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Original Research Article

Assessing Factors Contributing to Home Deliveries in Kazungula District, Southern Province: A Case of Kazungula District, Southern Province

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Abstract: ***Background*****:** Despite free maternal health services and increasing antenatal care attendance, home deliveries remain common in rural Zambia. This study explores the determinants of home deliveries among post-natal mothers in Kazungula District. ***Methods:*** A cross-sectional survey was conducted with 44 post-natal mothers who delivered at home in 2022 within Kazungula District Hospital's catchment area. Structured interviews were used to collect data on socio-economic factors, cultural beliefs, attitudes toward facility delivery, and maternal knowledge. Descriptive statistics were analyzed using SPSS v24. ***Results*****:** Key contributors to home deliveries included distance to health facility (45.5%), lack of transport funds (22.7%), short labor intervals (34.1%), and preference for traditional birth attendants (25%). Additionally, 62.5% of mothers lacked awareness of birth complications, and 65.9% expressed negative attitudes toward facility delivery. While 81.8% stated they would prefer facility births, structural, economic, and cultural barriers impacted actual behavior. ***Conclusion*****:** Persistent home deliveries in Kazungula District are primarily driven by socio-economic barriers, cultural beliefs, and maternal knowledge gaps. Addressing these factors through targeted health education, community sensitization, and transportation support is essential.

Keywords: Home deliveries, Maternal health, Rural healthcare, Facility-based delivery, Antenatal care.

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1. INTRODUCTION

Globally, maternal health remains a critical area of public health concern, particularly in low- and middle-income countries where women face significant barriers to accessing skilled birth services. The World Health Organization estimates that approximately 295,000 women died in 2017 due to complications related to pregnancy and childbirth, with sub-Saharan Africa accounting for two-thirds of these deaths (WHO, 2018). A significant contributor to this burden is the practice of home deliveries without skilled attendance, which increases the risk of maternal mortality, neonatal mortality, and severe postpartum complications such as hemorrhage, sepsis, and obstructed labor (Efendi. 2019).

Despite global progress in improving antenatal care (ANC) access, facility-based deliveries remain low in many rural African settings. In Zambia, although national guidelines mandate institutional deliveries and prohibit the use of traditional birth attendants (TBAs), compliance is still a challenge. The Zambia Demographic and Health Survey (ZDHS, 2019) reported that approximately 42% of women in rural areas still deliver at home. These patterns persist even when health facilities are geographically accessible, often within 5–10 km, highlighting the complexity of factors beyond simple proximity.

Kazungula District, located in Southern Province, Zambia, has witnessed a concerning rise in home deliveries in recent years. Institutional records from Kazungula District Hospital show that home deliveries increased from 48.2% in 2019 to 61% in 2022. However, such district-wide figures may not always reflect the dynamics in smaller populations. This study specifically investigates the 44 women within the

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hospital's catchment area who delivered at home in 2022, a clearly defined group representing a manageable and well-documented local cohort. Understanding their experiences provides insights into why home deliveries persist despite proximity to health services.

Several factors may contribute to this trend. First, economic barriers remain significant. Although maternal health services in Zambia are officially free, the indirect costs, particularly transport to health facilities, remain prohibitive for many families (Atusiimire 2019). In remote communities, women may need to hire motorbikes or private vehicles, which are unaffordable at the time of labor onset. Second, cultural and gender norms continue to shape delivery preferences. Some women feel discomfort being attended by male midwives or sharing labor wards with much younger women, leading them to perceive home delivery as more dignified (Gebregziabher. 2019).

Third, attitudes toward facility-based care are influenced by past experiences of disrespect, poor communication, or fear of being scolded for arriving late. Studies from other African countries have documented how perceptions of disrespectful maternity care discourage women from seeking skilled attendance during labor (Lusambili. 2020). In this study, such attitudes were reported by 65% of the women who delivered at home.

Finally, low levels of maternal knowledge regarding birth complications and danger signs can delay timely decisions to seek care. This is particularly true for women with low education levels or inconsistent ANC attendance. Research from Ethiopia and Indonesia confirms that limited understanding of complications such as hemorrhage or uterine rupture contributes to the preference for home deliveries (Yoseph. 2020; Efendi *et al*., 2019). In Kazungula, this was mirrored in our findings, where over 60% of women were unaware of common delivery risks.

