience in research and was able or prepared to live in this part of the country for nearly 4 months.

Time was spent identifying, interviewing and recruiting a woman who lived in Masanga Village, knew La-lenken section well, was a native speaker of Temne, and could speak Krio and English fluently. Identifying potential candidates was done through word of mouth with community leaders in Masanga village and health workers in Masanga Hospital. Four candidates were interviewed. A woman who had been born, grew up and educated in Masanga was eventually recruited. Although she did not have any previous experience working in qualitative research she was keen to learn, and we had a good rapport together. She had previously worked as a Nursing Aide on the Paediatric Ward at Masanga Hospital. She had stopped working there following the death of her oldest child to malaria a few years ago, and was now currently looking for work again. She had a two-year-old child, whom she lived with in Masanga village, along with her husband, mother and sister.
Time was spent discussing the research project to ensure a clear and common understanding between my research assistant and myself. Additional time was spent on training on the skill of interpretation in an interview setting, interview techniques, communication techniques and practise in facilitating Focus Group Discussions (FGD). Communication styles and techniques were taught and practised, for example using the ‘Meta Model’ as a method of questioning, and the use of ‘active listening’ during interviews (83).

Reflection exercises, where we reflected on what went well and what could be improved during an interview, were conducted regularly throughout the research project serving to improve and further cement the communication tools being employed. Reflection exercises also focused on how ‘she as the research assistant’ had a role in the data construction: who she is; her pre-understandings; positionality; and her own personal opinions. All of these could have an impact upon how participants related to us, again potentially affecting the validity of the data collected. In particular, emphasis was placed on the importance of informed consent rather than informing the participant that they were to participate, both to protect the participant but also to ensure that valid data was collected.

We also spent time getting to know each other thus allowing us to gain a greater understanding of each other and further improve our working relationship. As an example we would take walks through the villages together, and share meals with each other and her family. My research assistant was also able to meet with my partner when he visited Sierra Leone.

When discussing the research assistant and myself working together I shall refer to us as the research team.

2.3.3 Research participants

At each village 3 focus group discussions (FGD) were conducted, formed of 4-9 participants per group. These groups consisted of: 1) women who had given
birth within the last year, regardless of location (to be known as female FGD); 2) older women (>40 years) who had a close family member in the village who had recently given birth or had been involved in a delivery (to be known as older female FGD); and 3) men who had a close family member in the village who had recently given birth (to be known as male FGD). The last two groups were included as previous studies have identified the important role that older women and men have in Sierra Leone around the decision-making process of where to deliver (28, 46, 59).

In-depth interviews were conducted with women who had recently given birth in each village. Where possible and deemed necessary, repeated interviews were conducted. During the development stage of this research project, informal discussions with key informants were planned. However, once in the field, it was deemed appropriate to conduct formal interviews or group interviews with: the village chief, traditional birth attendants (TBAs) and midwives based at Masanga Hospital, community health officers on the surgical training programme based at Masanga Hospital and a group of four motorbike drivers.

Emergent sampling as described by Patton (2002) involves decision making about sampling during the data construction period. It takes advantage of unanticipated opportunities that were not foreseen before entering the research field (80). The decision to add additional participants, for example the motorbike driver group, was based on new themes and ideas that came up during FGDs and interviews with earlier participants.

Informal discussions with key informants such as national and international non-governmental organisations working in women’s health e.g. Marie Stopes\textsuperscript{11}; representatives from the local radio station to gain further insight into the local discourse around women’s health; and other health workers were conducted throughout the data construction period. At the end of the fieldwork a final FGD was conducted with 4 recently pregnant women at Mabereh Gbonkoh.

\textsuperscript{11} Marie Stopes Sierra Leone provides sexual and reproductive health services to women, men and young people in Sierra Leone (http://www.mariestopes.org/where-in-the-world#sierra-leone).
I attempted to formally interview the Mother and Child Health Aide (MCHAide) Nurse based at Masanga PHU, as it was felt that she would be able to provide additional and new information around the decision-making process. She was a main contact for women at the antenatal stage, postnatal stage, and I was informed by local people that she occasionally assisted women in Masanga Village to deliver in their own homes. However, after discussing the aims of the research, the role of the researcher and requesting permission from the PHU nurse, it was felt that she was a reluctant participant, so it was decided not to interview her.

3.3.4 Sampling and recruitment.

Upon arrival in each village the research team met with the village chief and other key persons, such as the youth leader and TBA. The research project was introduced and criteria for participants explained. As the research sites were quite small villages, information about the research spread around the whole village quite easily. Potential participants were identified and the project explained to each of them and informed consent then obtained. A suitable location for the FGDs was also identified in each village. Initially ‘lactating women’ were requested to participate by my research assistant. But it was agreed that this phrase might exclude those women who had lost their child during pregnancy, childbirth or as a newborn, so ‘recently pregnant women’ were requested instead.

A mixed purposeful sampling approach was taken to select the participants in this study. A homogeneous sampling technique was used initially to identify participants for the FGDs (80). This ensured that participants shared similar backgrounds and experiences, and were able to discuss their thoughts and opinions on the topic of pregnancy and childbirth. After each female FGD, one or two participants were approached and asked if they would speak to us again. Purposeful sampling was conducted to ensure maximum variation in the participants (80), for example those who spoke easily, those who were quieter, variation in dress or those from different parts of the village. Variation in dress
was specifically chosen in an attempt to include a spectrum of participants with different socioeconomic statuses.

The research team approached other potential participants for the in-depth interviews as we walked around the villages and spoke to people whilst they went about their daily activities and chores. Women were identified as potential participants if they were carrying or breastfeeding a child who looked under one year. Often, other members of the family or neighbours cared for each other’s children. In these situations we would ask who the mother was and then approach her and ask if she would participate. Participants selected for the interviews were purposively chosen for their ability to provide in-depth and personal knowledge on the topic (80).

In addition, the TBAs or other well-known women in each village suggested specific potential participants who the research team may not have easily been able to identify. For example, women who had lost their child during or after childbirth, those who had a non-complicated birth versus complicated birth; those who delivered in the village, hospital or elsewhere; those who were part of a polygamous relationship or not; widowed; divorced; husband in nearby location or not; primi- or multigravida. This snowball sampling strategy was utilised to identify potentially ‘information rich’ participants as well as to ensure maximum variation (80).

Where possible, women were approached to participate in the interview a day or two prior to the actual interview, then on the day they were re-asked. This enabled them to have time to decide if they really wanted to participate, or find a ‘culturally polite’ way of saying no. Of the women who were approached to participate in IDIs, three declined. One was due to the participant having poor hearing, and communication between the research team and the participant was not deemed good enough to conduct an interview. The two other participants were initially recruited through the Makamba female FGD. When approached a few days after the FGD, requesting if they would participate in an IDI, they both agreed. However, when the research team came back on the agreed day and time
they both declined. One stated that she had work to do on the farm, the other because she felt unwell. These participants were not approached again, as it was felt that their excuses were an indirect way of saying “no”. In addition, it was towards the end of the data construction period and there were not many other opportunities for the research team to come back to the village. Therefore, alternative participants were found.

The key informants were approached either at their work places, in the village or near their homes. Snacks and beverages were provided for all interviews and discussions but no other costs were covered for the participants since the research team travelled to the various sites.

During the FGD with the men in Makamba it was felt that there was a misunderstanding about the purpose of the discussions. A few of the men started by thanking the research team for coming to the village and teaching them about ‘good maternal health’. At this point the discussions were stopped, and the purpose of the research re-iterated, with an emphasis on wanting to learn from the participants rather than the other way round. Another issue that came up was during the FGD with the older women in Makamba. It became evident quite soon that the women were mainly there to ‘see what was going on’ with the research team, and to ‘collect the biscuits’ which they had heard the younger women’s FGD had all received. Again the discussion was stopped, the purpose of the research re-explained, with specific emphasis on voluntary involvement, therefore, if any of the participants wanted to leave they could – biscuits were provided regardless of participation level in this case. All of the participants wanted to stay but the discussions only continued for another ten minutes as I felt that the participants were becoming restless. Despite this shorter and slightly limited discussion, a few interesting topics and issues were still raised.

2.3.5 Data saturation
The aim was to continue collecting data until the point of saturation was achieved (84), therefore the exact number of participants was determined
during the data construction period. In total, sixteen younger women, thirteen men, and thirteen older women participated in the seven FGDs. All of these participants had either been pregnant and given birth within the last year, or had a close family member who had been pregnant and given birth within the last year.

Ten ‘recently pregnant women’ participated in in-depth interviews (IDIs), and six in re-interviews, with one participant being interviewed for a 3rd time. In Mabereh Gbonkoh the village chief and one TBA participated in IDIs, with the TBA also being re-interviewed. In Makamba the two TBAs participated in a group interview. In Masanga, two midwives, two community health officers (CHO) in the surgical training programme, and four motorbike drivers participated in group interviews. In total there were 61 participants.

This diversity of participants, including the close family, pertinent village members as well as wider community members involved in transportation and treatment at the hospital, were purposively chosen to enable the research team to gain insights and experiences from a wide spectrum of the community. Complete data saturation was not reached, as I believe that there could still be perspectives that remain unexplored. However, as few new themes were being identified towards the end of the fieldwork period, it was deemed acceptable to stop collecting new data.

2.4 Data collection methods

2.4.1 FGD/group interviews

Group-discussions are a form of communication naturally found in most communities and are therefore, usually well accepted in settings such as rural Sierra Leone (85). FGDs are considered cost effective, the diversity and consistency of views can be quickly assessed, as well as being a way to enhance data quality since interactions amongst the participants can highlight extreme or insincere views (80). Initially FGDs were conducted at each village, as their flexible nature of questioning allowed for new topics, attitudes and ‘socially
acceptable opinions’ to be explored. They also assisted in identifying locally used terms for issues around risk and childbirth, as well as identifying new themes and questions to be used in the later IDIs. It should be noted that FGDs are considered to work best when the group consists of strangers (80). Due to the nature of conducting this research in relatively small rural villages it was not possible to form FGDs where the participants did not know each other. A final FGD was conducted at the end of the fieldwork to test out the validity of the initial findings and to see if any new topics or themes emerged, or if in fact data saturation had occurred.

Prior to arriving in the field it had been planned that the research assistant would be adequately trained to facilitate the focus group discussions, with the researcher acting as the observer. Due to budget constraints it was not viable to employ an additional translator for these discussions. Some of the FGDs worked well, with the participants discussing between themselves, and coming up with new topics. But some of them were more like group interviews, as they required more individual questioning, and there were fewer discussions between the participants. This could have partly been due to the composition of the group, for example, some participants dominating the discussions due to hierarchical positioning which I was initially unaware of. It could also have been due to the limited experience and skill of my research assistant in moderating and facilitating such discussions. Despite training prior to commencement of the data collection, and continual feedback, reflection and discussion on techniques employed, my research assistant was unable to skilfully moderate each discussion. It was felt that she struggled to ensure each participant was able to speak (due to excessively dominant participants), and regularly questioned and prompted in a manner encouraging the participants to answer in one specific direction. Therefore, after the first FGD I proceeded to moderate and lead the FGDs, with the assistant predominantly interpreting. This strategy did at times impede the natural flow of discussion at times, but it ensured less biased discussions and allowed for new topics to be raised. Despite these setbacks, each FGD shed new information on the topic, and were deemed to be of value during the fieldwork and later analysis.
All the discussions lasted between half an hour and 1.5 hours. The seven FGDs in the two villages were conducted in the Seventh Day Adventist Church and a fairly secluded local sheltered meeting area. My research assistant in collaboration with the village chiefs chose these two locations. They both provided enough space for all the participants to sit comfortable in a circle with the research team, and were on the edge of the villages so as to provide some form of privacy. Most of the younger women were interviewed whilst breastfeeding or caring for one or more of their children. At times this created distractions for both the research team and the participant, but it is a reality of rural village-life, and perhaps helped to keep the conversations more relaxed and normal. There were regular interruptions during the FGDs with family or community members coming in to ask participants questions. Each time someone came into the church or meeting area the FGD was stopped, and resumed when that person had left.

I chose the location for the group discussion with the motorbike drivers. A quiet, private space at the edge of Masanga village was chosen that enabled the group and myself to sit in a circle to facilitate discussions. The motorbike drivers were keen to conduct the group discussion in English. One of the participants understood English but preferred to tell his experiences and opinions in Temne. His experiences and opinions were then summarised by one of the other participants. This was not an ideal situation, but my research assistant had felt it would be best if she were not present during this discussion. This was because she felt that the male participants would be more relaxed speaking with the ‘foreign female’ researcher about pregnancy and childbirth, than if she, a ‘local female’ was present. There were no interruptions during this FGD. After this group discussion the research team listened to the audio recording together and checked the translations for the Temne speaker in particular.

2.4.2 IDIs and group interviews

Qualitative interviewing has been described as: “aiming to understand the meaning of respondents’ experience and life worlds” (Warren, 2001) through a
guided conversation, where the researcher actively listens in order to hear the meaning of what is being conveyed (86). The flexible and private forum of an in-depth interview is important when exploring women's own thoughts, experiences and perceptions around the potentially sensitive and intimate topic of pregnancy and childbirth. This method allowed women to have the time and space to describe their own experiences, talk about what was important to them, and allowed me to gain a deeper understanding behind the processes and thoughts involved in the decision-making processes involved during childbirth.

Each woman was invited to choose a location for the interview to be held. The locations varied between the Seventh Day Adventist Church, a fairly secluded local sheltered meeting area, food preparation areas, and the front or back of the participant’s home. These were all areas where women felt the most comfortable, and retained some form of privacy away from family members and other members of the community. All of the participants were comfortable to speak with the research team alone, and the majority of interview locations were private enough to allow in-depth discussions around potentially sensitive topics without too many disturbances. Again most of the female participants were interviewed whilst breastfeeding or caring for one or more of their children. At times this created distractions for both the research team and the participant like in the FGDs, but since it is a reality of rural village-life it potentially helped to keep the conversations more relaxed and normal.

Due to the nature of life in rural Sierra Leone, there are few truly isolated and private places, especially since a number of families usually live in one house. Therefore, interruptions from various people in the community or family members were commonplace. When this occurred, the interview or discussion was paused, and resumed again when privacy was regained.

All of the individual interviews were conducted in Temne with my research assistant translating. A thematic interview guide was used and I asked the main questions, follow-up, probing and clarifying questions, with my research assistant translating the questions and then the participant’s answers. During
the first few interviews my research assistant occasionally expanded on what the participant had said in an attempt to make the meaning of what was being said clearer to me. This was noted during the transcribing sessions and used as reflection opportunities to ensure that what the participants said were translated, rather than my assistant add in her words and understandings. This meant that if experiences or opinions were unclear to me, the participant had an opportunity to explain further or clarify the meaning in their own words, rather than my assistant’s own words. Towards the end of the fieldwork period the research team were more comfortable working with each other, and my assistant would occasionally add in questions. This was mainly at the end of the interviews, if something had been discussed that she thought required more probing. These questions were usually useful as they added another dimension to the discussions that I had not previously considered.

The group interviews with the health workers were conducted on the front porches of the health workers own homes on the Masanga Hospital site. These locations were chosen by the participants themselves and were quiet and private spaces. There were no interruptions during these group interviews. I conducted these interviews in English alone. After the interviews the research team discussed the interviews and emerging themes together.

Repeated interviews were conducted with a number of participants, including the women who had been pregnant recently, the midwives and TBAs. Due to time constraints and/or difficulties in finding a mutually convenient time for both researcher and participant, only a selected number of participants were re-interviewed. These were strategically chosen depending on the rapport built during the 1st interview, for example, those participants whom it was difficult to build an adequate level of trust with in just one interview. It was deemed multiple interviews could enable deeper and more trusting discussions to be conducted. Another group was those that were identified as having areas needing further clarification after listening to the audio recordings and preliminary analysis. Finally those where pertinent new topics had emerged with other participants and it was deemed important to ask previous
participants especially about these new emergent themes. In total seven participants were re-interviewed on one or more occasions.

2.4.3 Use of an audio-recorder

Use of an audio-recorder with note taking was decided as the preferred method for documenting all of the interviews and discussions. The ability to repeatedly listen to each interview, especially the FGDs, ensured that accurate and meaningful translations were transcribed. During some of the FGDs the dialogues were dynamic and quick, so my research assistant summarised the discussion, rather than translate every participants ‘voice’ verbatim. Use of an audio recorder meant that the full discussion could be transcribed verbatim, even if the translation during the discussion was at times a summary.

Not all of the participants were fully aware of what an audio-recorder was, so prior to each interview/discussion the audio-recorder was shown and demonstrated. After this process they were then asked again if they were comfortable having the interview or discussion recorded. Every participant agreed to have his or her interview or discussion recorded. It should be noted that the presence of an audio-recorder may have affected what participants shared during interviews and discussions, however it was not felt that the presence of the audio-recorder hugely negatively affected the interviews or discussions. The benefits of being able to re-listen to each discussion was believed to out-weigh the potential for some more sensitive topics not to be discussed, especially since an interpreter was being used.

I took notes during the interviews and discussions in order to help contextualise the discourses. Non-verbal cues such as body language and facial expressions were documented, along with notes on the physical setting of the interview, and any interruptions that occurred. These notes were discussed with my research assistant afterwards.
2.4.4 Triangulation

The use of triangulation is considered to strengthen a study as a mixture of approaches are utilised to inform upon a topic from different viewpoints. It also means that not one single method, along with its potential weaknesses, is relied upon (80). I triangulated during my data construction in a number of ways. Firstly with method triangulation, using both FGDs and IDIs, as well as a variety of sampling techniques. The study also included triangulation with respondent sources, from mothers who had been pregnant and given birth themselves, to their family members, the TBAs, health workers in the local hospital as well as motorbike drivers. Furthermore the use of different research sites added strength to the data construction. Use of methodological triangulation strategies meant that deeper understanding about the issues and phenomenon being studied could be obtained (80).

2.4.5 Transcription of interviews and discussions

All formal interviews and discussions were audio-recorded and I transcribed them verbatim within 24 hours of each interview/discussion being conducted. According to Kvale (87), transcriptions can further decontextualize conversations or interviews. Therefore, in addition to transcribing the interviews as soon as possible in order to keep the situation and context as fresh as possible, field notes and summaries of the interview or discussion were also documented.

Summaries included a general outline of the interview/discussion; description of the participant; positioning during the interviews; non-verbal communication and expressions used; positive aspects of the interview and any challenges that occurred; wording that worked or didn’t work; any interruptions, when and from whom; and ways to improve for the next interview.

Hermeneutics, the field of study concerned with the philosophy and science of interpretation of texts, suggests that the meaning of something depends on the cultural context in which it was originally created and subsequently interpreted.
This means that although the summaries of each interview or discussion were not used directly in the preliminary analysis of the data they enabled the decontextualized transcripts to be read with the cultural context in mind. They also added a depth and valuable insight into the methodological reflections after each interview. Furthermore, they were useful during the analysis stage conducted in Norway when needing to contextualise quotes or information.

There is no way of fully ensuring that what is said during interviews or discussions truly convey the meaning of the participant (80). Some strategies were employed to try to guarantee that my research assistant and I shared a common understanding and interpretation of what the participants had said. After the initial transcribing, the summaries and transcriptions were read by both the research assistant and myself, whilst listening to the audio-recordings. Any mistakes or misunderstandings during the original interview translation were identified and corrected. Discussions were conducted around the ‘cultural meaning’ of certain parts of the text, and the overall context was discussed and clarified. Each interview/discussion transcription was then read at least one further time to identify potential new themes to explore, and enable the interview guide to be adapted.

During the FGD’s, not all of the discussions were fully translated verbatim at the time. Therefore, during the transcribing process the research team sat together, identifying the different participants, and ensuring that all parts of each discussion were documented. This was difficult at times as some participants would talk over each other, but it was deemed important that each voice and opinion be clearly documented and described.

A number of audio-recordings were re-translated by an independent person at regular intervals during the fieldwork. This person did not know the location of the interviews, did not know the participants, and were not able to identify them. This ensured the confidentiality of each participant. This re-translation was conducted in order to check the translation, but also the cultural meaning behind the various discourses, which in turn provided confidence in the quality of the
interpretation of the interviews and discussions. Each of the re-translated interviews was very similar to the original translation. Any sections that differed were due to choice of wording rather than meaning of the section. The main differences were due to my research assistant using medical words rather than lay words. For example, my research assistant used ‘retained placenta’ rather than what the participant had actually said, ‘the afterbirth not coming out’. My research assistant and I then discussed these medicalised translations, and emphasis was placed on the research assistant’s use of the participant’s own words, so that their voice was heard through the text.