In light of these challenges, this study aims to explore the specific socio-economic, cultural, and knowledge-related factors that contributed to the decision to deliver at home among the 44 post-natal mothers in Kazungula District Hospital's catchment area. By narrowing the focus to a defined and accessible population, the study avoids generalizations and provides targeted recommendations grounded in empirical evidence.

2. METHODS

2.1 Study Design

This study employed a quantitative, descriptive cross-sectional design, which is widely used to assess health-related behaviors and associated factors at a single point in time (Setia, 2016). The design was appropriate for identifying patterns and associations related to home delivery among post-natal mothers without establishing causality. It allowed for rapid data collection and analysis from a clearly defined population.

2.2 Study Site and Setting

The research was conducted in Kazungula District**,** located in the Southern Province of Zambia. This rural district is characterized by dispersed settlements, poor road infrastructure, and limited access to emergency obstetric services. The central referral facility is Kazungula District Hospital, which provides maternal and child health services to communities within a wide catchment area. Geographic barriers and seasonal flooding often make facility access difficult.

2.3 Target Population

The target population consisted of all post-natal mothers who delivered at home within the Kazungula District Hospital catchment area during the 2022 calendar year. A review of facility-based records showed that 44 women met this criterion and were included in the study.

2.4 Inclusion and Exclusion Criteria

Inclusion Criteria:

- Post-natal mothers who delivered at home within the catchment area within the past 12 months in Kazungula district.
- Be permanent residents of Kazungula district (living there for Atleast 1 year before delivery.
- Be willing to Provided informed consent to participate in the study.

Exclusion Criteria:

- Women who delivered at home but unable to communicate due to health complications.
- Those who had relocated outside the district or declined participation.

2.5 Sampling Procedure

Given the small and identifiable study population, a census approach was adopted. All 44 eligible women were included, which ensured a high level of representativeness and avoided sampling bias. However, only 40 participants were available for the study.

2.6 Data Collection Instruments

Data were collected using a semi-structured interviewer-administered questionnaire, developed with reference to tools used in previous maternal health studies. The questionnaire was written in English and translated into Tonga and Lozi. It consisted of four sections:

- Demographic details
- Obstetric history and ANC attendance
- Knowledge of delivery-related complications
- Cultural beliefs and facility delivery attitudes

The tool included both closed- and open-ended items to enhance completeness and depth of responses.

2.7 Pretesting and Tool Validation

The tool was pretested with six post-natal mothers (15% of the final sample) at Sikaunzwe Rural Health Centre, which shares similar socio-demographic characteristics with the study site. Feedback helped refine question clarity, order, and cultural appropriateness. Content validity was confirmed through consultation with three experts in maternal health and research methodology at Eden University and Kazungula District Health Office.

2.8 Data Collection Procedure

Data were collected over two weeks in late 2022 by trained female research assistants. Interviews were conducted privately during household visits, ensuring cultural sensitivity and respondent comfort. Unique codes were assigned in place of names to maintain confidentiality and anonymity. Written and verbal informed consent were obtained.

2.9 Data Management and Analysis

Completed questionnaires were checked for completeness, coded, and entered into Microsoft Excel before being exported to SPSS version 24 for analysis. Descriptive statistics (frequencies and percentages) were generated to explore the relationships between home delivery and variables such as economic status, traditional beliefs, and knowledge levels.

2.10 Ethical Considerations

Ethical approval for the study was obtained from the ERES Converge Institutional Review Board. Administrative clearance was also secured from the Kazungula District Health Office. Participants were informed of their right to withdraw at any time without consequence. Cultural appropriateness was emphasized throughout the study process by engaging local data collectors and ensuring translation of materials into the local languages.

3. RESULTS

Presentation of Findings

3.0 Introduction

The chapter showcases the findings to the research questions in the data collection tool. The findings were generated with reference to assessing economic status, attitude towards facility delivery, relationship of traditional beliefs, knowledge with home delivery. The findings have been presented in figures and tables in the following segments.