2.4.6 Preliminary analysis, the interview guide & how it changed

Thoughts and impressions of each day were noted in a field diary: interview setting, pros & cons, interactions between the assistant and researcher, as well as reflection on informal conversations and observations made during the day. After each interview/discussion transcription was completed, conceptual maps were made so that visual associations between potential themes and codes could be formed. This helped the research team adapt the interview guides and identify potential emerging themes to explore. Such “preliminary analysis” was conducted throughout the data construction period.

The ability to repeatedly listen to each interview and discussion through the use of the audio-recorder assisted greatly with the preliminary analysis of the data in the field. The ‘meaning’ of specific words, phrases and general topics were discussed and examined by the research team. This was done so that a common understanding of specific cultural discourses was gained, and data was ensured to be a co-construction of the participant’s reality by the participants and the research team, and not just the projected view-point from the researcher (89). This primary analysis after each interview or group discussion also helped shape future interviews and discussions.

Both the FGDs and interviews were conducted using thematic guides. The questions or wording were adapted depending upon the participant or group
being interviewed, with additional prompts to assist with particularly quiet or shy participants. The main themes initially discussed were: experience of pregnancy and labour; who was involved during the delivery process and their roles; differences between delivering in the village and in the hospital; risks or problems during pregnancy and childbirth; knowledge of the free health care initiative; knowledge of the bylaws.

The initial interview questions were translated by my research assistant, and then translated back by an independent person. This was done to ensure that the style and wording of the questions were appropriate and interpreted in the 'correct way'. For example, when I asked “can you tell me about your last pregnancy?” my research assistant actually asked “can you tell me about any problems in your last pregnancy”. This clarification of the questions meant that discussions between my assistant and myself further ensured a common understanding of what was wanted and needed during the interviews and group discussions. The thematic guides and interview questions were then tested on a group of recently pregnant women in Masanga village to identify any issues or problems prior to the first FGD and IDI in the villages.

The interview and discussion guides were adapted during the data construction period as necessary after the preliminary analysis, with new ways of asking questions identified, or new themes or topics to be explored. For example, asking, “what is the difference between giving birth in your home and in the hospital?” often appeared to confuse participants and they would say they did not understand. I therefore changed the question to “are there any good things about giving birth at home?” with another question of: “are there any good things about giving birth in the hospital?” These questions opened up the conversation and enabled us to discuss the differences between the potential locations of delivery. Additional themes that were explored included ‘exposure to witchcraft during pregnancy’. This theme came up during the female FGD in Makamba, and was subsequently discussed in the following interviews/discussions.
2.5 Data analysis

The final stage of data analysis and writing up of the final report occurred when I returned home to Norway. Malterud's systematic text condensation strategy was used as a guide to the final stage of analysis (89). This strategy follows four main steps from gaining an overall impression of the material by reading all of the data collected again, trying to formulate a global picture about what the data means and what was being said. Next, identifying and sorting the material into codes, condensing the ‘codes’ to ‘meanings’ or themes, and then finally analysing these themes so that descriptions and concepts are formed. These four steps were not used strictly consecutively and at times a more flexible approach was used. The analysis was treated as a process with the boundaries between the different steps often merging or overlapping, with much movement backwards and forwards between the steps as the analysis progressed.

In addition to the first step of Malterud’s strategy I also re-read all transcripts alongside field notes and interview/discussion summaries. A number of transcripts were shared and discussed with supervisors and peers, to explore alternative approaches, thoughts and analysis, and then compared to the themes that the research team had already tentatively identified. Next, each transcript was coded using the qualitative analysis software NVivo10. The codes were initially formed with suggestions from previously read literature, for example, ‘distance to hospital’, ‘transport options’. Some of the codes were expanded during this analysis process, for example ‘transport’ became three codes: ‘availability of transport’, ‘cost of transport’, ‘safety of transport’. A further code was added to this that emerged during the preliminary analysis that related specifically to ‘male transport provider’. Previously coded transcripts were revisited with the newly adapted codes. From the codes different themes were identified. The codes and themes were continuously reflected upon, and were adapted, subgroups formed, changed and merged as appropriate. For example, the codes ‘bearing up with the pain’, ‘preventing a crowd’, ‘strong woman’, ‘privacy’, ‘too many people interfering’ and ‘fear of witchcraft’ were all placed under one theme: ‘the meaning and importance of suppressing pain’. This was then adapted when it became clearer that the phenomena of ‘witchcraft’
alongside ‘jealousy’ were actually better placed under a theme ‘perceptions of symptoms and risk’. Again previously coded transcripts were revisited with these newly identified codes and themes. Conceptual maps were used at this stage to visualise the different associations between the codes and themes. One of the challenges met was to read the data with the original objectives in mind, and themes identified in previous literature, whilst remaining open-minded to new phenomena.

Finally each transcript, with all the identified codes and themes, was then printed out and re-read again. The codes and themes were analysed and described, highlighting the similarities and differences amongst the material, the participants and the different participant groups, as well as the different settings of each village. Finally descriptions and analyses of these interrelations and meanings were documented in the findings and discussion chapters.

I continued to read and explore the literature during the fieldwork, analysis and writing up of the thesis. As new themes and concepts emerged the literature search was widened in an attempt to include and understand more. Initially Thaddeus and Maine’s theoretical framework on the three delay concept (57) as well as Lupton’s concept around risk were used whilst in the field (64). During the analysis phase Mary Douglas’ work on “Purity and Danger” (65), Kleinman’s theories on medical systems and explanatory models (61) and Becker’s work on pre-disposing, enabling and supportive factors (78) were also included. Finally theories around feminism were also included during the analysis stage (66-68, 72, 74). All of these theoretical frameworks were used to help guide the interpretation and analysis of the findings.

2.6 Reflexivity

Reflexivity is described by Malterud (90) as “an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process”. Who I am and who my research assistant is, as well as our preconceived ideas about the phenomenon
we are exploring, will affect the construction of the data. With this in mind I have continuously reflected upon positioning and pre-understandings, and how they might shape and affect the data, throughout the whole research project (90, 91).

Being from a different culture, with white-skin, never having been affected by extreme poverty, nor lived in Sierra Leone before, will all have contributed to being viewed as an outsider by the participants. On one hand this may have allowed the participants to feel more open to express opinions not in keeping with local norms. On the other hand, more time was required to build trust and a feeling of openness, and in fact, this may not actually have been possible to the degree that I hoped. This difference in culture and background may also have meant that how I viewed and interpreted the material collected was different to the participant’s own viewpoint or understanding of the issues discussed. In order to improve my rapport with the participants I spent time in the villages, sat with different groups, particularly women, shared food and participated in social activities such as hair braiding.

One factor that I had not considered specifically before entering the fieldwork was of myself being British, not just western. Britain had significant roles to play in slavery, subsequent abolition of slavery, colonialism and more recently in the civil war of 1991 to 2002. It was because of the role of the British Armed Forces in the civil war that participants often greeted me more warmly than I expected when they learnt I was British. The history of my nationality is likely to have impacted upon the relationships I had with my participants more than I was, at least initially, aware of.

My research assistant’s husband was in fact originally from one of the research sites. I did not know this until half way through the fieldwork period, which created concerns that some participants could feel insecure regarding confidentiality. The research team therefore, spent extra time emphasising measures we were taking to ensure confidentiality at the particular village. The close tie to the research site and participants meant that my research assistant truly understood what it was to live in this area, could explain in detail about
cultural beliefs, everyday norms, activities and understandings. This pre-understanding was nicely balanced with my own lack of innate understanding of the research settings, thereby not presuming understanding for anything, in fact questioning everything.

Before entering into the research field I was concerned that not having been pregnant myself may have affected how the participants interacted with me. This did not appear to be a problem, as I had anticipated. In fact, participants appeared to be comfortable ‘teaching me’ about pregnancy and delivery through their experiences, and perhaps this difference in ‘life experience’ helped to balance out the potential power hierarchy between researcher and participant (92). My research assistant had been pregnant twice, and had her own experience of losing a child. She was therefore far more familiar with the everyday challenges the community members who we spoke with faced. Not being from the traditional societies was a bigger problem with regards to talking about certain ‘secret processes’. Some of the detailed aspects around the birthing process will not have been shared me. Again, the familiarity and understanding that my research assistant had with the communities and culture helped to a certain extent with this barrier

Being two women certainly helped with the rapport with the female participants, but this may have been a negative influence when interviewing the male participants. However, on the whole male participants spoke easily with the research team, and appeared very comfortable. My previous professional experience as a health care clinician enabled me to speak more easily with health workers. However, I had to be cautious in ensuring that my clinical experience did not affect my understanding or interpretation of what was said by or about the traditional birth attendants. In addition to my experience as a health professional, my research assistant had also worked in the local hospital. Potentially some participants may have been hesitant to discuss any negative issues connected with the hospital or health workers. It was important for us to emphasise that my research assistant no longer worked there, and that her role in the research was separate to the hospital.
2.7 Trustworthiness

The issues of validity and reliability, terms used in quantitative research, can not be addressed properly when discussing qualitative research (93). With this in mind I have decided to discuss the trustworthiness of this study using the concepts of credibility, transferability, dependability and confirmability as described by Guba (1981).

2.7.1 Credibility

Credibility is a way of demonstrating the confidence we have in the truth of the findings (93, 94). There are a number of ways to promote credibility including using well established research methods as well as evaluating the credibility of the actual researcher, since they are a major tool in the research process. The role of my main supervisor, an experienced researcher, has been invaluable in assisting me to continuously reflect upon choice of methods, adaptations that have occurred, my role as the researcher, as well as evaluate any ethical considerations that arose (80). In addition to discussing the process, findings and the analysis with my supervisor I also sought opportunities for peer scrutiny (93). This included discussions with fellow research students whilst in the field, discussing interpretation of transcripts and sharing of initial analysis and findings with peers when back in Norway. I also took the opportunity to present my initial findings to medical students in Norway with a special interest in humanitarian work and maternal health in Sierra Leone. All of these situations allowed for fresh perspectives on how I conducted the research, my assumptions and initial analyses.

Credibility also includes whether an accurate understanding of the context was gained or not (93). Since this was the first time I had been to Sierra Leone I viewed the preparation period as particularly important to try and understand the context as much as it was possible for an outsider. Upon arrival in Sierra Leone I spent a few weeks getting to know the area where I would be working, going to the markets and talking to many people, walking around the villages, taking public transport to different areas, which in itself was a great opportunity
to meet and talk with a variety of people. The use of a research assistant who was from the area where the study took place was also a strategic choice, in order to increase the likelihood of accurate interpretation and understanding of what was shared by the participants.

The use of triangulation in the form of different methods, sampling technique, different groups of participants, as well as including two research sites added further trustworthiness to this study. Conducting the final FGD was another way of strengthening the validity, and subsequently ensuring trustworthiness. Although not directed in a way to conduct ‘member checks’ (80), I presented some of the initial findings to new participants to see if it made sense to them, and to see if there was anything else they would add to the discourses and themes already highlighted.

Trustworthiness is also dependent upon whether participants are willing to share their experiences and opinions, or whether they have alternative motives for participating in the research (93, 94). This aspect of trustworthiness was evaluated throughout the research process. For example, whilst reflecting upon the interview conducted with one of the TBAs it was felt that she was not comfortable being interviewed, and her answers were given in a way to show that what she is doing is ‘the right thing’, as opposed to her own experiences and opinions. The research team, therefore, spent time building a rapport with her, before asking for a second interview. The second interview seemed much more open and descriptive.

Another aspect that was considered was the fact that both myself and my research assistant lived in Masanga village, which is connected with Masanga Hospital. In addition, my research assistant used to work in the hospital. There was the potential that some participants were not as vocal about negative aspects of care at the hospital, because they connected the research team with the hospital.
Although some women had given birth as recently as 2 weeks prior to their participation in the research, a number of women, and family members of the women, had given birth to their last child up to one year previously. This could leave room for recall bias in their description of their experiences. Where possible a number of participants were interviewed twice, or participated in the FGD and then were interviewed. This enabled the research team to identify inconsistencies in their experiences. If a pertinent discrepancy was noted, then the research team attempted to conduct a repeated interview with this participant in order to clarify any misunderstandings.

Another issue with regards to credibility was the use of an interpreter. The research assistant was regularly reminded to separate her own interpretation and preunderstandings from what the participants were saying during the translation process. The interviews and discussions were initially translated verbatim, and then the meaning behind what was being said was discussed and debated afterwards during the transcribing and preliminary analysis stage. An independent interpreter retranslated a number of the interviews and the meaning of what the participants shared were consistent between the two translations. This further adds to the trustworthiness that the data constructed do reflect the participants’ own words, meanings, and opinions.

2.7.2 Transferability
Transferability refers to the degree of which the data that are conceptually representative of people in a specific context, can be transferred to other contexts or other circumstances (94). It was not my aim to make my findings generalizable to other settings, but by giving ‘thick descriptions’ of the context it allows future researchers to decide if the findings can possibly be transferred to other settings (94).

Trustworthiness could have been enhanced further by inclusion of different participants or different research sites. For example, inclusion of family members where the mother had died due to complications during childbirth could have added further dimensions or perspectives to the topic being explored.
Including urban communities could also have added different perceptions, or highlighted similarities or differences in the decision-making process dependent upon living situation and proximity to different health facilities.

2.7.3 Dependability

In quantitative research the term reliability is used to show the extent to which the study could be repeated and the findings replicated. In qualitative research, due to the constant changing and dynamic social world that is being studied, this replication is not possible (94). Instead, the term dependability is often being used. Evaluating the dependability in a qualitative study implies ensuring that the process is consistent and that comprehensive information about each stage of the research process is clearly described. It includes a clear and logical relationship between the objectives of the study, the chosen design, sampling strategies and methods, and the interpretation and reporting of results (93). The main objective of this study was to explore the decision-making process during childbirth in rural Sierra Leone. I believe in this respect it was logical to use qualitative methodology that allowed for flexibility in the field with regards to methods and variation in participants, to accommodate the exploration of new themes and areas previously not considered. In addition the sampling strategies allowed for a wide variety of information-rich participants to be included in order to gain a deeper understanding of this phenomena, as discussed in the research design chapter.

2.7.4 Confirmability

Confirmability is a way of showing that the data, as accurately as possible, reflects the participant’s own perspectives and experiences. The very nature of qualitative research means that complete neutrality and impartiality of the researcher in the research process is impossible. By applying the concept of reflexivity (both throughout the research process and in the final thesis), my role in the data construction has been presented as transparently as possible (80).

Confirmability can be enhanced by the process of triangulation, as well as in-depth descriptions of the whole research process (93). To further improve the confirmability of this study, wherever possible, I tried to ensure I had
understood what the participant had told me, re-telling their story back to them to confirm that I had understood. I also conducted in-depth discussions with my research assistant to try to ensure that my understanding of what participants had shared was in line with what they had meant. However, this still leaves some room for misinterpretation, as the position of my research assistant will also affect the translation and interpretation.

2.8 Ethical considerations

During the planning stage of this project there were a number of ethical considerations that needed to be deliberated. Informed consent, which included individual and community consent, as well as risks and benefits were deemed of particular importance, and shall be discussed in this section.

Approval from the Ethical Committee for Ministry of Health Services of Sierra Leone was gained (see appendix 1) along with approval for storage of information through the Norwegian Social Science Data Services (see appendix 2). Both of these were gained before arrival in the field. Approval from the Regional Committees for Medical and Health Research Ethics in Norway was not needed (see appendix 3).

2.8.1 Informed consent

Informed consent is one of the basic principles in medical research ethics and must be sought in order to respect a person’s human dignity and right to self-determination (95-97). It is based on the principle that competent individuals are entitled to choose freely whether to participate in research or not, respecting the individual’s autonomy and protecting the individual’s freedom of choice (98). Participants need to be provided with adequate information, but also understand the information so that they can truly make an informed decision whether to participate or not (99).

The information sheets and consent forms were written in English as there is not a reliable/consistent written version of Temne, the local language (see appendix 4 for a copy of the consent form). This meant that additional time had to be spent
going through the whole form prior to consenting. This procedure was lengthy
and my research assistant particularly, was at times anxious about ‘running out
of time for interview/discussion’ as participants had other obligations or
responsibilities to attend to after the interviews. However, the importance of
informed consent was re-iterated, not only to protect the participant, but also to
safeguard the validity of the material collected (98). Convenient times for the
participants were then sought rather than rushing the process, which usually
meant arriving earlier in the village. Opportunities were given for the
participants to ask questions and clarify anything they did not understand.

Within rural Sierra Leone there are low literacy rates and low educational levels,
particularly among women (2). Therefore verbal consent with a thumbprint,
rather than written consent, was gained from most participants. The information
sheet was then provided to each participant, albeit in English, as it had the names
and contact details of the research team written on them.

2.8.2 Individual versus community
Within Sierra Leone it is very common for decisions regarding the community to
be made by community leaders, such as village elders or chiefs. Individuals trust
in these community leaders to make decisions that are best for the whole
community (100). In some societies this ‘community leader consent’ is
considered to be appropriate to be used instead of individual consent (99).
However, it is also strongly acknowledged that consent from the community
leader should not be mistaken for freely given informed consent on the part of
the individual (95).

With these concerns in mind, I treated informed consent as a process (92).
Permission was sought initially from the village chief at each research site, and
then individual informed consent from each participant. The informed consent
was completed in a private area so that women had the confidence and ability to
decline to participate in the research if they wished. Adequate time was spent
emphasising voluntarily participation, the freedom to say no and to withdraw at any point without giving a reason.

2.8.3 Risks and benefits
There were no specific benefits for the individuals participating in this research project. Many thanked the research team for taking interest in their village and requesting to hear the voices of the village community. There were no potential adverse risks associated with participating in the project, but there was the potential for recollection of distressing memories or negative emotions related to previous births (92). Recalling past childbirth experiences could bring up painful memories, which could warrant referral to a counsellor or psychologist. However there are a lack of mental health professionals within Sierra Leone for participants to be referred to if necessary (24). I therefore liaised with staff at Masanga Hospital, so that if I came across any women who would benefit from additional medical help or intervention due to problems post-pregnancy, I could refer them. One participant was subsequently referred to the hospital. Participants were also reminded during the informed consent procedure, and during the actual interviews, that they did not have to talk about anything that they did not want to or that made them feel uncomfortable. None of the participants were outwardly distressed after participating.

2.8.4 Confidentiality and storage of data
Qualitative research lends itself to description of the participants involved (92). Since most of the participants in this research project came from fairly small rural areas the risk of them being identified is quite high. Therefore the need to ensure confidentiality was even greater.

Data collected from the interviews and group discussions, including audio recordings, were stored on a password-secure laptop, known only to the main researcher. All data was processed without name or other directly recognisable types of information. A code number linked the participant to the data through a
list of names. All field notes and audio-recordings will be destroyed on completion of the thesis.

My research assistant also signed a contract that all information heard and discussed would be kept confidential and not shared with anyone else, including her family. All data was de-identified and any information that could link participants to written material was kept separate to ensure confidentiality (92). Throughout the fieldwork period, analysis and write up of the thesis, efforts were made to only identify the participant to the extent necessary. For the analysis and write up of the final report, gender, number of pregnancies and children as well as location of previous childbirths were used as descriptors to help place the quotes and interpretations into context. When using quotations in the text, participants were referred to as “FGD 4” or “IDI 8” in order to reduce the risk of identification.

2.9 Dissemination

This masters thesis will be delivered as part of the fulfillment for the master degree in International Community Health at the University of Oslo. A summary of the research results will be sent to any relevant and interested persons in Sierra Leone. A summary of the thesis will also be disseminated to the communities where the research was conducted. As the main researcher I also aim to turn this masters thesis into an article.
3.0 PRESENTATION OF FINDINGS

This chapter will begin with an introduction to the main findings. It will be followed by findings presented according to main themes and sub-themes identified during the analysis stage.

3.1 An overview of the main findings

The decision-making process during childbirth in rural Sierra Leone is a multi-faceted, dynamic and complex process. Each participant’s story is as unique to them, as they are unique in themselves. However, through construction and analysis of the data I was able to identify a number of common factors or themes, which were pertinent and influential in the decision-making process.

The majority of participants in this study described a safe delivery as one that occurred at home in the village. The hospital was predominantly seen as a place to go if a problem should occur. Of the women who did want to deliver at the hospital a number of prohibitive factors stood in their way, including money, transport, distance and perceived accessibility of the health services.

The decision to seek treatment, if a problem did occur, was often delayed by the need for privacy and secrecy during labour. The perceived cause of the problem also played a role in what type of treatment or assistant was sought and when. Participants were flexible in their health seeking behaviour, and decisions were either pragmatic depending on availability and accessibility, or ad hoc as the situation and circumstances changed.

Decisions were rarely made alone, rather in conjunction with older women, especially the TBAs or female family members. Male family members were predominantly responsible for providing money and transport. The many factors influencing the decision-making process were flexible, diversely shared and specifically transformed dependent upon who was involved and under which circumstances.
3.2 First time mothers

In this study, the findings showed that childbirth is a private and secret process in the villages. Those who had not experienced childbirth themselves were not typically allowed to be involved or assist during delivery. This included men and children, but also young women who have not yet had their own children. This then meant that a woman (or girl) who was expecting her first child would have limited knowledge and understanding about what would happen to her during the birthing process. This lack of knowledge about what to expect and what she should do, transcended to how she handled the initial labour pains and how much autonomy and authority she held with regards to the decision-making process.

It was found that a primigravid woman\(^{12}\) might speak out about the onset of labour pain sooner than a woman who had given birth before. She would usually tell an experienced woman close to her, for example her mother, a neighbour or the TBA. In turn, she was much more likely to be influenced by, and reliant on, these experienced women around her during the whole birthing process. As one primigravida who delivered in the village described:

“I really want the old woman to take me to the hospital to deliver, but when the other people told me to stay here, and wait for a time, that is why I stay. (...) I don’t have any understanding about delivering; they are the ones that have the experience. So anything that they tell me, I need to listen to them.” (IDI 40)

This young mother had heard that women should go to the hospital if they were unable to deliver. She was scared because she had been in labour for 2 days already and wanted to go to the hospital. She stayed, however, in the village on the advice of her mother and the TBA (who she referred to as the old woman).

\(^{12}\) a woman pregnant for the first time (http://medicaldictionary.thefreedictionary.com/primigravida)
In contrast, the community health officers (CHO) who worked in the hospital explained that in their experience predominantly primigravid women, especially teenagers, would attend the hospital during labour:

“I think the reason is because they are new in the game. So whenever they have pain, they are very tormented, they can’t cooperate, they don’t know most of the procedures (...) they will say ‘take me to the hospital, I will go to the hospital, take me’. They know that at least they will be taken care of at the hospital”. (IDI 53)

This suggested that the women’s inexperience in childbirth meant that they were more scared of the pain, and were therefore, more likely to seek assistance in the hospital. Multigravida13 women (those who have had 2 or more children) expressed having more control over their delivery, and were less likely to be influenced by others. According to most participants they were more likely to “bear up with the pain” and ask for help at a later stage. As explained by one of the TBAs:

“(…) pregnant women who have delivered more than 3 children, they know the symptoms which come to them, that is why they bear up the pain before they expose it to somebody, (…) some of them when the pain starts, it is 2 days before they voice it out.” (IDI 28)

The level of autonomy, authority and decision-making power that women felt they had varied greatly on an individual basis. Their experience as well as role within their own family, and within the community, often dictated how comfortable they were voicing their own opinions and having them listened to.

3.2.1 Previous problems and birth outcome

Typically if a woman had not experienced any problems with her previous pregnancy or delivery, any ‘new problems’ or ‘new symptoms’ that she experienced in later pregnancies could cause anxiety or worry. Thereby, what

13 Multigravida refers to women who is or has been pregnant for at least a second time (http://www.oxford dictionaries.com/definition/english/multigravida)
could be considered even minor complications could motivate women to seek help from the hospital. This was discussed among the recently pregnant women in the final FGD:

“Some of the pregnant women will be afraid because of their swollen feet. That is why they hurry to go to the hospital, saying ‘oh I should go to the hospital because my feet are swollen, I want to know what really happens with my feet’, because that has never happened to them before”. (FGD 60)

In the same way, other participants during this focus group explained that if a woman had never previously needed input from the hospital, and then was told that she needed an operation, the woman may ‘doubt the advice’ because she had not experienced this before.

The outcome from previous births may also play a role in where a woman prefers to deliver. Women expressed opinions that if they had previously experienced uncomplicated home deliveries, they would plan for future births to occur at home. This was deemed to be a problem by some of the health workers at the hospital, as explained by one of the midwives:

“Especially those multi-gravidas (...). They think there is no need for them to come to the hospital, because they have been delivering at home and they are ok. But they do not know that life is complicated, anything can happen.” (IDI 49)

Women who had experienced a serious problem during previous deliveries were more likely to plan to go to the hospital with subsequent deliveries. As described by one woman who required treatment for bleeding at the hospital with her first delivery:

“The reason why I planned to give birth at the hospital is because since my first delivery I have bleeding (...) because if I give birth in the hospital, the doctors and the nurses will cure me. But if I decide to give birth at home and unfortunately the bleeding occurs, the people will not have the treatment to help me.” (IDI 21)
It should be noted that this ‘plan’ to give birth in the hospital may not have resulted in her actually getting to the hospital due to a number of factors e.g. availability of transport, money at hand, precipitate\textsuperscript{14} labour. This was the situation with the woman quoted above. She had been pregnant five times in total, with four children delivered at the hospital. One of her children died during childbirth because the labour progressed too quickly for her to travel the long distance to the hospital in time.

3.3 Perceived role of the hospital during pregnancy and delivery

Most participants described the importance of attending the antenatal clinic (ANC) during pregnancy. Many women viewed attending ANC appointments as a strategy to ensure a safe delivery as problems such as ‘wrong position of the baby’ would be identified and solved. The CHOs and midwives also spoke about the importance of pregnant women attending ANC appointments so that ‘at risk’ women could be identified. Women reported being told to deliver at the hospital during their ANC appointments, but many still planned to deliver at home despite this advice.

Many participants spoke about the hospital having machines to scan the woman, identify what the problem is and ‘take the baby out’. This was a procedure that could not be done in the village, as discussed in one of the FGD for older women:

“When you take her (the pregnant woman) to the hospital, the doctors and the nurse examine her, and also do scanning, for them to know what is really wrong. As for us we don’t have any machine that is helping us to know what is wrong with the pregnancy” (FGD 16)

Despite the equipment, positive perception of treatment available at the hospital and the ‘official advice’ of giving birth in the hospital, a ‘normal delivery’ was still viewed as one that occurred at home in the village. Many participants viewed

\textsuperscript{14} Rapid progression of labour leading to birth of the baby (http://www.ncbi.nlm.nih.gov/books/NBK53622/)
attending the hospital for an uncomplicated delivery as unnecessary. The health workers were also aware of the tendency to only attend the hospital during childbirth if you have a problem or complication, not as a preventative measure. One of the CHOs elaborates:

“(…) Because they are not used to that. It is normal, even to us, to wait until you are sick before you go to the hospital (laughing). So the same thing with those people, so it is like they say ‘until I have a problem I will not go to the hospital’, so they will see it as a waste of time.” (CHO 54)

Attending the hospital as a preventative measure is often seen as unnecessary. This concept had also been discussed on the radio as it was considered that many women were ‘not used to the idea’ of attending the hospital during childbirth.

Many women articulated concerns that attending the hospital with a complication automatically resulted in an operation, which was something to be feared. The TBAs also discussed this:

“Some of them are afraid to go to the hospital to deliver, they think that if they go to the hospital they will be operated on.” (IDI 29)

Many of the women who spoke about the assumption of automatically being operated on had never attended the hospital themselves during childbirth. The information usually came from discussions with the older women or TBAs.

3.3.1 Symptoms motivating attendance at the hospital

Many participants described specific symptoms as strong motivators to give birth in the hospital, or to seek help during labour. The CHOs attributed bleeding to be one of the predominant symptoms that motivated women to attend the hospital, a view that was shared by many participants in the villages. One woman
explained during her interview why bleeding would encourage her to give birth in the hospital:

“If I was here in the village giving birth and bleeding occurred with me. There is no way for the TBAs to help me solve the problem (...) But when I give birth in the hospital, if the bleeding occurs they will give me treatment to cure it.” (IDI 8)

However, a few women also considered bleeding as a condition that could be treated in the village, as explained by one of the women in the final focus group:

“If that problem (bleeding) occurs with you, if you give birth in the hospital, they will give you treatment to stop the problem. But if you give birth in the village, they will give you native herbs which will also solve that problem.” (FGD 62)

Prolonged labour was another sign that participants considered as an indication that a woman needed to go to the hospital. Prolonged labour was often discussed in the terms of slow pain or long pain. However, it should be noted that prolonged labour was often difficult to measure in the village because few people had access to watches or other means of telling the time. In addition, if women did not disclose their initial labour pains, those assisting her may not know how long she had truly been in labour for.

3.4 The meaning and importance of supressing pain

Many participants, both women and men, as well as lay and health workers, spoke about women ‘bearing up with the pain’ when they first experienced labour pains. This usually involved keeping the onset of labour quiet or secret, and only telling someone about their pain when the labour had progressed quite far. Most participants spoke about ‘bearing up with the pain’ in order to prevent a crowd being drawn. There were a number of potential problems that could arise if a crowd was drawn to where the woman was giving birth. For example, shame caused by interpreting the pains incorrectly, as described by one woman in a FGD:
“*If you feel the pain and after, you explain yourself to the people, later (...) if it is not yet time to deliver it is very shameful.*” (FGD 23)

This feeling of shame about misinterpreting the signs of labour also related to a few participants who spoke about women who bear up with the pain being viewed as strong women. Therefore, those who did not bear up with the pain were often viewed as lesser or weaker women. Some participants spoke about women who needed to attend the hospital during childbirth were simply those who could not bear up the pain, rather than them having a problem.

One of the TBAs spoke candidly about the desire not to have a crowd present, relating this to the tendency that people would gossip about what they had seen during the delivery:

“...*if there is a crowd there (during delivery), (...) people take the information to the next one and say ‘oh I went there, I saw a shit coming out’, that is why people don’t allow a crowd to be there.*” (IDI 28)

This necessity for privacy also related to women not wanting too many people giving their own opinions or shouting at them to ‘give birth now’. In addition to the crowd giving unhelpful advice, there was also the fear that some may interpret any delay in the labour as a sign of infidelity on behalf of the woman as will be discussed later in this chapter. The fewer people present, the less chance there was of unhelpful or potentially untruthful suggestions being made.

### 3.5 Perceptions of symptoms and risks

The health workers based at Masanga Hospital and the ‘lay’ people in the villages discussed both shared and different perceptions on symptoms and risks involved during pregnancy and childbirth.
During the interviews, both the midwives and CHOs clearly demonstrated a high level of knowledge of the main medical reasons and treatment options for potential complications during both pregnancy and childbirth. They also highlighted potential causes of problems specific to the rural areas where they worked. Teenage mothers were described as being particularly vulnerable to additional problems or complications. They were typically viewed as having married too young, with their bodies not being properly developed yet. This then increased their risk of obstructed delivery and potential for obtaining an obstetric fistula\textsuperscript{15}.

Both the CHOs and midwives discussed the problem of the TBAs not being properly skilled to manage deliveries, as described by one CHO:

“(...) so they will try all mechanisms to make this woman deliver. By forcing them to push before time, which can cause complications, maybe ruptured uterus, or tear (...) so they will create a lot of complications.” (CHO 53).

The health workers described how the TBAs were more focused on the baby rather than the mother, and used forceful manoeuvres to get the baby out. These forceful manoeuvres in turn could result in further problems, a ruptured uterus for example.

The midwives spoke about the role of women in society as the main workers, thereby not getting enough rest during pregnancy. This view of women typically working much harder than men was also shared during discussions at the radio station. Representatives from the local radio said that they had a higher percentage of men contributing to the programs because men have more time to relax, whereas women are busy 24 hours a day, going to the farm, going to the market and caring for their families. The majority of participants, both health workers and lay people, deemed heavy work, often related to gold mining, as a general risk to the health and well being of the mother.

\textsuperscript{15} An obstetric fistula is a hole between the vagina and the rectum or bladder that is caused by prolonged labour, leaving a woman incontinent of urine, faeces or both. (http://www.who.int/features/factfiles/obstetric_fistula/en/)
Inadequate amounts of food, in particular lack of nutritious food was another problem highlighted during the group interview with the midwives. They described a number of taboos surrounding food believed not by themselves, but by communities in the rural areas. These taboos included: eating eggs whilst pregnant would result in your child stealing when s/he is older. These specific food taboos were not readily shared by the participants in the villages, instead the women and men spoke about the importance of eating good food and preparing food properly i.e. with oil palm and groundnut. A number of women and older women spoke particularly about the importance of eating good food either before giving birth or directly afterwards.

Signs and symptoms such as swollen feet could be interpreted in a number of ways. The health workers and a number of the women in the villages discussed how swollen feet could indicate a problem, such as eclampsia\textsuperscript{16}. In contrast a number of women thought that it was a sign of the sex of the baby. The midwives were aware of this potential confusion over signs and symptoms amongst the rural communities, but only held the biomedical viewpoint regarding dangerous signs and symptoms themselves.

\subsection{3.5.1 Jealousy and the fear of witchcraft}

One of the main reasons for wanting to keep the number of people who know that a woman is in labour to the minimum was associated with the fear that those with bad intentions might hear about her vulnerable position. Many participants spoke about the fear of someone halting the progression of labour, killing the baby or even the mother. This was usually related to ‘witches power’ as described by a recently pregnant woman during one interview:

\textit{\textsuperscript{16}Eclampsia is the onset of fits in a woman whose pregnancy is usually complicated by pre-eclampsia. The fits may occur in pregnancy after 20 weeks gestation, in labour, or during the first 48 hours of the postpartum period. There is a high incidence of maternal death in women with eclampsia. (http://www.who.int/maternal_child_adolescent/documents/5_9241546662/en/)
“if you have been quarrelling with someone before, some of them have hated mind for you, as soon as they heard that "oh this woman she is in labour", they go somewhere else and do witches power. That is why they don’t want to circulate the information.” (IDI 24)

Some women referred to this type of ‘witches power’ as ‘tying up their cottons’, which is when a woman takes a stone and ties it up in her lapa. This act prevents the woman being able to give birth. Therefore many women would not share the onset of labour with others until the labour was well established. This also meant that they did not want to highlight their condition by attending the hospital. The bad intentions from another person, predominantly a woman, could be due to previous arguments, or because of jealousy. Jealousy was usually spoken about with regards to polygamous households between the different wives. A female participant elaborated on this phenomenon during her interview:

“The first wife, just because she hasn’t given birth with that husband yet, she will try by all possible means to kill the second wife or the baby, in the country-way. Like fighting, to go to the sorcerer. Because she doesn’t have a child.” (IDI 30)

This participant was describing how jealousy between two wives might result in one wife killing the other or her child through witchcraft. Jealousy usually centred on the husband paying one wife more attention than the other, or if one wife had already conceived with the husband, but the other wife had not. Killing in the country way referred to witchcraft or sorcery. The health workers did not believe that witchcraft caused maternal or child deaths, but one of the CHOs acknowledged that they do not know everything, and that perhaps witchcraft should not be underestimated as there is ‘power in evil things’.

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17 Lapa is the name given to the cloth women wear as a skirt.
18 Power in evil things referred to powers of the devil or supernatural powers.
3.5.2 Interpretations of women’s actions during pregnancy

‘Lay’ participants in the two rural villages, often perceived causes of illness or problems during pregnancy, childbirth or with the newborn child, as being related to the woman’s behaviour or actions. Most participants explained that wearing a lapa or scarf around your neck would result in the cord being wrapped around the neck of the baby. Another action relating to clothing was that a woman wearing her husband’s clothes could result in her transferring her ‘pregnancy tiredness’ to her husband. This then had consequences related to him not being able to work, which in turn meant that he would be unable to bring in money for the household.

Another obvious risk was related to how physical trauma to the mother during the pregnancy could affect the baby, as described by one young mother during her interview:

“During the time when I gave birth with the first baby, she had a problem with her skull (...) During the time of pregnancy, we were fighting with my companions, they took a big stone and threw it on my head. That was the time when the baby had that problem (with her skull).” (IDI 24)

This mother saw the stone thrown at her own head as the direct cause for the problem with her child’s head, which was identified when the child was born and was described as a hole in the skull.

Many participants spoke about the risk associated with bathing in the river at night without covering up the pregnancy bump. It was believed that a demon would enter into the mother and cause the child to become a demon, which was a term typically used to describe a child with a disability. A demon could also cause the mother to have fits or convulsions during childbirth; this type of demon entered the mother when she ate the wrong bush meat. However, not all women in the villages accepted that demons were the cause for convulsions during childbirth. One woman during the female FGD in Makamba explained that she had also experienced convulsions. She did not believe that it was due to
demons consumed through bush meat, but through not attending the hospital during her pregnancy and taking all the treatment that she was meant to receive.

The health workers did not perceive these types of actions as the cause of problems during pregnancy or childbirth, but were aware that many people in the villages held these beliefs.

3.5.3 The link between immoral behaviour and complications

Behaviour perceived as immoral was often linked with social problems, which in turn could cause problems during pregnancy or labour. Many participants in the villages spoke about infidelity as a potential cause for a delayed or obstructed birth. The woman in labour needed to ‘speak out’ or confess to the adultery in order for the birth to proceed. The midwives also discussed how this pressure to confess could delay communities in bringing a woman to the hospital, as one midwife explained:

“Yes, if the labour is long and she is delayed, they will say ‘she has something to say. She has been cheating on the husband’ (…). They will keep the woman and say ‘unless she says something, nobody talk to her or touch her’.” (IDI 50)

The midwife proceeded to explain how the community will go to a traditional sorcerer who, according to the midwife, will tell lies and say that the woman needs to say something in order for the birth to proceed. If the woman does confess an action like infidelity, her husband will often leave her. If she does not confess and the baby dies, her husband may still leave her, as he will believe that she is a wicked person who would rather kill the baby than speak out.

In the final FGD the women discussed how they interpreted the difference between an obstructed birth due to infidelity rather than ‘other biomedical reasons’. It was often dependent upon the woman’s own conscience or the community’s perception of her potential wrongdoings. A bad conscience could also be due to stealing another’s property or quarrelling with her husband or
neighbours. Women described these situations being solved by the woman or her parents apologising to the ‘wronged party’ so that problems were prevented.

The health workers and some of the participants in the villages did not believe that infidelity caused prolonged or obstructed births. As explained by one of the participants in the older women FGD:

“During our colonial days\textsuperscript{19}, our old people they had that system, where somebody had a prolonged labour (...) because you have a boyfriend or demons, you need to call, you need to say that. But as for us at this present time, we don’t have that system.” (FGD 19)

This participant defended her beliefs further by explaining that prostitutes in the big towns gave birth safely without having any problems. Therefore having many lovers or committing adultery was no longer considered the cause for obstructed births.

Sex during early pregnancy causing problems to the baby's skull was, according to some participants, another out-dated belief. A number of participants referred to this as a risk they no longer considered a threat. In contrast, one participant spoke about the risk of the husband not having sex with his wife during early pregnancy. She believed that this could cause an obstructed birth:

“If the pregnancy is young and the husband start to treat you badly, without sleeping with you, at the time of giving birth, you will see the road blocked like this (referring to the vagina being tight and not expanding), because the husband don’t have contact (sex) with his wife”. (IDI 51)

Another participant had also heard about this risk, but did not believe it, and argued:

\textsuperscript{19} Participants used the term colonial times when referring to something in the past, not necessarily a time during the colonial history of Sierra Leone.
“Eh! As for me, that one has never happened to me (...) during the time when I became pregnant with this last baby, my husband left me for 6 months. When he came now, he saw me with a baby. So I don’t have any problems to give birth.”

(IDI 8)

Her husband had left their village to find work elsewhere. Through her own experience of her husband physically not being near her during the pregnancy, and therefore, unable to have sex with her, she did not believe this risk spoken about by others.