3.1 Demographic Characteristics

Table 3.1: Demographic Factors

Age	**Frequency (n = 40)**	**Percentage (%)**
18-20 years	5	12.5
21-25 years	12	30.0
26-30 years	16	40.0
Above 30 years	7	17.5
Marital Status	**Frequency (n = 40)**	**Percentage (%)**
Married	28	70.0
Divorced	3	7.5
Single	9	22.5
Religious Denomination	**Frequency (n = 40)**	**Percentage (%)**
Baptist Church	5	12.5
Catholic	10	25.0
Seventh Day Adventist	11	27.5
Presbyterian	9	22.5
Pentecost	5	12.5

Table 3.1 depicts demographic characteristics of respondents. Findings reveal most respondents 16(40%) were 26-30 years and 12(30%) were 21-25 years of age with the least 5(12.5%) being below age of 21 years. Majority of respondents 28(70%) were married, with 9(22.5%) single and 3(7.5%) divorced. The results also reveal 5(12.5%) were Baptists, 10(25%) were Catholic, 11(27.5%) were Seventh Day Adventist, 9(22.5%) were Presbyterian and 5(12.5%) were Pentecost.

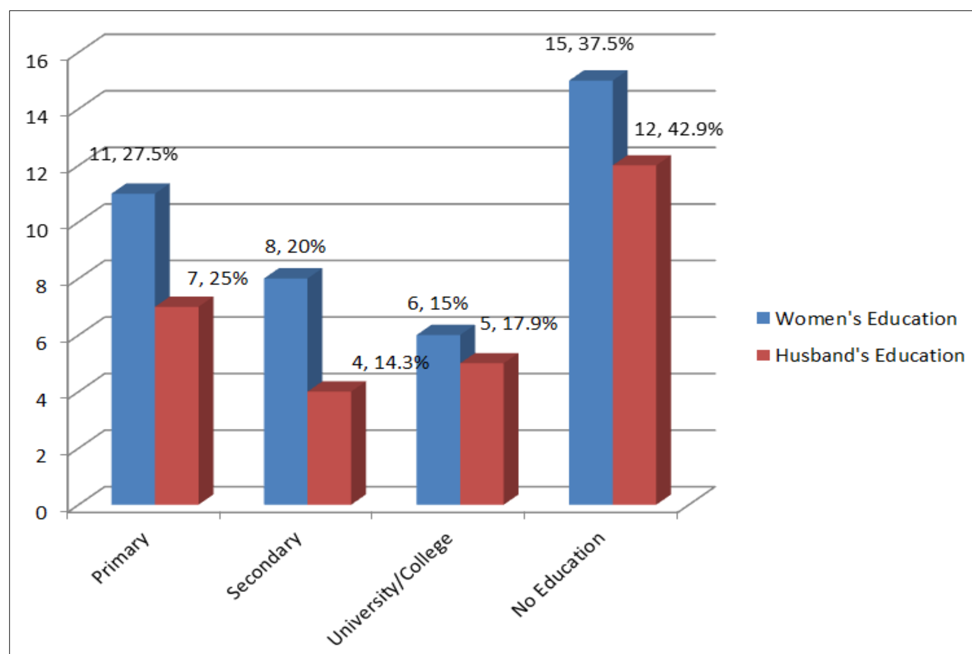

Figure 3.1: Education Level Attained

Figure 3.1 showcases findings on women's and their husbands' education level attained. It is revealed 11(27.5%) women attained primary education, 8(20%) women attained secondary education, and 6 (15%) women attained university/college education with 15 (37.5%) women having no form of education. Whereas, 7(25%) husbands attained primary education, 4(14.3%) husbands attained secondary education, 5(17.9%) attained university/college with 12(42.9%) not attaining any form of education.

3.2 Obstetric Characteristics

Table 3.2: Obstetric Factors

Parity	Frequency (n = 40)	Percentage (%)
1	8	20.0
2-4	21	52.5
>4	11	27.5
Previous place of birth	**Frequency (n = 40)**	**Percentage (%)**
Home	17	42.5
Health Facility	23	57.5
Birth attendance attitude	**Frequency (n = 40)**	**Percentage (%)**
Positive	14	35.0
Negative	26	65.0
Distance to health facility	**Frequency (n = 40)**	**Percentage (%)**
Within 5km	12	30.0
More than 5km	28	70.0

Table 3.2 highlights obstetric characteristics of respondents. Findings show more than half 21(52.5%) had 2-4 children, 11(27.5%) had more than 4 children with 8(20%) having only 1 child. The results show 17(42.5%) had last place of birth at home and 23(57.5%) their last place of birth was at the health facility. Among the women that delivered at the health facility, 14(35%) indicated birth attendance attitude being positive and while the majority, 26(65%) revealed birth attendance attitude being negative. In addition, 12(30%) of the women disclosed residing within 5km to the health facility whereas 28(70%) reside more than 5km to the health facility.