3.6 The role of God

Many participants referred to the role of God as a way to explain problems during pregnancy or childbirth. During one of the older women’s FGDs some of the women debated the cause of problems during delivery, and agreed that they did not understand what caused these potential problems, only God understood. An old woman in that group argued that women would not die during pregnancy unless god decided it:

“When somebody is pregnant it is not easy for her to die (...) unless God has marked that this person needs to die during the pregnancy or childbirth.” (FGD 47)

This view of being marked by God was also shared by some of the women in individual interviews, with one woman stating that it does not matter how you try to prevent it, if God has marked you to die, you will:

“If God has marked you to die during that pregnancy, whatever situation you are in, or whatever you choose to do, if God has marked you to die there you don’t have any other way”. (IDI 1)

In contrast, during the final FGD with recently pregnant women, one of the participants argued that women relied too much on God and that they needed to
ensure that they got the best help available. This involved proactively attending the hospital during pregnancy:

“The reason why those problems occur to the pregnant woman, some of them since when they became pregnant, they never went to the hospital, neither to take tabs or to take native herbs, they will just relax, without going to the clinic (…). They will say my hope is with God.” (FGD 60)

God was also used as a justification for women delivering in certain locations as described by one of the men in a focus group:

“We prefer our wives to give birth in the hospital, but if God marks them to give birth safely here (in the village), they will.” (FGD 12)

‘God marking you’ to deliver in a specific location was not described as a specific process, but linked with circumstances or the situation a woman may find herself in. For example, women in one of the FGDs explained how feeling the labour pains, but still having work on your farm to complete, would mean that you may still go to the farm, and then god will help you to deliver there safely. Many participants also used God as the justification for an action or decision taken which might have contradicted the husband’s decision or the official advice given by the Government to give birth in the hospital.

3.7 Fluctuating rights and responsibilities of men
Most participants agreed that husband’s have the right to tell their wives what to do, as they had married her and were now responsible for her. This right often translated to ‘permission’ needing to be sought from the husband before a decision could be made to go to the hospital. The health workers also discussed having to acquire the husband’s consent before commencing treatment. One CHO described a recent situation at the hospital where a woman required a caesarean section, but the staff were reluctant to operate before they had the husband’s permission:
“They were very, very reluctant, because the husband was saying that ‘if somebody does a C-section on my wife without my permission I will take that person to court’.” (CHO 53)

Waiting to get the husband’s permission, especially if he was not in the vicinity of the hospital could be another delay that prevented the pregnant woman receiving the appropriate and timely care that she needed. The midwives, however, emphasised that if it were an emergency, staff in the hospital would not wait for permission if they had to act immediately to save the woman’s life.

A number of men in the group discussions spoke about their responsibilities as the husband to a pregnant woman. These responsibilities included ensuring adequate food, providing money and securing transport, and providing advice, such as attending the hospital for antenatal appointments. This advice originally came from the TBAs or via the radio. The women in the focus groups predominantly spoke about men being responsible for providing money for transport and buying food at the hospital. One mother described a situation when her husband had not provided her with money to attend the antenatal clinic. She then earned the money herself, and went to the clinic, illustrating that increased financial independence allowed some women more autonomy in the decision-making process.

In contrast, the older women expressed opinions that it was not the responsibility of men to know about childbirth during their group discussions. The secrecy around childbirth thus meant that men, in fact, had little knowledge to base their decisions on. A husband would often wait outside the home where his wife was delivering and rely on female family members to share information about the progress of the birth. One man explained that men usually prefer their wives to give birth in the hospital, but they do not know why they end up giving birth in the village:
“As for us who marry the wives. We really want them to go to the hospital to give birth. But some will not. We don’t know the reason why they decide to give birth here.” (IDI 13)

Although men are ‘decision-makers’ in the community, they do not have deep insight into why or how decisions are really made with regards to childbirth. Some men went away to other provinces or areas regularly to find work, usually mining, so being absent during the time of delivery was not uncommon in the villages. In these situations the responsibility to assist the pregnant woman fell to family members, usually the mother-in-law. Some women stated that they had actively decided to go and stay with their own mother’s because they had experience in delivering, and assisting with the baby after the birth. This was particularly the case if the woman moved with her husband to a new area and did not have a familiar social network there.

A number of women argued that the husband had the right to decide, but if there were a change in condition e.g. an increase in the pain intensity, then the woman would decide for herself. This suggests that a birthing plan is likely to alter and be flexible dependent upon the situation. In complete contrast, some women in both the FGDs and interviews stated very strongly that their husbands did not choose for them, they decided what they should do because they felt the pain. A women states this point during one interview:

“It depends the way you feel the pain. The husband does not have the right to tell me what I am doing, because I am the one who feels the pain. If the pain causes me to give birth here, then I give birth here, but if it causes me to go to the hospital, I will go there and give birth. ” (IDI 21)

This woman, the first wife in a polygamous relationship, had given birth to five children, one in the hospital and the other four in the village. She strongly felt that she decided, rather than her husband, where she should give birth.
3.8 The role of the traditional birth attendant

The TBAs explained how the community chose them to be the village TBA as they had experience in helping women give birth. They appeared to be chosen due to their role and position in the community rather than formal competence. A few of the TBAs spoke about how they had received training at the hospital some years ago, but one reported that she had not had any formal training. One of the midwives spoke about how the TBA is usually a figurehead in the community, particularly within the traditional societies, and that often she is the only person who women in very remote villages can turn to for assistance. One of the TBAs described how she was friendly with staff at Masanga Hospital, but none were officially integrated into the hospital services.

The TBAs gave advice to the pregnant women, for example not bathing in the river with an exposed stomach. If a problem subsequently arose and the women had ignored the advice given by the TBAs, then the TBAs would not always be able or willing to help. The TBAs themselves also spoke about their “rights” to tell the pregnant women what to do during delivery, as explained in one interview:

“If I can’t help the woman to deliver (...) I have the right to tell the pregnant woman to go with me to the hospital because, if any problems occur with that pregnant woman, the government will handle me” (IDI 14)

‘Handle me’ implies the TBA being taken to the police station or being told off for not referring the pregnant woman to the hospital. However, none of the TBAs spoke about this situation of ‘being handled’ actually occurring to them. At what point, or with what specific complications, the TBAs would take the pregnant woman to the hospital often remained vague in the discussions, despite much probing and clarifying questions. The health workers did not share the TBAs’ strong convictions that they would take a woman, who was unable to deliver or had complications, to the hospital in a timely manner. They described experiences of TBAs not recognizing problems or keeping the pregnant woman too long in the village. As explained by one of the midwives:
“The TBAs keep the women there for 2 days, 3 days, without communicating to the people that there is a problem, assuming that the women would be able to deliver. (...) Most of the pregnant women who come into hospital (...) will tell you, ‘Nurse it’s not me, they kept me there for 5 days, they said I will be able to deliver and nothing happens, only when they see that I am about to die they decided to come with me’.” (IDI 49)

The midwife continued to explain that often the family are reliant on the advice from the TBA. They do not always know that a problem has occurred until it is too late.

Women explained that they would tell another female in the village that they were in labour, but it was not always the TBA. Often they told their mother, a neighbour or the second wife, if in a polygamous relationship.Regardless of who they first spoke to, it was rare for a woman to make the decision to go to the hospital or not alone. This decision was usually made in collaboration with those around her.

3.9 Financial factors
In spite of the free health care initiative (FHCI) for pregnant women, economic factors, specifically having ‘money at hand’, still played a large role in the decision-making processes during birth. This was discussed among the female participants in the final FGD:

“And the old people who have experience of delivering, they will come and advise you (...) they will say ‘you need to take this woman to the hospital’. Maybe the husband will think (...) if you take that pregnant woman to the hospital, the nurse will take money from you. So the husband also will worry not to take the wife to the hospital. Or the wife will say ‘I will bear the pain because my husband doesn’t have the money’.” (FGD 62)
This quote illustrates how the worry about money affects both the pregnant woman and her husband in their decision-making process.

### 3.9.1 Direct Costs

Despite the FHCI, direct costs relating to treatment at the hospital were perceived as huge barriers to accessing treatment at the hospital. In particular, paying for transport, medication, and “good treatment” from the staff were all highlighted. As illustrated in this discussion from the male FGD at Makamba:

(34) *The other people who have money gave a lot of money to the nurses. You will see they give a lot of treatment to that wife…*
(35 interrupting) *… a lot of medicines.
(34) *… while you who does not have money, they will only give you paracetamol. For the other people, if you take your wife to the hospital, without giving extra money, they won't take care of your wife.*

(31) *The nurse told us ‘this is our area where we can eat, so you need to give us something’.*
(32) *We here in Africa (…) everything is very costly if you don’t have money."

(FGD 31, 32, 34, 35)

The men in this FGD spoke about the need to pay the hospital staff to ensure good treatment for their wives or daughters during childbirth. This concern over money needed for treatment was re-iterated by many participants. Sometimes participants who had not actually experienced this problem themselves still spoke about it. For example, one woman in Makamba Village who had given birth to all of her children in the village said:

“If you take your baby to Masanga Hospital, unless you give money like bribing, they won’t treat your baby well.” (IDI 51)

Even though this woman had never given birth in the hospital, there was still a strong perception that you would have to pay to ensure *good* treatment for
yourself or your baby. In contrast, some participants saw this ‘additional money’ not as a bribe but as a sign of appreciation, as explained by one woman:

“It doesn’t mean that when I give birth in the hospital the nurses took money from me. But when somebody helps you to give birth safely, you need to do good things to her.” (IDI 8)

This woman had given birth to most of her children in the hospital and did not view this “gift” of money to the staff as a problem or a reason not to attend the hospital. Furthermore, one of the CHOs also spoke about giving money as a sign of appreciation:

“In life different people take things differently. And some will say I am doing this for you, it’s free, you are not paying anything, although I am being paid, but at least a sign of appreciation, you need to appreciate.” (CHO 54)

He went on to explain that the ‘sign of appreciation’ could sometimes demonstrate a good relationship between the health worker and the patient. The patient in turn may believe that this good relationship will ensure that they are seen quickly, and treated well.

This need to show your appreciation was also acknowledged when receiving care by the TBAs or the older women, but the payment could be in the form of services such as washing clothes or fetching firewood rather than hard cash. As explained by one of the women during her interview:

“For us here, if the elder people help you to deliver, the little thing which you have you can do good for them. Like cooking rice, soup or fetching water for them”

(IDI 40)

This woman had delivered in the village with assistance from her family and the TBA. Payment for services within the village could be in the form of work, as illustrated above, or could be negotiated or credited, and thus paid back at a later
stage. This was the situation described by one of the women in the village who delivered at home in the village with assistance from a local trader:

“For us here, the man who gave me the injection we only credit to him to inject me (...). The man was charging me 20,000Le\textsuperscript{20}, we talked a price, and later he told me to give him 15,000Le. He gave me 3 injections together with the medication tablets. That was the time I gave birth.” (IDI 24)

This woman shared her experience of receiving biomedical medicine in the form of tablets and injections from a trader in the village. These tablets and injections were thought to speed up labour and reduce pain. Obtaining biomedical medicine this way was deemed easier as the trader with the medication would come to the labouring woman, rather than the woman having to travel to the hospital. Two participants from Makamba village discussed this situation of a male trader providing advice on the progress of labour and administering biomedical medicine. He was described as an “old granddad with experience in childbirth” that lived in a village nearby Makamba. How he acquired his knowledge and experience in childbirth, which is typically viewed as “women’s business”, was unclear.

Obtaining food was also considered easier in the village than in the hospital. In the village family or friends could give you food, but in the hospital it would need to be paid for with cash. Previously, food was supplied by Masanga Hospital, but over the last year, due to financial constraints, food had not been provided for patients. It should be noted, that at the end of my fieldwork, Masanga Hospital had started to provide inpatients with food again.

3.9.2 Indirect Costs

In addition to the direct costs of delivering at the hospital, indirect costs were another factor that could influence where women gave birth. Some participants spoke about a perceived social expectation of buying items for their newborn,

\textsuperscript{20} Le refers to Sierra Leone leones (currency). 20,000 Le is roughly $5
such as a cloth to wrap the baby in. If they were unable to afford these items then people might laugh at them, or they would feel ashamed, therefore they would not attend the hospital to deliver.

Women who were expected to stay as ‘waiting mothers’ often bore the brunt of indirect costs. Staying in the hospital meant that they were no longer earning money through business, mining or farming. In addition, for every woman admitted, a carer had to be with her, to wash her, or cook for her. This carer was also not able to carry out her own usual tasks and responsibilities. Husbands or other family members were then expected to care for children at home, again limiting their ability to work or do their farming. One woman described how she refused to be admitted as a waiting mother at the hospital:

“(…) the nurse told me I needed to be admitted but I refused, just because there is nobody taking care of my children at home.” (IDI 1)

She did not want to stay as a waiting mother because this would involve her abandoning her responsibilities at home, as well as the burden of finding food whilst staying in the hospital.

3.9.2.1 The burden of distance and transport

The distance to the hospital, as well as the poor condition of the roads, especially in the rainy season, were strong motivators not to attempt to go to the hospital to deliver. Many women were reluctant to walk so far; did not want to walk alone; and were fearful of giving birth along the bush road, a situation that many had already experienced. One woman shared her experience of trying to get to the hospital along the bush road:

21 Maternity waiting homes are residential facilities where women who live remotely can wait before giving birth at a hospital or health centre. Within Masanga Hospital women who were deemed of being at risk of a complicated birth were admitted to the maternity ward where they waited until they gave birth.
(http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/MSM_96_21/en/)
“(…) as soon as I felt the labour pain I decided to go to the hospital to deliver there. But since I started to give birth, I have never been to the hospital yet, although I have (had) the plan to go there. I have given birth to 3 children along the bush road when I was going to Masanga Hospital.”  (IDI 22)

This woman had tried on many occasions to get to the hospital, but had either had to turn back or had delivered along the bush road. Women, who did attempt to walk along the bush road from Mabereh Gbonkoh to Masanga Hospital, were accompanied by a number of female relatives or neighbours. Occasionally women would be carried by the village men in a hammock, but this mode was reliant on enough men being willing and able to carry her. The difficulties with distance and lack of transport were also highlighted by one of the CHOs describing a recent case at the hospital:

“They brought the woman in a hammock. The woman was in labour (…) there is no access for a vehicle to go to that village, and she had to be carried in the hammock. Strong men had to carry her, and they rushed with her here. By the time they arrived it was too late (…) it was too late for the baby to survive”. (CHO 53 )

The CHOs and midwives described many situations where women experiencing difficulties during labour or delivery were delayed in deciding to come to the hospital. Due to lack of transport and long distance, this delay became fatal. Another problem was crossing the many rivers, especially in the rainy season, as pointed to by one of the community health officers:

“There is a river in this place (…) people don’t have access to cross this river. Suppose you are a pregnant woman, how can this woman cross this water here?”  

(CHO 54)

The CHO was referring specifically to the rainy season when many of the rivers are impassable, or require women to wade up to their necks to get across. Even if the rivers do have a bridge, many of them are temporary and dangerous to cross, especially if you are reliant on a motorbike, as many of the women in the villages
Further away are. Obvious discomfort of being on a motorbike whilst in labour, as well as danger of the narrow and slippery roads, were both factors many participants spoke about when deciding to travel by motorbike or not. Payment for the motorbike could not be credited, and would usually be paid for up front. In addition to the cost of carrying the mother, they would also have to pay for the carer and often the TBA to accompany her. Since it was deemed the responsibility of the husband to provide money and find transport, unwed or single women were reliant on their family to help them instead.

If the family could afford the motorbike and additional passengers, the situation would have to be deemed enough of an emergency to outweigh the negative aspects of discomfort and risk of the road. Furthermore, availability of a motorbike was not always guaranteed, especially at night. Availability of a willing driver was also not certain, as discussed in the female FGD in Makamba:

“Some of the motoboys\textsuperscript{22} will be afraid, they say that they won’t go with the pregnant woman to the hospital when they are in labour. They think that the pregnant woman will give birth along the way (...) They don’t want to see where a woman gives birth (...) he is afraid to take me along, so I can’t force him”. (FGD 26)

All motorbike drivers in this area are male, and since men are not permitted to view a woman give birth, neither the pregnant woman, nor her motorbike driver want to be in the situation where he may witness her give birth on route to the hospital. The motorbike drivers themselves also spoke about the difficulties in taking a pregnant woman as a passenger:

“If a pregnant woman told me to go with her, I was afraid of the pregnant woman (...) to carry her. If I carry a pregnant woman on my motorbike, I am afraid to take speed. I need to take my time because she is in pain. That is why I find it so difficult to carry the pregnant woman on my motorbike.” (FGD 56)

\textsuperscript{22} Motoboys is the locally used name for motorbike drivers
The motorbike drivers also linked this need to drive extra carefully with the fact that they felt responsible for two lives when carrying a pregnant woman. The motorbike drivers also risked losing money when taking a pregnant woman unexpectedly during an emergency. They spoke of leaving their current (paying) passengers, in order to carry the woman in labour, but not feeling it appropriate to discuss cost of the fare in an emergency situation. This was at odds with the perceived view of many of the women, who believed that motorbike journeys always had to be paid for up front.

3.10 Perceived accessibility

Another potential barrier to attending the hospital during childbirth was the perceived potential behaviour or reception by the staff. A few of the participants spoke about the lack of respect they expected to receive at the hospital. A number of participants also spoke about ‘advice’ that had been given by the nurses at the ANC, as explained by one woman during a focus group:

“The nurse told me to go to the hospital to give birth there. (She said) if you force yourself to give birth in the village and unfortunately a problem occurs (...) don’t then come here (to the hospital)” (FGD 24)

This related to the fact that many women believed that if they tried to deliver at home, but then a problem arose, the nurses may not treat them, or would treat them badly because they delayed attending in the first place. Another woman, who had delivered at the hospital, shared her experience of being alone because her mother had not being allowed to be in the delivery room with her. She emphasised the importance of having her family there, to give support and hope.

There was also a perception that multigravid women would be treated with less patience than primigravid women, a notion explained by one man:
“The nurses will say ‘Oh don’t come and cause noise for us. We thought this was the first born, you have given birth for four children, now you want to cause noise for us, don’t shout here’... that is why people are afraid to go to the hospital”. (IDI 13)

He was describing that many feel that if you have delivered before, you are expected to give birth easily and quietly with your subsequent deliveries. In the hospital, this expectation is perceived to result in impatience or lack of care from the staff. Other participants, again many who had in fact never attended the hospital to deliver, shared this concern about women not being treated as well.

3.10.1 Impact of Free Health Care Initiative (FHCI)

Nearly all participants were aware of the FHCI at the hospital, but predominantly in relation to free health care for children under 5 years of age. One female participant from a FGD told that they had not experienced any child deaths in their village since the FHCI had started. However, there were a number of participants who were not aware of the FHCI for pregnant or lactating women. Some women, particularly those who had only delivered within the village, were unaware if treatment in the hospital during delivery was free or not.

One woman had given birth to all four of her children in the village and had been to the hospital prior to delivery and also afterwards for vaccinations for her child. She had heard about the FHCI on the radio but did not know if treatment provided during delivery at the hospital was actually free or not. Other women also spoke about this uncertainty about whether the treatment would actually be free:

“The nurse who has been working in Masanga has gone, this one is a new nurse, we don’t know about her. The first nurse who stayed with the people at Masanga never took money from us. We don’t know for this present nurse.” (IDI 22)

This woman, who had given birth in both the hospital and the village, articulated that she could not guarantee that treatment at the hospital would be free now
that the staff had changed. One participant who had recently given birth in the hospital felt that because the care was free, women ought to deliver there:

"Whether you have a problem or not, as long as the government have given free health care you have to give birth at the hospital". (FGD 7)

This participant had given birth at the hospital to her last 4 children, and was very clear in her opinions that the treatment was free, and therefore, women should attend the hospital to deliver. Many men in the FGDs had heard about the FHCI, often stating that they should take their children and pregnant wives to the hospital, since everything is free for them. However, many of these participant’s wives had given birth predominantly in the village.

The TBAs and the CHO’s discussed the issue of unreliable supply of medication since FHCI had come into place. Recent discussions on the radio had also centred on drug distribution problems, limited supply of equipment and lack of adequate hospital buildings to cope with the increase in patient numbers. The midwives discussed the difficulties associated with ensuring trained midwives were accessible throughout the country, specifically in the rural areas.

3.10.2 Awareness of Bylaws

The use of bylaws has been spoken about in previous research in Sierra Leone as a way of encouraging women to attend the hospital to deliver. Introducing bylaws implied that those who did not deliver at the hospital would be fined.

In Mabereh Gbonkoh none of the participants were aware of the bylaws and they were not implemented in the village. In Makamba some participants were aware of the bylaws, but there were differing opinions about who would be fined and whose responsibility it was to fine someone. Most participants agreed that you would only be fined if a problem occurred, therefore, a normal ‘safe’ delivery in the village without any complications would not result in a fine. If a woman did develop complications, this fear over a potential fine could in fact lead her to
further delay the decision to attend the hospital. As explained by one woman during her interview:

“If you give birth in your home and later a problem occurs with you (...) they will fine you. You will be thinking that ‘oh right now I have a problem (...) But if I go to the hospital, maybe they will fine me’…” (IDI 51)

This participant had never been to the hospital to deliver and had never been fined herself. She had this information from her sister who had experienced a stillbirth in another village and had subsequently been fined at the hospital. In addition, the men described how you could avoid being fined if you ‘explained your problem correctly’. For example, explaining that you were unable to find transport, or that the labour progressed quickly. None of the participants had been fined themselves, or had actually fined anyone. Over all the ‘bylaws’ or ‘threat of the bylaws’ did not seem to influence the decision-making processes during childbirth in this particular area of rural Sierra Leone.

3.11 Flexibility in care seeking approaches

When discussing types of treatment for problems during pregnancy, many women interchanged fairly easily between the traditional native herbs provided in the village, and the ‘oporto’ 23 medicine typically provided in the hospital. Often equal value was placed on both types of treatment and the decision regarding which treatment to use depended on accessibility to that treatment. As one woman in one of the focus groups explained that she sought help in the hospital because the person who usually provided the native herbs was not at that moment in the village:

“I went to the hospital because the one who knows the native herbs to stop that bleeding while I was pregnant, she was not around, and that is why I went to the hospital.” (62 FGD)

23 Oporto refers to any foreigner, typically a white western person.
In some instances oporto medicine could be obtained in the villages from tradesmen or peddlers. Two women shared their experiences of having an old man assess them during labour, offer advice, and provide them with tablets or injections. One of the benefits of obtaining treatment from these tradesmen is that they can come to the woman in labour, rather than her having to get on a motorbike and travel elsewhere for care. Also the cost of the treatment could be negotiated or credited.

Some participants described situations where they would try one form of treatment in the village initially, and if it did not help they would then access the hospital. As explained by one participant during an interview:

“As for us we don't have oporto treatment (in the village) (...) we give the native herbs to the pregnant woman for her to give birth safely, and if that pregnant woman does not give birth, we take her to the hospital.” (IDI 13).

Many women explained that if they had used the native herbs initially, they would not usually tell the staff at the hospital that they had done so. This was because they had been told at the ANC appointments not to use the native herbs. Regardless of this advice, trust was still placed in the native herbs and used regularly in place of, or in conjunction with oporto medicine.

In general women’s health seeking behaviour was influenced by many of the interrelated and dynamic factors described above, such as previous experiences, perceived accessibility and direct and indirect costs. But in the end, the decisions made were often pragmatic and ad hoc, based on the fact that one or two factors had changed. For example, sudden lack of availability of one type of healthcare provider or a change in the woman’s condition.
4.0 DISCUSSION CHAPTER

The findings from this study show that the decision-making process during childbirth is complex, multi-faceted and constantly changing. Decisions are rarely made by one individual, but are rather an amalgamation of the many people involved in the pregnant woman’s life. The different opinions and experiences each of these individuals brings with them will also influence any decisions made. Furthermore, structural factors such as direct and indirect costs, as well as health care system factors, add an additional dimension to this intricate and dynamic process.

This discussion chapter shall bring together the array of findings using elements from different theoretical frameworks, and incorporating other relevant literature, in an effort to increase the understanding of the findings in this current study. I will start by exploring the concept of a normal delivery, then discuss the different actors involved in the decisions and how and why they think as they do; in other words illuminating their explanatory models. I will discuss the different perceptions of risk and how these affect peoples’ way of thinking, as well as the role and position of men and women in the communities and how different roles can impact upon their decision-making abilities. The next section of this chapter will explore the different structural factors that can facilitate or hinder certain decisions and accessibility of health services, as well as the flexible and adaptive approaches illuminated through people’s health seeking behaviour.

4.1 Home delivery as the norm

Kleinman, a psychiatrist trained in anthropology divides the health care system into three over-lapping sectors: the popular sector; the professional sector; and the folk sector (61). The popular sector consists of the individual, family and community beliefs and activities, and represents the sector where “ill-health” is first defined (61). Whether a community perceive childbirth to potentially represent a risk of ill health, and thus requiring some form of treatment from the different sectors, will strongly influence whether a woman actively seeks
assistance prior to and/or during childbirth. The professional sector is the organised and institutional part of health care, in the case of this project it is the Primary Health Unit (PHU) and Masanga Hospital, both located on the same site. The folk sector consists of sacred or secular types of folk medicine, and in this project this includes traditional healers, typically herbalists or sorcerers, but also travelling drug sellers, often called peddlers (60). I am also including and referring to the traditional birth attendants (TBAs) as belonging in the folk sector since they are not officially integrated into the professional health sector nor are they recognised by the Government as skilled attendants (46, 62, 63). TBAs in the rural Sierra Leone have either received some form of training in the past from the government or non-governmental organisations, or are untrained (46). Within this study the TBAs described either have no official training, or some training years ago at Masanga Hospital. All were chosen to be the village TBA due to their experience assisting women deliver and due to their respected positions within the communities.

This study has shown that within the rural Sierra Leonean context a normal and safe childbirth is seen as one that occurs at home, a phenomenon supported by several other studies in Africa (28, 31, 33, 40, 101). Preventative care seeking in the form of planning to go to the hospital with an uncomplicated birth is not the norm, and treatment within the professional sector is generally only sought if a problem or complication has already arisen. These findings are in line with several primary studies as well as a systematic review of drivers and deterrents of facility delivery in sub-Saharan Africa (29, 40, 102). In this current study the health workers promoted the benefits of attending the hospital for all deliveries, but were aware of the general populations' view of the hospital as a place to treat, rather than prevent, complications. The community norms about where to deliver and that a normal delivery occurs at home in the village seemed to have a strong impact upon individuals health-seeking behaviour. Health seeking behaviour can be described as a socially negotiated process that leads to actions being taken when an individual is perceived as ill, so that appropriate care is obtained (60). Findings supporting the strong influence of community beliefs and norms have also been reported by Stephenson et al. (103) who examined
community-level influences on the decision to deliver a child in a health facility across six African countries.

Elements of behavioural sociologist Becker’s work on theories around individual’s adherence to medical treatment can be helpful when discussing approaches to treatments chosen by participants in this study (78). According to Becker, pre-disposing factors can facilitate individuals in different directions when making choices about treatment. Pre-disposing factors can consist of health beliefs and attitudes towards a specific condition and its treatment, including perceived susceptibility and severity of that condition. They also include willingness to seek and accept specific types of medical assistance, as well as perceived availability of different health services (78). These pre-disposing factors, in isolation, are seldom responsible for the use of a specific health care service, but can motivate patients towards one type over another (78). The individual making the decision whether to seek healthcare or not, and if so from which health sector, will also be strongly influenced by those around them and their own pre-disposing factors.

4.1.1 Previous experience and knowledge of childbirth
Kleinman uses the concept “explanatory model” to express how individuals explain and understand illness and disease\(^2\), and justify the treatment that they seek (61). These models help to explain questions regarding aetiology, pathophysiology, course and consequences of illness, and appropriate treatment choices (61). Explanatory models are formed through experience and are strongly affected by personality and cultural factors (56, 61). They can also be open to change depending on circumstances and can be influenced by social norms and expectations (56, 61). How an individual perceives the origin and severity of a condition will play a major role in finding acceptable solutions and appropriate care, which ultimately affects their health seeking behaviour. Previous experience and birth outcomes will help women to form their own explanatory models and may affect whether they choose to attend the hospital,

\(^2\) “Disease refers to a malfunctioning of biological and/or psychological processes. Illness refers to the psychosocial experience and meaning of perceived disease” (Kleinman A. Patients and Healers in the Context of Culture - an Exploration of the Borderland between Anthropology, Medicine, and Psychiatry. Berkeley: University of California Press, Ltd.; 1981. p72)
or plan to deliver at home. Previous contact with the different health sectors and the plethora of health providers will also assist individuals in forming their own explanatory models, again impacting upon which health sector to access and when.

A review article by Gabrysch and Campbell (20) suggested that previous use of a health facility to deliver meant that women were more likely to use the health facility with subsequent deliveries. Women in this study who had delivered at the health facility before and planned to deliver there again were predominantly those who had experienced a complicated delivery requiring ‘hospital treatment’ to deliver safely. These findings are similar to a study in Timor-Leste, which reported that women who planned to access a health facility prior to deliver were those who had experienced complications with a past pregnancy (104). In addition, in this current study, women who experienced symptoms that were new to them were more likely to be motivated to seek help from the hospital.

In contrast to the review by Gabrysch and Campbell (20) some women within this current study, who had attended the hospital with one delivery, did not necessarily attend the hospital with the subsequent ones, even if they had planned to. This varied approach to using the hospital with repeated pregnancies is in keeping with other studies such as one conducted in Ethiopia in 2011 (101). The author’s reported that women considered current pregnancies separately from previous pregnancies. Thereby if a woman delivered at the health facility once, she may not necessarily plan to deliver there again (101).

In this current study many women who had already delivered safely at home once, generally planned to deliver at home with subsequent pregnancies, and doubted any advice to the contrary. Other studies have also found that women who previously delivered safely at home will continue to do so (29, 40, 104). This could reflect the fact that previous experience of a safe, uncomplicated home delivery strengthens the individuals’ belief in the safety and norm of home deliveries. In addition, these positive experiences can lessen perceptions of
vulnerability to complications, as well as increase familiarity and confidence in utilising health providers in the popular and folk sector.

The multigravida women in this study appeared to have more autonomy and perceived control during their deliveries. This could possibly be due to having their own experiences and perhaps more “robust” explanatory models for understanding what was happening, and subsequently better ability to justify choices that they were making. In addition, a woman who has given birth before has already gone through the transitional period of being a young girl or woman to becoming a mother (105). Therefore, now with her subsequent pregnancies she is already viewed as an experienced woman in her own right, which provides her with more authority and respect within her community (73). The health workers did however acknowledge that multigravida women were often very late in attending the hospital if a problem had occurred. The findings suggest that this was due to the fact that many multigravida women kept the onset of their labour secret, occasionally up to two days, as reported by the TBAs, thereby delaying any decision to go to the hospital (57). These findings are similar to Herschderfer et al. (46) study from Sierra Leone in 2012.

In contrast to the multigravida women, the findings from this study suggest that most first-time mothers lack detailed knowledge of the childbirth process, which in turn affects their ability to make and justify choices during childbirth. A study by Bedford et al. (101) found a similar situation in rural Ethiopia where labour and childbirth were never discussed so as ‘not to frighten the expectant mother’. The explanatory models of the first-time mothers in this current study seemed to be based on hearsay or limited information from family members. The women were heavily reliant on the advice and support of their family, specifically their mothers or mother in laws, as well as the TBAs during the actual childbirth process. The health workers in this study suggested that these first-time mothers are more likely to attend the hospital to deliver – a phenomenon also found in other studies from sub-Saharan Africa and Timor-Leste (40, 104).

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25 Multigravida refers to women who is or has been pregnant for at least a second time (http://www.oxforddictionaries.com/definition/english/multigravida)
Most women in Sierra Leone belong to a secret society, where girls are initiated into womanhood making them eligible for marriage. They are also assisted by the society throughout their adult life (106). The word secret is taken literally as women are not meant to discuss what takes place during the initiations with those who have not undergone the initiation themselves (46). During this rite of passage from childhood to womanhood, women are circumcised and educated about pregnancy and childbirth (46, 59). How much is explained about the exact childbirth process remains unknown to outsiders. Therefore, gaining further insight into first-time mother's knowledge, and thus a deeper understanding of their explanatory models related to childbirth, has been impeded.

4.2 Decisions rarely made alone

Regardless of whether it was the first or ninth pregnancy, all the women in this study who had recently given birth initially disclosed their labour pains to an older female in the village. This could be their mother, an older woman living in the same household, or the village TBA. Previous studies in Malawi, Ethiopia and Sierra Leone have found that women often turn to the TBA as their first port of call for assistance (29, 33, 46). This varies slightly to the findings in this study where only the mother, for example, and not the TBA assisted some women.

Whether it is the TBAs or female family members who assist the woman in labour, these women and the social networks they are part of are key members of the decision-making process. The findings show that their beliefs about the cause of a problem and advice for managing the problem can be very influential. Supportive factors, including social pressure or social support as introduced by Becker (78), can be helpful when discussing some aspects of the critical role of social networks involved in decision-making. Social pressures can produce beliefs about a certain course of action, or motivate an individual to act in a particular way in order to conform to the wider social group (78). This means that the social context women are living in, along with the norms and beliefs of that community, can have strong effects on the women’s health seeking
behaviour. The TBAs and the female family members who are assisting the woman during childbirth will also carry their own flexible explanatory models (61). These models; with their inherent opinions and experiences, will subsequently strongly influence the woman in labour and act as barriers or facilitators to seeking certain forms of health care, as noted in other studies from sub-Saharan Africa and Asia (33, 40, 43). The TBAs can be particularly persuasive in the decision-making process since their experience and position in the community means that their opinions and advice are often well regarded and trusted (46, 59).

Furthermore, it is the role of the TBAs or female family members to inform the rest of the family about the progress of the labour, if any complications have occurred and if additional care is required. The male members are particularly reliant on this information since they are not allowed inside the birthing room. This has also been documented in previous research conducted in Sierra Leone by Herschderfer et al. (46). All of this highlights how influential the female family members and TBAs can be on the whole decision-making process during childbirth in rural Sierra Leone.

Previous studies in Sierra Leone and Malawi have found that women using the TBAs, and the TBAs themselves, acknowledge their limitations especially concerning management of complications during childbirth (27, 33). This was also the case in this study, but understanding at exactly what point and what signs and symptoms the TBAs would deem a complication beyond their capabilities remained unclear. Some of the TBAs shared their fear of getting into trouble if they did not take a woman to the hospital that was struggling to give birth. This fear of reprimand might act as an enabling factor in encouraging TBAs to accompany or refer women to the hospital during labour.

Other studies in Sierra Leone and Indonesia found that TBAs were deemed to be more experienced than the ‘young nurses’ in the hospital, however participants in this study did not mention this (10, 18). The health workers demonstrated scepticism as to whether the TBAs in this area of rural Sierra Leone had the
knowledge and necessary skills to ensure safe deliveries, or identify and handle complications in a timely manner. This scepticism seems to reflect a lack of trust, and potentially lack of respect, between health providers in the professional sector and those in the folk sector. The TBAs are often the only person pregnant women can turn to for assistance in remote settings, and can be incredibly influential in the decision-making processes. Therefore, any negative rapport between the TBAs and health workers may adversely affect women seeking help from the professional sector. This has been highlighted in a previous study in Sierra Leone by Jambai and MacCormack (59). The authors described the negative impact TBAs can have on the introduction of any professional health service, if a respectful working relationship is not first negotiated between the TBAs and professional sector health workers. For example, TBAs could influence the local village to socially ostracise a governmental health worker so that she would not be willing to stay working in that area (59).

4.3 Interpretation of risk

Risk has been described as a socially constructed interpretation and response to potential dangers (64). Therefore, the use and value of risks need to be viewed from the perspectives of the ‘actors’ within a certain sociocultural setting. How these actors perceive, place significance on, and understand risks will vary from setting to setting. With this in mind, it was deemed important to understand the risks that are considered, and how they as pre-disposing factors could potentially affect the decision-making processes during childbirth in rural Sierra Leone (78).

Although pregnancy is seen as a normal condition in this rural Sierra Leone setting, individuals and communities are aware of many different risks associated with both pregnancy and childbirth (59). Within the popular sector (61) the role of witchcraft seemed to play a large role in this current study. It was believed that witchcraft could occur at any point during a pregnancy, but the most feared time was when the woman went into labour. This was when she was most vulnerable, and witchcraft could stop the progression of the labour, kill the
baby or even the mother. These findings are in line with other studies from Sierra Leone and Malawi where women waited until labour was well established before attempting to access the hospital due to fear of witchcraft complicating the delivery (27, 33, 46).

The findings in this study show that people perceive the risk of being exposed to witchcraft particularly high if the pregnant woman had recently quarrelled with someone, or if other women were jealous of her. This illustrates how the conditions of the body during pregnancy and childbirth can be closely intertwined with social interaction within the community, a phenomenon also discussed in a study from Indonesia (104). Jealousy and witchcraft are often synonymous in Sierra Leone (59) and many participants spoke about jealousy occurring in polygamous relationships which are common in this context. In order to understand the causes or origin behind the phenomenon of jealousy resulting in witchcraft one has to look at the social organization of the society. One of women’s predominant roles in rural Sierra Leone society is to produce children. Children are often seen as an investment bringing wealth to the family in the future, or supporting the parents in their old age (107). Women who have raised many children are thought to gain more authority within their community (73), therefore the more children one has, the better. In addition, boys are particularly revered, so a woman giving birth to a boy is likely to be treated particularly well (107). If there are two or more wives in a relationship, there is the potential for them to compete for their husband’s affection and attention through pregnancy and the number of children they produce. Jambai and MacCormack (59) reported that who choses the second and subsequent wives, can influence how comfortable the wives are with each other. If the first wife has chosen the second wife, she may feel comfortable giving birth in the same village with support from the other wife. If however, the second wife was chosen by the husband alone, the feeling of mistrust between the two wives may cause the pregnant woman to want to return to her mother’s village, viewed as a place of safety (59). If a feeling of mistrust persists between the wives, the pregnant woman may not disclose the onset of labour until the last possible moment to reduce the risk of witchcraft caused by the jealousy between the wives.
In this study the fear of witchcraft during childbirth implied that many women did not immediately tell anyone about the initial onset of labour pains, in an effort to ensure a safe delivery. They would rather bear up with the pain so that less people would be aware that they were in this vulnerable position, and thus, the chance of someone conducting witchcraft on them would be lessened (46). This also meant that women would be less likely to travel to the hospital during the initial phase of labour, the time when they were most able to travel the long distance. It was perceived that abandoning their household chores and travelling to the hospital would instantly highlight that this women was in labour, and therefore vulnerable to any potential witchcraft. These findings illustrates how explanatory models involving witchcraft may prevent a woman from seeking assistance; facilitate her to access care from a traditional provider; or act as an obstacle to, or delay her in seeking alternative health services at the hospital (57). Within the professional sector the health workers did not attribute witchcraft to be the cause of prolonged labour, nor maternal or newborn death. However, the health workers were aware of this belief as part of many women’s explanatory models, and some of them also acknowledged the ‘power in evil things’ (56).

They did not know how these powers could negatively impact upon health, especially during pregnancy and childbirth, but stated that they should not be underestimated. This reflects that although they work and operate within the professional sector, many health workers’ explanatory models will have originally been formed in the popular sector. This can potentially imply that health workers might struggle to balance their professional knowledge with their own belief systems when advising and treating pregnant women in this rural setting.

Risks do not occur in isolation but are often considered and compared alongside other potential risks (64). Findings from this study illustrate how women’s choice to deliver in the village is not a result of passive inaction or lack of knowledge about the potential risks she may face, but rather an active choice to reduce risks that she perceives as being of more importance. For example,

26 Power in evil things referred to powers of the devil or supernatural powers
women may consider the risk of witchcraft causing their labour not to progress being greater than the risk of bleeding, therefore, they will keep the onset of labour secret to reduce this more significant risk. This often implied staying in their home to deliver. If however, the woman started to experience bleeding during the delivery, she may then decide to access care at the health facility, as this risk is now deemed as a greater threat to her health. This syncretic use of the different health systems and health providers depending upon the identification and interpretation of different risk, illustrates Kleinman’s perspectives related to the dynamic movement between the different sectors as triggered by perceived needs (61).

In the systematic review by Moyer et al. (40) it was found that many women did not want to access treatment at the hospital during childbirth due to a fear of having an episiotomy27. In this study, participants instead spoke about a fear of having an operation if they sought treatment at the hospital. Women viewed having an operation as a potentially large risk to their health, thereby choosing not to access the professional sector for treatment during labour. In contrast, one of the factors presented by participants as to why they would choose to access the hospital, was the fact that equipment was available in the hospital but not in the village. This equipment was used to scan and identify problems, and had the ability to ‘remove the baby safely’. This finding was also reported in the 2013 systematic review of drivers and deterrents of facility delivery in sub-Saharan Africa and in a study from Indonesia (40, 102).