4.3 Economic and Social Factors

Table 3. 3: Economic and social factors associated home deliveries

Birth Assistants	Frequency (n = 40)	Percentage (%)
Family member	9	22.5
Traditional Birth Attendant	10	25.0
Friends	16	40.0

No Assistance	5	12.5
Factors to giving birth at home	**Frequency (n = 40)**	**Percentage (%)**
Lack of transport money	9	22.5
Distance to the health facility	18	45.0
Short labour interval	14	35.0
Previously gave birth at home	4	10.0
Traditional Birth Attendants' Services	**Frequency (n = 10)**	**Percentage (%)**
Good	5	50.0
Bad	1	10.0
Better	1	10.0
Essential	3	30.0

Table 3.3 depicts among the 40 women that delivered at home, 9(22.5%) were assisted by a family member, 10(25%) by traditional birth attendants, 16(40%) by friends and 5(12.5%) women delivered by themselves with no assistance. Results further show stated factors lead some women giving birth at home are 9(22.5%) lack of transport money to get to the health facility, 18(45%) distance to the health facility, 14(35%) due to short labour intervals and 4(10%) stated due to previous successful birth at home. In addition, among those attended to by traditional birth assistants, 3(30%) stated they are essential with 5(50%) rating traditional birth attendants' services as good.

3.4 Institutional Factors

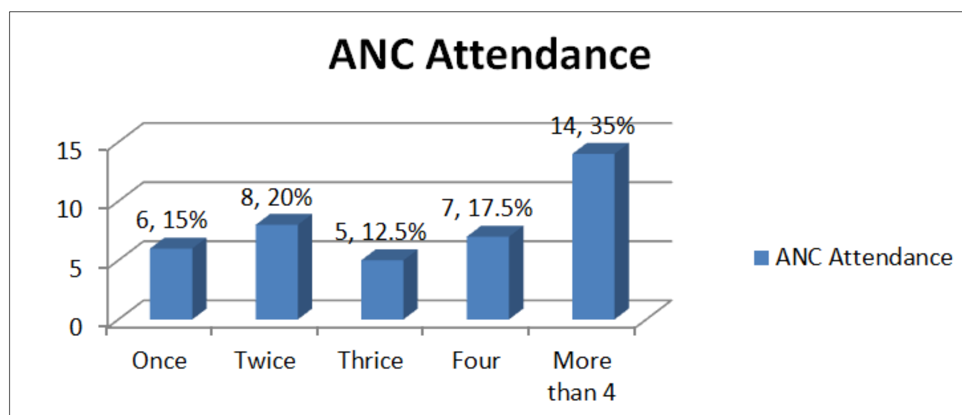

Figure 3.2: ANC Attendance

In figure 3.3 showing ANC attendance, 6(15%) attended once, 8(20%) attended twice, 5(12.5%) attended thrice, 7(17.5%) attended four times and 14(35%) being the majority attended ANC more than four times.

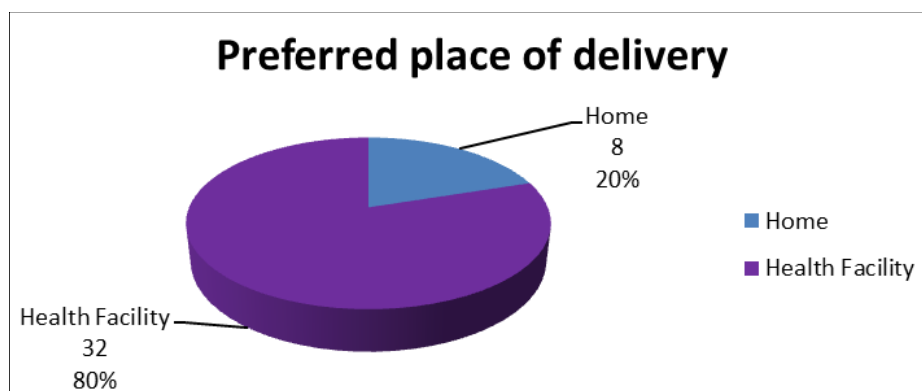

Figure 3.3: Preferred place of delivery

Figure 3.3 depicts preferred place of delivery. Majority of respondents 32(80%) preferred delivering at the health facility whereas 8(20%) preferred delivering at home.