Unreliable supplies of medication and equipment at the hospital were, however, another concern highlighted by participants in this current study, particularly since the introduction of the Free Health Care Initiative (FHCI). Inadequacy of hospitals and health clinics to cope with the increased number of women accessing them was also discussed on the local radio. These failings in the infrastructure of hospitals and health clinics reduce the health workers abilities to provide adequate care for women in need, and highlight the 3rd phase of

27 Episiotomy is a surgical cut made at the opening of the vagina during childbirth, to aid a difficult delivery and prevent rupture of tissues (http://apps.who.int/rhl/pregnancy_childbirth/childbirth/2nd_stage/jcom/en/)
Thaddeus and Maine’s 3-delay concept (57). A study conducted in Nigeria reported that when free health care was initiated there was an increase in the number of women accessing care. The health facilities and personnel were overstretched and unable to cope with the new demands (108). Ability of the staff to manage the caseloads in Masanga Hospital was not discussed by participants in this study, but the midwives themselves highlighted the unreliability of having trained midwives in rural locations such as Masanga. Many midwives are either from the capital Freetown or trained in Freetown. Therefore, they are often reluctant to move to the provinces where the infrastructure is much less developed. This is similar to a study conducted in Indonesia which reported that midwives often preferred to live in urban areas resulting in a shortage of health professionals in remote rural areas (102).

Before arriving in the field, two midwives seconded from Freetown to Masanga had recently left. They had stayed in their posts for less than a month, citing poor living conditions and missing family as reasons for leaving. Although the midwives present at Masanga Hospital during the time of this research stayed for their full six months as planned, it is likely that future midwives from Freetown may not be as willing to stay. Women will consider this unpredictability in trained midwives being present at the hospital, as well as the perceived unreliability of adequate supplies of medication as a risk to receiving proper treatment within the professional sector. In turn, they may perceive better and more reliable treatment to be obtained within the folk or popular sectors.

This study also found that there are a number of other reasons why women in rural Sierra Leone suppress their pain, particularly at the beginning of labour. One of these reasons was fear of shame if the woman misinterpreted the pain and was not yet in labour. A number of women also related being able to bear up with the pain as being a sign of a strong woman. Subsequently women would not risk losing their honour or position by exposing themselves as weak or unable to make good judgements about their condition. Previous studies in India and Sierra Leone also reported a perceived relation between ability to bear up with pain and being a strong woman, and subsequently an important part of what constitutes womanhood (4, 20). Expressing too much pain or drawing the wrong
conclusions as to how her labour was progressing was thought to be even more detrimental if the woman were to expose these failings in front of a crowd. Limiting or preventing a crowd forming represented another predominant reason for suppressing labour pain. In rural Sierra Leone it is the norm for several generations to live together within one home (107), therefore, securing privacy especially during childbirth can be difficult. Having a limited number of people assisting the woman ensured a certain level of confidentiality, a phenomena also highlighted as important in a study in Malawi (33). Being exposed to a crowd was seen as a particularly difficult situation since women would be vulnerable to gossip as well as many people’s interpretations and advices. This advice could potentially cause the woman to feel pressured to make choices she was not comfortable with (e.g. starting to push too early).

In her book “Purity and Danger”, Mary Douglas (65) discusses the ideas of “dirt and pollution” in relation to taboos, danger and risk. These ideas typically emerge from cultural concepts regarding boundaries and violation of values and expectations, thereby trying to discipline individuals into being ‘good citizens’ (65). The ideas of pollution that Douglas (65) discusses uses laws of nature to endorse moral codes within different societies, thus reinforcing social pressures and order. Misbehaviour or immoral behaviour are then linked with disease, for example, in some societies cultural taboos like incest or adultery are perceived to cause cultural-specific diseases or conditions (65). In this study ‘advice’ during a complicated or prolonged labour, as discussed above, could come in the form of people accusing the woman of having behaved immorally during her pregnancy. Within the rural Sierra Leone context this usually relates to infidelity during pregnancy, a concept discussed in a previous study conducted in Sierra Leone (46). If a woman committed adultery during pregnancy, it was thought that the other man’s sperm would become mixed or contaminated with her current pregnancy, and would ultimately cause an obstructed birth. This then firmly places the blame on the woman since her obstructed birth has been caused by her immoral behaviour during pregnancy (65).
The midwives in this study discussed how the family of the pregnant woman might choose to access the folk sector in the form of a traditional sorcerer if a labour appeared to be prolonged. The sorcerer would be able to identify if the obstructed labour was due to the woman’s need to ‘confess to the adultery’. If this is the case then there is no need to seek help from the professional sector, as the labour would not be able to progress until the pregnant woman had confessed her act of adultery. The findings indicate that such perceptions of risk surrounding the woman’s alleged adultery (rather than risk of an obstructed birth due to a small pelvis, for example), could greatly delay any decisions to seek help from the professional sector. The first phase of Thaddeus and Maine’s work on the 3-delay framework is useful to consider here (57). The first phase in their framework is the delay in deciding to seek care by the individual, family or both. It involves factors such as beliefs about causes of an illness or condition (57). In this situation, the belief that an obstructed birth is caused by infidelity means that treatment is in the form of the woman confessing her sins. The decision to seek additional help is therefore postponed, thus further delaying the access to potentially life-saving medical intervention (57). It should be noted at this point that the ‘easy solution’ of the woman confessing is actually not always that simple. Confessing to adultery during pregnancy risks the position that the woman holds in society, as she is deemed immoral. In addition, she risks her husband divorcing her. Since women are often heavily dependent upon their husbands this is not a situation women will risk entering into lightly.

4.3.1 Variable and dynamic perceptions of risk

The discourse and knowledge around risk, similar to Kleinman’s explanatory model, is apt to vary over time just as the sociocultural context changes. Perceptions of risk also differ between actors depending upon their experiences, knowledge and positions. It is therefore, important to consider the collective rather than just the individuals’ assessment of risk (64, 65). This is especially pertinent since family, friends and the community often have huge influence over individuals’ decisions. In this study there were often distinct differences in risk perception between health workers and lay people in the village. The lay
people referred to some of the biomedical signs and symptoms that are considered as risks during pregnancy and childbirth within the professional sector. These were primarily bleeding, pain, prolonged labour and breech position of the baby. Pain was interpreted as that which was too intense, long or so-called “slow” pain. Slow pain referred to pain that lasted for longer than expected, the exact ‘time’ was often vague and depended upon the experiences of the different people involved. Long and slow pain signified prolonged labour, which could be interpreted by the women as obstructed labour. Most lay participants did not fully comprehend the biomedical explanations for these conditions, as learned and understood by the health workers. This in turn meant that many participants considered that these risks could be treated and managed by health providers within both the folk sector and the professional sector.

The health workers in this study identified teenage and primigravid\textsuperscript{28} women as being at the greatest risk of complications during childbirth. This was because they were viewed as having married too young and become pregnant whilst their body was not yet fully developed. This could result in obstructed deliveries, in turn increasing the risk of complications such as obstetric fistulas\textsuperscript{29}. The health workers also believed that this group of pregnant women were more vulnerable to incorrect management by the TBAs. This typically involved encouraging the women to push too early, or the use of forceful manoeuvres, which increased the risk of serious complications such as a ruptured uterus. The women and men in the villages did not usually associate teenage mothers with increased risk of complications. This is perhaps reflecting the acceptance of girls marrying young and therefore becoming teenage mothers as the norm.

There was also flexibility in risk perceptions noted over time amongst the same group of participants. These were often dependent upon individuals’ own lived experiences or observations. For example some of the ‘lay’ participants in one village did not believe in the risk of adultery causing an obstructed birth. They

\textsuperscript{28} a woman pregnant for the first time (http://medicaldictionary.thefreedictionary.com/primigravida)
\textsuperscript{29} An obstetric fistula is a hole between the vagina and rectum or bladder that is caused by prolonged obstructed labor, leaving a woman incontinent of urine or feces or both.
stated that the beliefs were out-dated and belonged to colonial\textsuperscript{30} times. Some participants related this to the common knowledge that ‘prostitutes in larger towns’ are able to give birth safely, despite ‘committing adultery’ with many men during their pregnancy.

The different and dynamic interpretation of risks by different individuals also implied that different health care systems would be accessed for the same problem. For example, one woman experienced convulsions during her childbirth, which were perceived to be due to a demon entering into her when she ate the wrong bush meat during her pregnancy. A phenomena also discussed in other studies in Sierra Leone and Malawi (42, 46). A sorcerer from the folk sector was sought to rid her of the demon, thereby treating the convulsions. Another woman in the same village also experienced convulsions during delivery. She connected the convulsions with the risk related to her not attending all of her antenatal clinic (ANC) appointments during pregnancy, nor taking all the necessary treatment advised, such as tetanus toxoid\textsuperscript{31} injections and anti-malarial tablets (46). Her family, therefore, sought help from the professional sector: Masanga Hospital. Again, these varied types of knowledge and different interpretations of risk, contributed to the formation of diverse explanatory models. This in turn influenced which sector of the health system members of the community chose to access.

4.4 The Role of God

Findings from this study indicate that the role and importance of God was not static and would often change depending on the circumstances, the level of knowledge regarding risks, and the strength of the individuals belief system. A number of participants referred to God as an explanation for specific problems during childbirth, especially when a plausible reason for a problem or condition

\textsuperscript{30} Participants used the term colonial times when referring to something in the past, not necessarily a time during the colonial history of Sierra Leone.

\textsuperscript{31} Tetanus toxoid injections are given to women during pregnancy to protect infants from neonatal tetanus (Leone SS. Sierra Leone Demographic and Health Survey (Preliminary Report Without Results of HIV Prevalence). Freetown, Sierra Leone: ICF International, 2013.)
was unknown. For example, the older women seemed unable to explain some of the causes of complications such as bleeding during childbirth, stating that only God knows why it happens. This lack of knowledge, combined with a reliance on God as an elucidation, will strongly influence individuals’ explanatory models, justifying why particular actions are taken or treatment options chosen.

A number of other studies conducted in Sierra Leone reported God being referred to as the ultimate decision-maker with regards to location for childbirth (28, 46), as was also the case for many participants in this current study. Several participants expressed knowledge that the official advice from the Government was to deliver in the hospital. When the pregnant woman delivered in the village, the use of God as the ultimate decision-maker meant that the participants were not actively going against the official advice, but their actions were explained by the higher power of God.

God was also used to explain why some women die during childbirth. In this respect women were considered as ‘marked by God’ to die, thus their death could not be prevented, no matter what was done or where they were during childbirth. This fatalistic approach (64) to childbirth has also been documented in other studies in Ethiopia and Sierra Leone (28, 39). It reflects that many individuals in the rural villages view potential complications during childbirth as being unavoidable. Therefore, choosing to access one health sector over another may not be viewed as a critical decision, since God is present in all health sectors, and God ultimately decides the fate of the woman and her newborn child. In contrast, some participants argued that God should not be relied upon, and that people should take responsibility to help themselves by actively seeking healthcare.

4.5 The role of men and position of women

Aspects of feminist theory can be useful when discussing and understanding the effects of the role and position of men and women on the decision-making process during childbirth in rural Sierra Leone (66-68, 72). Sierra Leone is a
patriarchal system, whereby men are the head of the household and responsible for main decision-making (46, 73). Following radical feminist theory, the family is deemed to be a central part of society's power structure, and therefore, patriarchy within the family, which can be seen to oppress women in their own homes and lives, in turn transcends across to power on a political level (72).

Since men are dominant with regards to household matters in Sierra Leone, they also play central and controlling positions in the wider sphere of community and political discourses.

Within the context of Sierra Leone, a number of actions and policies have been implemented to improve gender equality in the country but large inequality still remains (69). In 2011 it was estimated that only 9.5% of females in Sierra Leone gained at least secondary school education, whereas 20.4% of males gained secondary education (70). Other estimates suggest that 85% of women remain uneducated (69). This lack of education, along with exclusion from public positions, may negatively impact upon women's abilities to negotiate and participate in household decisions, including decisions regarding healthcare.

Many men in this current study spoke about a sense of responsibility they have towards their wives, especially when she is pregnant. These findings are in line with a study conducted in Malawi, which reported that husbands felt responsible for seeking care in the case of obstetric complications because they had given their vows in marriage (42). With responsibility often comes a sense of rights and ownership men have over their wives. This means that women are required to gain permission from their husbands before seeking care at the hospital. A number of other studies in Sierra Leone, sub-Saharan Africa and Asia have also identified that women often require permission from their husbands to attend the hospital (3, 4, 17). It should be noted that within this current study the health workers usually emphasised this discourse of the husband's permission. The women in the villages rarely mentioned it, unless it related to the need of money to pay for or access care. Potentially this was because the women did not view requiring permission in itself as a problem, or accepted that this is the norm, and subsequently not worth discussing.
Some studies in sub-Saharan Africa reported that men were involved in planning where their wives delivered (42, 101). They were also aware of danger signs during childbirth and knew when their wives ought to go to the hospital. This knowledge enabled them to make decisions, along with relatives, during the time of delivery. These findings are in contrast to this current study where childbirth is seen as “women’s business” (46, 59) and men were not actively involved in the decision-making processes, nor were they aware of the danger signs during childbirth. Men’s main responsibilities were considered as providing money and acquiring transport if either were needed. These findings are similar to studies conducted in other parts of Sierra Leone and Ethiopia (39, 46).

At odds with the view that childbirth is “women’s business”, some participants spoke about a man being actively involved in the treatment of women in labour in one of the villages. The role that this man had was a bit unclear, but he was portrayed as an adviser and administrator of biomedical medicine in the form of tablets and injections to speed up contractions or provide pain relief. This ability to advise on the progress of the labour and administer biomedical medicines in certain situations provided an unusual role for this man, and a surprising degree of direct influence in the decision-making process during childbirth. How this man came to have knowledge and experience in treating complications or problems during childbirth remains unknown. Potential reasons could be that he had financial means to buy biomedical medicine in a larger town, or had contacts in the hospital through which to acquire the medicines. These situations have been described in another study conducted in Sierra Leone on the use of western pharmaceuticals by Bledsoe and Goubard (109). In addition, he may have worked previously as a health worker and therefore, had knowledge in how to use and administer injections. Purely the fact that he had access to the medicines and confidence to administer them could partly explain how he gained this role during childbirth in the village.

Predominantly though, men were not found to be actively involved in the decision-making process during childbirth in this study. However, their control
of assets and finances, as well as their position over women in society would often ensure some degree of power over the decisions made. Other studies have also documented this position of men being in control of resources and thereby asserting power over a large part of the decision-making process (43, 46). A systematic review in 2013 found that women who had access to their own money, and therefore were not solely reliant on their husband for financial assistance, demonstrated more empowerment and autonomy during the decision-making process during childbirth (40). Feminisation of poverty is another branch of feminist theory which can be used to shed light on these findings (77). The combination of gender biases in society and governmental positions, along with the predominant control of men over the household assets and finances leave women in Sierra Leone at a greater risk of poverty (72). This position of poverty in turn strengthens the dominance men hold over decision-making processes concerning health and the use of health care services.

The amalgamation of gender inequality, poverty and reduced autonomy in decision-making processes all mean that poorer women often experience reduced access to health care services, in turn putting them at increased risk of poor health (56). This vulnerability can be referred to as caused by “structural violence”, a concept introduced by Paul Farmer (110). Women’s social status, as dictated by their gender and level of poverty systematically denies them access to certain resources such as education and health services. This becomes a vicious circle as reduced access to health services increases their risk of ill health, further limiting employment opportunities and ability to earn money, thereby additionally reducing their autonomy in decision-making in the home.

Women within rural Sierra Leone who do have access to income-generating opportunities are unlikely to earn as much as men, and money earned from agriculture is likely to provide an unreliable source of income (59, 104). UNICEF’s 2007 report on the state of the world’s children, noted that women’s estimated earnings are substantially lower than men’s (75). It is expected that women in Sierra Leone, like many countries, will conduct the majority of the unpaid domestic chores, and when married, will undertake the majority of
childcare. Both of these roles can be seen as part of the female identity in Sierra Leone, an identity that can be viewed as an important part of womanhood within the community, or oppressive, depending on the stance held by the observer (59, 73, 107). Whichever viewpoint is taken regarding these roles, both can limit women’s opportunities and abilities to work outside of the home, as they take up much of the women’s time. This situation of reduced involvement in the paid work force can negatively influence the possibility of women gaining influential positions in their communities. In turn, further establishing their inferior position in society and reduced influence on decision-making processes.

These labour inequalities go beyond household and family duties, and extend to food-production activities, which are commonplace for women in rural Sierra Leone. According to the International Fund for Agricultural Development poorer women in rural West Africa not only work longer hours than men in similar circumstances, they usually work harder too (76). This is similar to findings in this current study where the health workers reported that pregnant women were not able to rest enough during pregnancy due to their high workload. Representatives from the local radio also attributed the higher percentage of male participation within their shows to the fact that women typically worked more than men. Both the health workers and radio representatives highlighted this discourse on the unequal division of labour amongst the men and women in rural Sierra Leone. All of these inequalities due to gender and women’s position in society in themselves become risk factors for ill health (110). Ill health in turn reduces the likelihood of pregnant women having a safe and successful birth.

A study conducted in Sierra Leone in 2012 discussed the disempowerment in the decision-making process during childbirth for teenage or unwed women in particular (28). For teenagers this could be due to the fact that despite the law prohibiting marriage before the age of 18 years, it is estimated that 62% of women are married by the age of 18. This means that many young girls drop out of education prematurely and become mothers early (69). This limitation in accessing education can result in a lack of voice and assertiveness in the decision-making process. In this current study participants did not often relate
to unwed women as all the women described themselves as married. When the situation for unwed women was discussed it was in relation to the woman not having a husband responsible to organise transport to the hospital should she require it. Male participants in the villages discussed the additional burden to parents, specifically financially, if their teenage daughter became pregnant before she was married and still at school. This was typically the case if the father of the unborn child did not take responsibility for the pregnancy.

In this current study, it was not only the unwed teenagers who relied on assistance from their family during childbirth. A number of couples had moved from their village to another province or area to find better income-generating opportunities, usually in the form of mining. Pregnant women were therefore in a particularly vulnerable situation as they would not be familiar with the local community or have a particularly strong social network. Some of these women had actively decided to move back to their parent’s village, thereby ensuring familiarity during the time of childbirth. This would then mean that her husband, the source of financial support, would not be present during the time of delivery and she would therefore be more heavily dependent upon her family. Husbands being absent during the time of childbirth appeared to be a fairly common occurrence. This pattern of male absence has also been noted in a study in Malawi where the author’s reported that this situation of men working far away is unlikely to change in the near future(42). This in turn places an important obstacle to male involvement during childbirth, especially if the man is required to give his permission for his wife to access the hospital during labour. Time spent trying to find or communicate with the husband who is away may delay any decisions to seek help at the hospital (57). Husband’s being absent may not be deemed as of particular significance if he is not usually involved in the childbirth process, but it increases the role and responsibilities of other family members and the influence that they can have on the decision-making process.

It should be noted that some women within this study held strong opinions and claimed that they themselves made the decisions during their childbirth. The majority who reported making the decisions by themselves stated that since they
felt the pain of the childbirth, they were in charge of deciding what they would do and where they would deliver. Some women reported leaving their husband's village and travelling back to where they grew up. This was specifically to be near their own mothers, as they felt confident relying on her experience and ability to assist them during childbirth. This example illustrates that a number of women felt independent and able to take autonomous decisions around where the give birth. As with all communities, there will be individual variances between people, such as stronger and weaker personalities, regardless of cultural and external influences (61). This also reflects that some of the feminist theories discussed are from a western perspective, and women in rural Sierra Leone may not in fact identify with all aspects of them (67, 74). For example, the patriarchal family is typically discussed from the viewpoint of a western, white middleclass family. Many women in the Sierra Leone context may take strength and pride in their position as care provider for their children and responsibilities they hold over domestic chores and farm tasks. The women in these rural villages may not view these gender-assigned tasks in the same light as the negative, victimising, western-viewpoint that radical feminism does (67, 72, 74). Actively seeking familiar surroundings for childbirth demonstrates that in some situations women in rural Sierra Leone can be dynamic, not passive, engagers in the decision-making process despite apparent gender and economic inequalities.

Other studies in Sierra Leone (28, 46) have also found that women hold a large degree of control regarding the decision-making process during childbirth, especially if a problem or complication occurred. This phenomenon of the onset of a complication increasing a woman’s perceived autonomy over decisions, illustrates how individuals rarely refer to one explanation for their health seeking behaviour. Instead they may utilise a number of different explanatory models and rationalise their behaviour according to different models, or parts of models, at different times, adjusting to expected and unexpected events. One example of this is the many women in this study describing situations where they obeyed their husband's decision to deliver in the village. This action was viewed as the norm since the husband has the right to decide where his wife delivers. However, if the circumstances changed, and the woman identified a risk
she perceived as a serious threat to her health, she could over-ride her husband’s decision, and decide to access care at the hospital. Again, the possibility of altering the husbands’ decision will of course also be related to factors characterising the individual woman and the inherent nature of the relationship between the woman and the man.

4.6 Structural factors

As argued by Becker, pre-disposing factors may motivate individuals towards certain health services, but there must be some factors which enable individuals to do so (78). Enabling factors are related to availability and accessibility of specific health services; use of time, the possibility to combine attendance with work, money needed to pay for transport and poor treatment by health workers (78). These enabling factors can also be considered in the form of social determinants of health, which are the circumstances, in which people are born, live and work (111). These circumstances or external factors can influence and limit the opportunities individuals and their communities have to make independent choices with regards to health. These circumstances are in turn influenced by wider factors which operate at local, national and global levels, such as distribution of money, power and resources (111). Again Paul Farmers concept of “structural violence” can be used to understand how some of these social determinants affect health seeking behaviour in this context of rural Sierra Leone (110).

4.6.1 Poverty

Prior to the introduction of the FHCI in Sierra Leone, many studies documented the prohibitive costs of services as the main factor in preventing people accessing care in the hospitals during childbirth (26-28, 46). Despite the FHCI, poverty remains significantly influential in the decision-making processes during childbirth for many people living in rural Sierra Leone. These findings are in keeping with a number of other studies in low resource settings (20, 29, 40, 42-44). In this study participants described the importance or enabling influence of money being readily available in order to access care at the hospital during delivery. Although several of the participants in this study were aware of the
FHCl for pregnant women, many did not trust that treatment would entirely be free at all times. Women spoke about previously receiving free treatment at the hospital, but this did not necessarily guarantee free treatment the next time they went, especially if there were new staff at the hospital or in the primary health unit.

Money was also needed to pay the staff at the hospital to ensure good treatment either for the woman herself, or her baby. A study conducted before the FHCl in Sierra Leone also reported a perceived need to pay staff in the health facilities, to ensure ‘good treatment’ (46). Some participants in the current study did not view this additional money as ‘payment’ but rather a sign of appreciation or a ‘gift’ to thank the staff for helping deliver the baby. The notion of seeing this payment as a “gift” is similar to a concept reported in a study in Tanzania (112) and can perhaps be related to the western concept of giving a “tip” for good service. This perspective of ‘showing your appreciation’ versus ‘paying’ was also discussed by the health workers in this study. The health workers emphasised that if someone did not have money available, then they were not expected to give money as a sign of appreciation. Despite this, most participants in the villages still perceived this as a direct cost, and would be reluctant to attend the hospital without money at hand.

The health workers ease at discussing this ‘sign of appreciation’ seems to illustrate how readily acceptable it is, at least in this area of Sierra Leone, to still expect money from women accessing health services when pregnant. There appears to be a cultural understanding of still paying for services, even though the government has declared that all medical services for pregnant women are free, as discussed in a report by Amnesty International (52). This demand of ‘under-the-table’ payments could be to supplement the health workers potentially low or unreliable state salary or could be a culturally acceptable form of corruption (113). It is beyond the scope of this thesis to fully discuss this potential cultural phenomenon of accepting bribes for good or swift treatment, and/or corruption within the health system. However, what is apparent is that the perceived fear of informal fees directly impacts upon decisions made,
especially for those living in extreme poverty (113). This barrier can be seen as representing yet another example of structural violence; limiting people’s abilities to access health care as required (110).

The need to show a ‘sign of appreciation’ for services was also apparent in the villages, especially since the FHCl does not extend to services provided by TBAs, who are therefore dependent on payments from the women they help (59). In contrast to the hospital where payment was in hard cash, one of the enabling factors (78) for delivering in the village was that payment could be ‘in kind’ e.g. collecting wood or cooking a meal. This meant that families would not necessarily have their financial status or level of poverty so evidently exposed when paying for services in the village. In addition, this act of gratitude could be conducted later, when the woman had recovered from the childbirth, unlike in the hospital where payment had to be issued at the point of seeking treatment. This also suggests that women could have more control over this form of payment despite limited access to the household finances, as they were able to pay for the TBAs services through their own work at a later stage. These findings are similar to a study from Indonesia where payment to the TBA could be paid in instalments (102). This was easier for many women who may not have the full amount of money easily accessible at the time of delivery, and thereby preferred to deliver with the TBA, rather than the midwife. In a study conducted in another part of Sierra Leone, the authors described additional types of direct costs in the shape of informal ‘bylaws’; where those who did not deliver in the health centre were fined (46). In contrast, in this current study the use of informal ‘bylaws’ or ‘threat of bylaws’ did not seem to influence the decision-making process during childbirth in this particular area of Sierra Leone.

Other costs were related to food; where both lay persons and health workers discussed the importance of nutritious food, both during pregnancy and after birth. The perception of good food as being crucial for health, as well as some foods having the ability to treat illnesses, has been discussed in other studies from Sierra Leone (60, 109). The difficulty in being able to access or buy nutritious food in the hospital was described by many women in this study,
findings which are similar to a study conducted in another part of Sierra Leone (28). Being prevented from accessing nutritious food was of particular concern for women who were ‘waiting mothers’ or those who lived further away, and could act as a prohibitive factor when deciding whether or not to give birth at the hospital.

Indirect costs that were highlighted in this study as factors influencing the decision-making process during childbirth could often be related to the woman’s position in society. Since women are expected to carry out the majority of domestic duties, tend to the farms and look after the children, they would need to ensure that someone could take over these responsibilities if they were to attend the hospital to deliver. This was again particularly pertinent for women who were expected to stay in the hospital as waiting mothers. In the study by Herschderfer et al. (46) in Sierra Leone, waiting homes for expectant mothers were positively spoken about as a strategy to reduce maternal mortality. Women who live remotely and/or are considered to be at risk of a complicated birth typically use maternity waiting homes. The participants who spoke about being waiting mothers in this current study were reluctant to be admitted due to worry about money for food, and concerns for who would look after their children and do their regular domestic chores. A number of participants spoke about other women they knew absconding from the hospital, as they were unable (or unwilling) to stay in the hospital as had been recommended by the hospital staff. These findings illustrate that in such cases the perceived advantages of staying at the hospital, such as: the perceived severity of the risks identified by the hospital staff as well as the perceived necessity and effectiveness of hospital treatment; versus the perceived difficulties caused by staying in the hospital such as: loss of potential earnings, and being unable to care for her own children, would be analysed and weighted (78).

32 Maternity waiting homes are residential facilities where women who live remotely can wait before giving birth at a hospital or health centre. Within Masanga Hospital women who were considered at risk of a complicated birth were admitted to the maternity ward where they waited until they gave birth.
When being admitted into the hospital women must have a ‘carer’ accompanying them. Whilst this carer is in the hospital looking after the pregnant woman, she is also unable to earn money or carry out her own domestic chores. This concern has been highlighted in a number of other studies conducted in Africa and Asia (33, 39, 41, 102). The carer is usually a close family member or woman who lives nearby in the village, and will assist the woman with washing, cooking, and cleaning her clothes. This is the typical procedure in Masanga hospital, since nurses are busy with ‘nursing duties’ and are unable to ‘care’ for the patients; although it should be noted that there is some debate as to what the exact role of nurses in sub-Saharan Africa should be (114). A hospital system that relies on unpaid carers to assist the patient generates additional costs for the pregnant mother and her family; despite the fact that the healthcare provided is supposed to be free. The social and financial costs associated with requiring a carer when being admitted to the hospital can therefore directly impact upon women’s health seeking behaviour. Health care provided in the professional sector may be the preferred option for some women, but is perhaps seen as not worth all the direct and indirect costs involved in obtaining it.

Another phenomenon that was highlighted in the findings was that of social expectations around birth. Social expectations expressed through family or community members can impact upon health seeking behaviour by acting as another factor to consider when deciding where to give birth (40). Women in this study spoke about the expectation to provide a clean or new lapa\textsuperscript{33} for their newborn. In the village, family and friends could wash the pregnant woman’s cloth, ensuring she had a clean lapa to wrap her newborn in, negating the need to actually buy a new one. In the hospital where washing clothes is not as easy, they would feel pressure to buy a new lapa. Not having money at hand to buy a new one could identify a woman as being poor. A position of poverty can sometimes mean the individual is perceived as being of a lower level in society, which in turn could bring with it neglect or lack of respect from those around her, in particular the hospital staff. In addition, the hospital is a public space, and therefore, what happens in the hospital can rapidly become known by a wider

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\textsuperscript{33} Lapa is the name given to the cloth women wear as a skirt.
audience. Any shame associated with not meeting social expectations in the hospital, and thus being identified as in a position of poverty, becomes publicly known. This creates a double burden of being poor that further inhibits the ability to access healthcare services (115). The fear of being shamed, and subsequently laughed at for not meeting these social expectations, was ultimately enough to motivate some women to deliver at home rather than in the hospital. These findings are similar to a study in rural Tanzania where attending the hospital wearing your best clothes and carrying items for delivery, such as gloves, was socially expected (112). To arrive in poor or dirty clothes increased the risk that staff would abuse or neglect the women. Again, this fear of being publically shamed for not attending the hospital with the correct clothes or delivery items could be enough to convince the women to deliver at home (40, 112).

The burden of distance from the villages to the hospital, poor road conditions and the lack of transport were additional structural factors affecting the decision-making process. These inhibitory factors have been discussed in previous studies conducted in other parts of Sierra Leone (27, 28, 46) as well as studies conducted in other low resource settings (33, 40, 43). Many women were fearful about, or had experience of, giving birth on the way to the hospital, especially if they experienced precipitate labour34. They would subsequently decide to give birth at home to prevent the risk of delivering on route. In one village where it was possible to access Masanga Hospital via a bush road, women would travel to the hospital by foot, with female family and friends accompanying them. In the case of an emergency, and where the woman was unable to walk, the woman would rely on male members of the community to carry her in a hammock. Although this does not require money, it does rely on willing and able men available to carry the hammock, another potentially inhibitory factor that plays a part in the decision-making process (101).

34 Rapid progression of labour leading to birth of the baby (http://www.ncbi.nlm.nih.gov/books/NBK53622/)
The health workers also highlighted the issues concerned with poor road conditions, and limited access to transport. Many roads in this rural area are only accessible by foot or motorbikes, and during the rainy seasons community members can be required to wade up to their necks in the high rivers. Some rivers become completely impassable, whereas those with bridges are often temporary structures, which can be dangerous to cross, whether in the dry or rainy season. Communities living in these rural areas often lack basic infrastructure such as safe roads and reliable transport, especially in comparison to communities in the urban settings. These inequalities and failings in the infrastructure are often outside the direct control of the communities but can directly limit people’s ability to access and utilise health services (110).

Most participants, specifically those living in the village further away from Masanga, relied upon motorbikes to access the hospital. If women were able and willing to take a motorbike whilst in labour, factoring in the evident discomfort and potential risk involved, money was another area for concern. Payment for motorbikes could not usually be credited; so potential passengers needed to have money at hand. In addition to carrying the woman in labour, family members would also have to pay for at least one carer to accompany the pregnant woman, thereby increasing the cost of transport even more. The significances of cost, poor road conditions and difficulty in accessing transport have been demonstrated in a number of other studies in low resource settings (20, 29, 31, 43, 102), and all impact upon the 2nd phase of Thaddeus and Maine’s 3-delay concept (57).

Another factor, concerning transport that was raised during this study was the difficulties communities faced in finding an available and willing motorbike driver, especially at night and if it was raining. Due to cultural norms in this patriarchal society, men from the villages are not allowed to witness women give birth, which is a problem when all the motorbike drivers in this area of Sierra Leone are male. In this context, it was not considered appropriate for women to drive motorbikes. This could be related to the fact that in some societies women are perceived as having lesser intellectual and physical capabilities (67, 68) and
would therefore be considered unable to drive a motorbike. Many women, as well as the motorbike drivers themselves, reported being scared to take a pregnant woman to the hospital, as they did not want to see her give birth. This reflects yet another situation where the woman’s position in society, alongside cultural taboos, potentially affects their ability to access health care.

4.6.2 Accessibility of health services at the hospital
Perceived accessibility to health services at the hospital is another structural factor that can impact upon health behaviour and delay individuals’ decisions to attend the hospital (57). A number of women spoke about the “advice” that they have been given by the nurses at their ANC appointment. This advice suggested that women who attempted to deliver at home, but then developed a problem, should not come to the hospital. If they did they should expect poor treatment, or in some cases, no treatment. The information was perhaps meant to scare women so that they actively chose to attend the hospital when labour first started, rather than try at home first. Unfortunately, this advice appeared to have a detrimental effect if a problem did arise, so that the decision to attend the hospital was delayed even further, illustrating delay in phase 1 of the 3-delays concept (57). In addition to this fear of poor or limited treatment, there was also a perceived fear of lack of respect and impatience from staff members. These perceived negative aspects of delivering at the hospital have also been reported in a number of other studies from sub-Saharan Africa and Asia (29, 40, 41). Subsequently, expected lack of respect and impatience can act as potential barriers to the use of the professional sector.

Previous studies conducted in Sierra Leone found that participants discussed long waiting times at the hospital as deterrents to accessing health services at a later stage, however this was not highlighted by participants in this study (27, 46). As discussed earlier, perceptions of unreliable medication supplies, ill-equipped and poorly staffed health facilities, become further structural barriers women unwillingly have to face when accessing health services at the hospital.
These issues have also been identified in other studies in Sierra Leone as prohibitive factors for accessing care in the professional sector (27, 28, 46).

4.7 Flexibility and dynamics in health seeking behaviour

There are many different factors influencing people’s health seeking behaviour, such as perceived origin and severity of a condition; previous experience and outcomes with using different health providers; availability of transport; costs involved; and accessibility of different health services. In order to fully understand the dynamics in the different health seeking patterns, these factors all need to be seen and considered together.

Most participants in this study described using both traditional medicines, in the form of native herbs or sorcery, and biomedical medicine, often described as ‘oparto’ medicine. Use of the different treatment options was flexible and interchangeable, and there was rarely a clear dichotomy between those who accessed health services from the professional sector and those who utilised the folk sector (61). Instead medical syncretism (56) was demonstrated as participants dynamically moved between the different health sectors and health providers available to them. This flexible approach to health seeking behaviour has been identified in previous studies conducted in Sierra Leone and Timor-Leste (28, 46, 104). Following Kleinman (61), the different health care providers or actors within the various sectors interpret and form clinical realities in different ways, thereby providing different explanations and treatments for health problems. The medical pluralism that exists within the rural Sierra Leone context enables members of the community to choose between the various options available depending upon the situation that they are currently in (56). This can also depend upon how the different individuals interpret the clinical realities, and which explanations best fit their belief system around the cause of the condition or problem, and therefore, which treatment option is required (61). For example, witchcraft could only be solved in the ‘traditional manner’, so

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35 Oporto was the term typically used to describe a non Sierra Leonean person: typically a white or western person.
participants would not consider use of the professional sector for this problem; rather, the folk sector would be more appropriate.

Kleinman describes characteristics of explanatory models as being vague, with multiple meanings and frequent changes (61). The indistinctness and frequent fluctuations in participants' explanation for causes and appropriate treatment in this current study meant that treatment from all health sectors would often be used concurrently. In addition, participants often viewed treatment from all the sectors as having equal efficacy and value. The different treatments could then be used to address different potential causes of the same problem, playing complementary rather than competitive roles (109). Use of treatment from the different sectors would therefore help ensure healing of symptoms or a cure. This flexibility in treatment approaches illuminates the dynamic movements between the different health care systems and providers. Healthcare seekers negotiate the various options available to them, thereby strategically obtaining the best possible treatment and management (61).

Nearly all women in this study attended the hospital to access the ANC as this was deemed the norm, and the 'right thing to do'. This is in keeping with the latest statistics from the 2013 Sierra Leone Demographic Health Survey (48). In this current study, attending ANC during pregnancy was often viewed as a protective mechanism thereby ensuring a safe delivery, which has also been found in other African studies (42, 101). This view of women attending ANC appointments to identify 'at risk women', and therefore reduces the risk of complications during childbirth, was also acknowledged by the health workers. A number of other studies have found that being advised during the ANC appointments to attend the hospital for delivery increased the likelihood of women institutional deliveries (33, 40). This was in contrast to the findings from this current study, where many women shared experiences of being advised to attend the hospital during delivery, but either actively chose not to, or were unable to, due to a number of prohibitive factors. It should be noted that for many women in this study planning to attend the ANC appointments at a set time is a realistic scenario. They can organise who will look after their other children,
and ensure that they have completed all necessary domestic chores and farming tasks. Labour, in contrast, does not start at a predictable time and planning to attend the hospital can be difficult. Especially if labour starts in the middle of the night; when it is raining; the husband is away from the village working; and there are no motorbikes available

Becker (78) discusses patients’ intention to comply with what health workers have told them to do. He argues that in some situations the desire to do “as the doctors tells you” can motivate patients to accept some forms of preventative treatment. In this study, this was shown in women’s readiness to access ANC as a form of ensuring a safe pregnancy and delivery. Becker (78) also highlights that in other situations people often have no intention to comply with advice from health workers; as was the situation for many women in this current study with regards to attending the hospital to deliver. This could be related to the fact that many women did not perceive themselves to be susceptible or vulnerable to complications during childbirth (78), perhaps because they had never previously experienced complications that required hospital attention. This presumed lack of vulnerability could be seen as surprising since the high rates of maternal mortality in Sierra Leone mean that nearly everyone will know of someone who has died during childbirth. However, the various different fears involved with attending the hospital, such as the risk of having an operation, fear of being poorly treated or not receiving any treatment, could outweigh the potential vulnerability and perceived risk of not delivering at the hospital.

A study conducted in Ethiopia found that women often attended ANC at the local health facility, then gave birth at home as this was the norm, but would re-access the health facility if complications arose (39). This was in keeping with findings from this study where women would initially attend the hospital for the ANC services, give birth at home, but then re-access the professional sector if their situation or circumstances changed. If a complication did arise, biomedical treatment at the hospital was not automatically the first option. Oporto ‘biomedical’ treatment could also be obtained and used by non-medical people in the village as described previously in this chapter. This use of biomedical
medicine in the villages is an example of popularisation: professional medical tradition filtering down into the popular sector (56). This has been demonstrated in a study conducted in India where hospital medication was also used at home by non-medical practitioners (41). The decision, therefore, to access oporto medicine in either the professional sector i.e. the hospital, or the folk sector i.e. the village, would be influenced by other enabling, supportive or prohibitive factors (78).

Enabling factors as described by Becker (78), specific to accessing oporto medicine in the village, included the ability to negotiate or credit\textsuperscript{36} the treatment fees. In addition, the woman in labour did not have to travel to receive the treatment; instead the treatment provider would travel to the woman’s home. These enabling factors illustrate why many participants would turn to the peddlers within the village first, before attempting to travel to the hospital if the need eventually arose. In addition to enabling and prohibitive factors, supportive factors are also influential in decision-making processes (78). These can include social pressure or social support, often found in the family or wider community (78). In this current study there were examples of women who had attended the hospital to deliver speaking about being separated from their mothers during the delivery. This was a negative situation as one often relies on having the family nearby for emotional and practical support. In a study from Timor-Leste, Wild et al. (104) also reported the need for family and social support during the birthing process. They found that women would actively resist hospital delivery because they could not access the necessary social support that was available to them during a home delivery (78). Equally, the social support that can be provided easily within the village acts as another enabling factor to home delivery.

Perceived severity of a condition or symptoms was another feature that could influence and change the rationale of people’s health seeking behaviour. Becker (78) argued that physical symptoms can exert a realistic impact on perceived severity of a condition, which is another pre-disposing factor related to health seeking behaviour. In this study the main symptoms motivating women to seek

\textsuperscript{36} credit refers to payment being paid at a later date.
care specifically at the hospital were excessive bleeding or obstructed labour as discussed earlier. Although these physical symptoms are often perceived as best treated by representatives from the biomedical sector, trust was often placed in the expertise found in the folk sector. This persistent trust in the folk sector probably relates to the fact that traditional medicines have been around for much longer, and at times have been the only form of health care available to many people, especially during the recent civil conflict (60). Furthermore, accessibility to health care within the folk sector remains easier for most in the remote rural villages. However, many people have experienced that representatives of the biomedical professional sector are highly competent at handling acute, serious life-threatening situations that are often seen as impossible to be dealt with in the village. Therefore, care may immediately be sought from the professional sector in situations interpreted as life threatening, and where the cause is considered to be within the reach of biomedicine.