Table 3.4: Reasons for preferring delivering at home and health facility

Preference of delivering at home	**Frequency (n = 8)**	**Percentage (%)**
No transport cost	8	100.0
Privacy guaranteed	3	37.5
Not being disrespected by health workers	5	62.5
Preference of delivering at health facility	**Frequency (n = 32)**	**Percentage (%)**
No penalty charges for home delivery	11	34.4
Serviced by trained nurses/midwives	30	93.8
Averts mortality in case of complications	23	71.9

Table 3.4 presents justifications for preferring delivering at home and at health facility. As shown in the table, among 8 preferring delivering at home, 8(100%) avoids transport costs to health facility, 3(37.5%) privacy guaranteed unlike in a Labour ward with young women and 5(62.5%) not being disrespected by rude health workers. On preferring health facility, 11(34.4%) due to no penalty charges for home delivery, 30(93.8%) serviced by trained nurses/midwives and 23(71.9%) averts mortality in case of maternal complications.

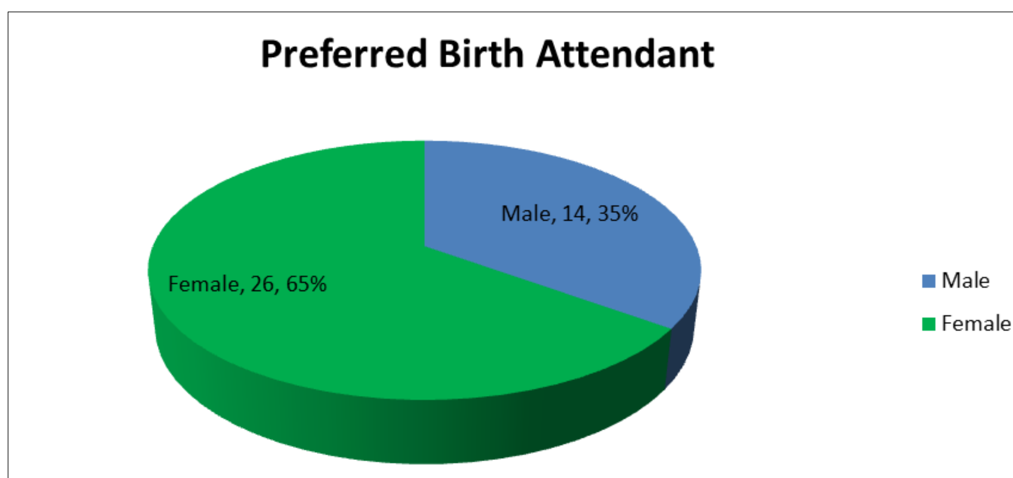

Figure 3.4: Preferred birth attendant

Figure 3.4 showcases preference of either male or female birth attendants when giving birth. Majority of women 26(65%) preferred female birth attendants and 14(35%) preferred male birth attendants.

Table 3.5: Reasons for preferring the specific birth attendant

Preference for male birth attendant	**Frequency (n = 14)**	**Percentage (%)**
Gentle and caring to woman	12	85.7
Respectful	10	71.4
Approachable	14	100.0
Preference for female birth attendant	**Frequency (n = 26)**	**Percentage (%)**
Understand Labour from experience	19	73.1
Gentle to the new born	22	84.6

Table 3.5 attaches justification of respondent's preference over birth attendants. Among respondents that preferred male birth attendants, 12(85.7%) believe male birth attendants are gentle and caring, 10(71.4%) males are respectful and 14(100%) disclosed male birth attendants being approachable. Whereas 26 preferring female birth attendants 19(73.1%) took female birth attendants to understand Labour from experience and also the 22(84.6%) of the respondents indicated female birth attendants are gentle to the new born.

Table 3.6: Awareness of complications

Dangerous delivering at home	**Frequency (n = 40)**	**Percentage (%)**
Yes	16	40.0
No	24	60.0
Aware of birth complications	**Frequency (n = 40)**	**Percentage (%)**
Yes	15	37.5
No	25	62.5

Birth complications	Frequency (n = 15)	Percentage (%)
Excessive bleeding	11	73.3
Convulsions	4	26.7
Raptured placental	7	46.7
Returned placental	5	33.3
Raptured uterus	9	60.0
Fetal distress	5	33.3

In table 3.6, it is shown most of the respondents 24(60%) are not aware of dangers from delivering at home. Only 15(37.5%) were aware of birth complications while the majority 25(62.5%) were not aware of birth complications. The stated birth complications by the 15 respondents were 11(73.3%) excessive bleeding, 4(26.7%) convulsions, 7(46.7%) raptured placental, 5(33.3%) returned placental, 9(60%) raptured uterus and 5(33.3%) fetal distress.