Findings from this current study illustrate that decisions are guided in certain directions by specific predisposing, enabling and supporting factors. The realities of structural factors as well as the perceived accessibility to different health services may make care seeking within the village a more pragmatic and viable option. If complications occur during the labour the family may seek additional help from the TBA first, then a peddler with access to biomedical medicine. But if the complications persist further and the perceived severity of the risks increase, then these factors may no longer be deemed as sufficiently inhibitory and all efforts may be made for the family to transport the woman to the hospital. Therefore, the final decisions may eventually be ad hoc, governed by new circumstances or events.

4.8 Strengths & Limitations

Findings from this study should be interpreted in light of several limitations. The literature review was limited to articles published in English and available via English-language search engines. This is of particular note since many of the West African countries are French speaking, and information and experiences
coming from those neighbouring countries may be different to those described only in English. This language barrier was also apparent within the field with the main researcher being dependent upon an interpreter. In addition, the main researcher was new to Sierra Leone and the culture, which meant that some of the subtleties and understandings might have been misunderstood.

A mixed purposive sampling technique was used when selecting the participants, implying that they were not randomly selected nor were they necessarily representative of the whole community. In addition, those who were included may have been more the confident members of the community, or those with adequate time to speak with us. There was the risk that potential participants who had a lot of responsibilities and daily tasks, and therefore limited time, were excluded. This could have been a group of participants who may have brought other insights, different experiences or even stronger opinions or views. Although the project tried to capture a variety of perspectives from a number of different participants, the results may not be transferable to all rural areas of Sierra Leone nor to all low resource settings. However, if the contexts are similar regarding health facilities available and infrastructure in situ, then the likeliness of the findings being transferable is larger.

Despite these limitations, there are a number of strengths worthy of note within this study. In particular, in order to understand women’s choices, one has to explore the processes she is going through, as well as map all the dynamic factors that interact and interrelate, and subsequently influence health seeking behaviour. Understanding the processes behind decisions, including the many choices already being taken and how all the variables interconnect can be difficult to capture through quantitative studies. Therefore, the use of qualitative methods ensured a deeper understanding of the decision-making process was gained. Due to the relatively long time in the field and the flexibility of the research team, fairly remote villages were included. This meant that views and experiences of communities in these secluded areas were included, rather than communities in fairly easy to reach locations. Two different villages were purposively chosen to ensure variation with regards to geographical site and
socio-demographic variables of the communities involved. This was deemed important so as to add more perspectives, which helps contrast and validate the findings. In addition to triangulation of research sites, this study also triangulated with respondent sources and methods so that a richer understanding about the issues and phenomena being studied could be obtained. The qualitative methodology employed in this study allowed for flexibility within the field meaning that new themes could be explored as they emerged. Furthermore, different members of the community whose perspectives had not previously been considered could be included as their importance was emphasised during the course of the fieldwork.
5.0 Conclusions and recommendations

The results of this study demonstrate that the decision-making process during childbirth in rural Sierra Leone is dynamic and intricate, and needs to be understood within the broader social context that it takes place in. Decisions are rarely independently made and are usually socially negotiated. The past experiences, social expectations and relationships of those involved, as well as the perceived risks of the individual and their community influence how decisions are made. The power relations within households and the communities of rural Sierra Leone may impact upon a woman’s ability to make fully autonomous decisions. However, the findings demonstrate that the women involved can be dynamic engagers in the decision-making process despite apparent gender and economic inequalities. Individuals may have their own preferences for where to give birth and with whom assisting, but these are weighed up against the complexity of enabling, supportive and inhibitory factors that are present within the health care systems and social context. A woman and her family may prefer for her to deliver at the hospital, but ultimately it may not be worth the cost (directly, indirectly and socially) of doing so. Decisions are often pragmatic and rational, made within the constraints of poverty and other social determinants out of the direct control of the individuals involved. Final decisions can be ad hoc at times as new and unexpected circumstances or events occur.

The findings also demonstrate that there are a number of important issues to consider when implementing strategies to improve access to, and utilisation of, safe health care for pregnant women in rural Sierra Leone. Future initiatives need to be based on adequate knowledge of women’s preferences, cultural-specific traits, capabilities, perceptions of risk and the constraints in which they may live. For example, this study has shown that certain belief systems, such as the perceived influence of witchcraft, strongly impact upon decisions made during childbirth and may ultimately prevent a safe delivery. Future strategies that are implemented to affect health seeking behaviour must be compatible with current belief systems (55).
Introduction of the Free Health Care Initiative has been a positive and significant approach towards improving access to healthcare for pregnant women. However, steps need to be taken to ensure access includes the most vulnerable and socially marginalised, especially the poor women living in isolated rural areas (116). Investigations into what drives the informal fees from health workers will guide future strategies in abolishing them (113). This will be an important step towards securing truly free health care for all women at the point of need. In addition, continuous monitoring of health services and the providers to ensure that treatment remains free, without any informal or under-the-table fees being demanded will also be important (52). Further research into the role of male traders and their use of biomedical medicine in the village will also be useful. This should include how they gained their knowledge, trust and experience in treating certain complications during childbirth. In addition, further research should look at how non-medical practitioners obtain biomedical medicine and whether the administration of these medications is detrimental or beneficial to women's health.

Steps to enable women to be admitted to hospital if necessary, without worrying about extra burdens and costs that using the current health system implies, is necessary. Making it possible to be admitted to the hospital without the need for a carer, whilst still maintaining good quality care, is an example of a measure that could have positive impact upon the women's possibility to utilise the health services. In addition, provision of nutritious food for inpatients could be another factor that encourages women to be admitted to the hospital if necessary. Efforts at the community level that provide support for the woman and her family, should she need to be admitted into the hospital, should also be encouraged. For example, local strategies to provide families with support in childcare and other domestic and farm tasks will be beneficial for women who need to be admitted for a longer period of time. Local community strategies to provide alternative forms of transport, especially in emergencies, should also be encouraged, as has been suggested by Herschderfer et al. (46).
The norm for many women in rural Sierra Leone is still to deliver at home, and removing them from their homes and responsibilities adds extra burdens for the women themselves. Since health facilities are often under-resourced and understaffed, imposing sanctions to ensure that women attend a health facility for a non-complicated delivery may not be the best strategy for communities in rural Sierra Leone. Furthermore there remains debate whether the hospital is the safest environment for women with non-complicated births in low resource settings such as rural Sierra Leone (45, 46, 117). Therefore, delivering at the hospital may not be the optimum or most realistic approach for all women at present.

It should be noted that the 5th MDG focuses on skilled birth attendants rather than institutional deliveries (6). Bringing health services closer to the communities may be a better option, with focus on ensuring skilled birth attendants in the community rather than institutional deliveries (116). This will leave the health facilities with more resources to deal with complicated deliveries. Decentralising the health services will rely on adequate number of trained, competent, supervised and supported health workers or midwives who are willing and able to live and work in the more rural areas with limited infrastructure in situ. There is a lack of skilled birth attendants at present in Sierra Leone, and those who are trained are often reluctant to live in isolated rural locations (46). It is therefore advisable to start in the community and build on the positive resources or possibilities already existing there. The WHO recommend the use of lay health workers (which includes TBAs) to promote behaviours and services for maternal health (118). If the role of TBAs within the health system in Sierra Leone is to be re-considered, then training courses, supervision and means for them to refer and liaise with health facilities needs to be ensured. Health Poverty Action (63), and Concern Worldwide (62) both work within Sierra Leone on maternal health issues and have published work on incorporating TBAs into the professional health system. It is beyond the scope of this study to suggest the best way to incorporate TBAs into the health system, but strategies to do so must consider practicalities around training, support and supervision.
Efforts are already being made to tackle gender inequality within Sierra Leone (69). Improvements in gender inequalities may secure women more autonomy and power in making independent decisions regarding their own health. However, true gender equality is a long way off in Sierra Leone (and arguably globally) and will require sustained efforts at local, national and international levels (69). This will not occur quickly or easily. What this study has shown is that regardless of women’s autonomy during the decision-making process, decisions are rarely made alone. There are a number of people involved and their opinions and preferences can be highly influential on decisions made and actions taken. Therefore, it is imperative that those involved in the decision-making process during childbirth are part of the planning and implementation of future initiatives. All efforts should incorporate community participation in order to promote transparency and sustain links between villages and health facilities.

This study has also demonstrated that local bylaws aimed at increasing the utilisation of health facility deliveries are neither implemented nor effective in all areas of Sierra Leone. The underlying burden of poverty along with many inhibitory structural factors is often out of the control of the individuals themselves. People often make pragmatic and subsequently highly rational choices within the constraints that they find themselves in. Fines that punish individuals for factors and circumstances that they cannot control may not be constructive. Social determinants of health, including poverty and gender inequalities, form part of the basic causes of health inequality in rural Sierra Leone (110, 111). For all women in Sierra Leone to have equal opportunities to access and utilise good quality healthcare during pregnancy and childbirth, the global community will have to demonstrate much more will and true involvement in tackling these basic causes of health inequalities.
Reference List

5. Starrs A. Safe motherhood initiative: 20 years and counting. The Lancet. 2006;368.


Appendix 1: Approval from the Ethical Committee for Ministry of Health Services of Sierra Leone

GOVERNMENT OF SIERRA LEONE
Office of the Sierra Leone Ethics and Scientific Review Committee
Directorate of Training, Non-Communicable Diseases and Research
Connaught Hospital
Ministry of Health and Sanitation

22nd July, 2013

Ms. Laura Treacy (MPhil Student)
Institute of Health and Society
Faculty of Medicine
University of Oslo, Norway

Dear Ms. Treacy,

Exploration of the Decision-Making Process During Childbirth in Sierra Leone

This letter refers to the above proposed study submitted for review.

The Committee hereby grants Ethical and Scientific clearance for this study to be conducted in Sierra Leone.

The Committee stipulates as follows: that,

1. It must be notified in advance, if you decide to amend the research design and/or methodology at any time during the conduct of the study.
2. It must be informed if for any reason, the study is terminated prematurely.
3. On the conclusion of the study, you submit a report or any publication based on the study.
4. The approval is valid for a period of twelve (12) calendar months. You may apply for an extension beyond this period explaining why an extension is needed.

Yours sincerely,

[Signature]

Professor Hector G. Morgan
Chairman, SLESRC

Email: hgmorg2007@yahoo.com / williattav@yahoo.com
Appendix 2: approval for storage of information through the Norwegian Social Science Data Services

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Mette Søvikken
Institutt for helsetjenester
University of Oslo
Postboks 4130 Blindern
0316 OSLO

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER
Vi viste til melding om behandling av personopplysninger, mottatt 03.05.2013. Meldingen gir projekteret
24441 Exploration of the decision-making process of where to deliver during childbirth in rural Sarra Louna: a qualitative study
Behandlingsansvarlig University of Oslo, ved instituttens egen eier der
Daglig ansvarlig Mette Søvikken
Student: Laura Tracey

Personvernområdet har vedtatt projekten og finner at behandlingen av personopplysninger er medfelt i behov for personvernsloven § 21. Behandlingen ifølge loos kravene i personvernsloven.

Personvernområdets vurdering: Foruten at prosjektet gjennomføres i tråd med opplysningerne i tekst i meldingen, korresponderer med området, områdets kommunikator samt personvernsloven og behovet etter behandlingen av personopplysninger kan notere i 1992.

Det gjøres oppmerksom på at det skal ges ny melding denne behandlingen endres i forhold til de opplysninger som legger til grunn for personvernområdets vurdering. Føringen av meldingen på en egen skjermbild: https://www.gjonn.no/personvernomr/medie/medje.htm. Det skal også gi melding etter tre år demen

Personvernområdet har lagt ut opplysninger om prosjektet i en offentlig database,
https://personvern.no/om-os/

Personvernområdet vil ved prosjekten avslå, 01.05.2014, rette en henvendelse angående støt for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namvold Knudsen
Lana Merethe Reid 06 65 58 89 11
Vedligeholdelse/Projektvurdering
Kopiar Laura Tracey, Thorvald Meyers Gade 85E, 0330 OSLO
Appendix 3: Regional Committees for Medical and Health Research Ethics in Norway letter

Laura Treacy  
Institute of Health and Society  
University of Oslo

**Project manager:** Laura Treacy

We refer to your enquiry received 26.4.2013 concerning the project “Decision making around child birth in Sierra Leone”. The aim of the project is “to explore the decision making process of where to deliver, including what and who influences the process. It also aims to explore how women and the local community perceive the potential risk of pregnancy and delivery.” The method used is qualitative interviews.

We understand the aim of project to describe the beliefs, the opinions and the understanding of the informants. As the project is described we consider that this study protocol lies outside the remit of the Act on medical and health research. The project can be implemented without the approval by the Regional Committee for Medical Research Ethics.

Yours sincerely

Gunnar Nicolaysen  
Chairperson, Section A  
Regional Committee for  
Medical Research Ethics, South-East Norway  
(P.P.)

Jørgen Hardang  
Committee Secretary
Appendix 4: Informed Consent Form

Title: Exploration of the decision-making process during childbirth in rural Sierra Leone  Date: 18.07.13

Informed Consent Form for exploration of the decision-making process during childbirth in rural Sierra Leone

Name of Principle Investigator: Laura Treacy, Student M.Phil. International Community Health.

Name of Organization: University of Oslo, Norway.

Name of Project: Exploration of the decision-making process during childbirth in rural Sierra Leone: a qualitative study.

This Informed Consent Form has two parts:

I. Information Sheet (purpose: to share information about the study with you)

II. Certificate of Consent (purpose: for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

PART I: Information (Introduction, Chapter A and B).

Introduction (handout hard copy and explained orally to each interviewed)

I am (Name of the interviewer), doing research on exploring the decision-making process during childbirth in rural Sierra Leone. I am going to give you information (verbally and written) and invite you to be part of this research. You have been selected to participate as you, or someone close to you, has experienced giving birth, or assisted in a delivery, within the last year. This study is part of a Masters project at the University of Oslo, Norway. Before you decide, you can talk to anyone you feel comfortable with about the research.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or of another researcher.

Background and purpose of the research

Maternal mortality is a huge burden in Sierra Leone. There is a lack of qualitative research exploring where and with whom women in Sierra Leone prefer to give birth. This research aims to explore the decision making process around where to deliver, including who and what influences the process. It also aims to explore how women and the local community perceive the potential risk of pregnancy and delivery, especially in rural areas of Sierra Leone. It is hoped that information gained through this project will help guide future plans and initiatives in improving maternal health in Sierra Leone.
**Title:** Exploration of the decision-making process during childbirth in rural Sierra Leone  
**Date:** 18.07.13

**Study procedure**  
Participants will either partake in a group discussion in the form of a focus group discussion, or participate in individual interviews (in-depth interviews).

**Potential advantages and disadvantages**  
There will not be any risks involved with participating in this study. You will be compensated for transport or any other indirect costs associated with participating.

**What will happen to the information about you?**  
Information about you will not be shared with anyone outside of the research team. Any information about you will be recorded as a number instead of your name. The information collected will be kept private, protected by a password, and be locked up with a lock and key.

**Voluntary participation**  
Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. If you wish to participate, sign the declaration of consent on the final page. If you agree to participate at this time, you may later on withdraw your consent without any consequences whatsoever. If you later on wish to withdraw your consent or have questions concerning the study, you may contact:

Principal Investigator: Laura Treacy. Mobile number: (0780886177) or l.c.treacy@studmed.uio.no  
Research assistant: (Hawanatu Kamara) Mobile number: (078119057)

This proposal has been reviewed and approved by the Sierra Leone Ethics and Scientific Review Committee. This committee has the task of making sure that research participants are protected from harm.

If you wish to have more information about Sierra Leone Ethics and Scientific Review Committee, or the formal approval in Sierra Leone for this project contact the Secretariat, Nr. Ward 10, Connaught Hospital, Freetown, +23278463696 or williettaw@yahoo.com

**Further information on the study can be found in Chapter A – Further elaboration of what the study entails.**

**Further information about privacy and insurance can be found in Chapter B – Confidentiality and funding.**
Chapter A – Further elaboration of what the study entails

Criteria for participation
- Mother who has given birth within the last year.
- Person whose family member has given birth within the last year.
- Health professional, traditional birth attendant or member of the community involved in deliveries within their community.

Contact with participants
The main researcher and research assistant will have contact with all participants.

Procedures
You will be asked to participate in either group discussions and/or an interview. The interview or discussion will last between 1 and 1.5 hours. You may be asked to be interviewed a second time to clarify previous discussion points. If permitted by participants, interviews/discussions will be audio-recorded.

Schedule – what happens and when does it happen?
A suitable location and time will be agreed with each participant for the group discussion and/or interview.

Potential advantages
Nil specific to individual participants, but it is hoped that information gained through this project will help guide future plans and initiatives in improving maternal health in Sierra Leone.

Potential adverse events
There are no known risks at present. The participant has the right to contact the ethics and scientific review committee, if the participant sustains a research-related injury.

Potential discomforts or disadvantages
There is the potential for recollection of distressing memories or negative emotions related to previous births. You may feel uncomfortable talking about some of the topics. You do not have to answer any question if you do not wish to do so. You do not have to give any reason for not responding to any question, or refusing to take part in the interview.

The patient’s/study participant’s responsibility
To attend the discussion or interview at the agreed time and place

Changes to study plan
The study participant will be informed as soon as possible in case new information becomes available that might influence the participant’s willingness to participate in the study. The study participant will be informed as soon as possible should potential decisions/situations occur, meaning that their participation in the study might be ended earlier than planned. There are no anticipated circumstances where this might happen at present without the participants consent.

Compensation
Participants will be reimbursed for transportation based on fares for motorbike between home and the site where interviews/discussions are conducted.
Chapter B – Confidentiality and funding

Privacy
Information that is registered about you will be your name, address and personal phone number or contact details of trusted relative so that if a repeat interview is needed you can be contacted. All data will be stored in a secure location and will be de-identified to ensure confidentiality for the research participants. All the data will be processed without name, ID number or other directly recognisable type of information. A code number links you to your data through a list of names. Data collected from the interviews and focus group discussions will be stored on a password-secure laptop, known only to the main researcher. When permitted by participants, focus group discussions and interviews will be audio recorded. These recordings will be destroyed upon completion of the analysis and masters thesis.

Only authorised project personnel will have access to the list of names and be able to identify you. The accumulated information will be deleted when the main researcher has completed writing the master-thesis. This will be no later than 01.06.2014. The Norwegian Social Science Data Services, represented by its managing director, is responsible for the data processing and storage.

As far as possible, an attempt shall be made to publish the results in such a manner that the identity of each participant will not be disclosed.

Releasing material and data to other parties
None of your data will be released to other parties.

Right to access and right to delete your data and samples
If you agree to participate in the study, you are entitled to have access to what information is registered about you. You are further entitled to correct any mistakes in the information we have registered. If you withdraw from the study, you are entitled to demand that the collected data are deleted, unless the data have already been incorporated in analyses or used in scientific publications.

Funding and the role of Ivar Helles Legat Foundation
The study is funded by a research grant from The Ivar Helles legat foundation. The role of the sponsor is purely as a financial contributor and there are no conflicts of interest. The main researcher is applying for other sources of funding. Any additional sources of funding will have no conflict of interest.

Information about the outcome of the study
A summary of the research results will be sent to any relevant and interested persons in Sierra Leone. Participants are entitled to receive information about the outcome of the study.

Personnel
- Principal Investigator (PI): Laura Treacy. Student M.Phil. International Community Health
- Main supervisor: Mette Sagbakken, RN, M.Phil., PhD. Institute of Health and Society, University of Oslo
- Co-supervisor: Håkon A Bolkan, MD, Department of Surgery, St. Olav’s Hospital, Trondheim. Research fellow, Department of Cancer Research and Molecular Medicine, Norwegian University of Science and Technology. Chairman of CapaCare, an organisation providing surgical training in Sierra Leone.
- Research assistant: to be decided once PI is in the field.
Part II: Certificate of consent

I have been asked to participate in research about the decision-making process around childbirth in rural Sierra Leone.

I have read (or been verbally informed about the research project) and received a hard copy of the research information. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant: ____________________________

Signature of Participant: ____________________________ or finger print:

Date: ________________________ Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that an interview or participation in a group discussion will be conducted.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this consent form has been provided to the participant.

Print Name of Researcher/person taking the consent: ____________________________

Signature of researcher /person taking the consent: ____________________________

Date: ________________________ Day/month/year