4. DISCUSSION OF FINDINGS

4.0 Introduction

This chapter discusses the findings presented in the previous chapter. The discussions a premised on economic status, attitude towards facility delivery, traditional beliefs and knowledge of post-natal mothers impacting home deliveries.

4.1 Economic Status and Home Delivery

Among the factors influencing pregnant women delivering from home are economic factors. It is often the case most women delivering from home do not meet the cost of heading to the clinic when it's their due time to deliver. Study findings have revealed 62.5% among the women that delivered at home had no funds to help them book for transport. Transport cost has been highlighted as the most significant factor hindering expectant mothers deliver from the clinic. In a related study in Uganda, Atusiimire *et al*., (2019) found that 91% of women delivering from home encountered challenge of meeting transport cost. The study was undertaken in rural Ethiopia where occupation of most men and women is farming which signifies a lack in consistent income. Findings revealed the women and their spouses lacked enough income for transportation. Delivering from home was viewed as a cost-effective measure and saved funds which could allow the couple buy other items for the new born baby.

4.2 Attitude towards Facility Delivery Contributes to Home Delivery

Study outcome has shown 78% of women that delivered from home exhibited negative attitudes towards facility delivery. The factors stated hindering facility delivery is lack of privacy especially for elderly mothers who regarded delivering in a clinic alongside their daughters' age mates as a taboo. This was reflected into most home deliveries occurring among elderly women. According to Efendi *et al*., (2019), elderly women were found to resent facility delivery due to being attended to by young nurses and sharing of the delivery ward with young mothers in rural Indonesia. Elderly mothers were also of the view needed minimal supervision as compared to first time women delivering a baby. Another factor disclosed by women avoiding facility delivery is being attended to by male nurses. The women stated felt inappropriate to be attended to by a male when traditionally birth process is witnessed and directed by women. However, a study by Hogan (2017) in Bangladeshi revealed male nurses and midwives were found to be more accommodating and patient as compared to female nurses and midwives. Findings showed 69% of women attended to have positive compliments concerning males. Hence, for some women avoiding facility delivery because of male nurses and mid wives can be attributed to negative attitude founded on myths.

4.3 Traditional beliefs and Home Delivery

Findings have revealed traditional beliefs have an influence on home deliveries. Most women holding strong beliefs in traditions concerning disposal of the uterus after births preferred delivering from home. Among the 42.5% of women that gave birth at home, 41.2% were attended to by traditional birth attendants. A study done by Gebregziabher *et al*., (2019) in South Sudan has shown women and their husbands entrenched in traditional religious beliefs have often been preferring giving birth at home as the rituals needed to be performed immediately the baby is born performing the rituals at the facility was deemed impossible due to the unnecessary attention it would attract. The fear in most women of mystical powers among rural women compel them deliver at home.

4.4 Knowledge of Post Natal Mothers and Home Delivery

Information influences in the decision making of individuals pertaining to choices they make. This study has shown home deliveries were predominant among women with primary education or no form of any education attainment. The women fail to understand the risks involved in delivering from home. Study outcome presented in figure 4.3 reveal most women attended ANC at most 4 times. They accounted for 65% of the women that attended at most half of ANC sessions. This outcome is an indication of the level of knowledge acquired on the understanding of importance of delivering at the facility. A similar study undertaken in Ethiopia revealed home based deliveries were high among women that attended less than 5 ANC sessions (Yoseph *et al*., 2020). Shiferaw and Modiba (2020) associated home deliveries to absconding ANC lessons on knowing the risks involved in delivering from home

in Brazil. Study outcome presented in table 4.4 reveals 62.5% of respondents were not aware of birth complications and 60% did not associate the risks with home delivery. This outcome signifies the importance of knowledge in influencing the women deliver at the facility. Sato *et al*., (2019) related women opting delivering at home as a consequence of lacking awareness on the risks involved in giving birth off the watch of certified nurses and midwives. The findings correlate with this study's finding on lack of knowledge being an influencing factor women decide to deliver from home.

5. CONCLUSION AND RECOMMENDATION

5.0 Introduction

This final chapter of study concludes and makes recommendations concerning the outcome of the study. It highlights the key findings presented in chapter four in relation to the specific objectives formulated in the first chapter.

5.1 Conclusion

The outcome has revealed factors that are prevalent among women delivering from home. In terms of economic status, it has influenced the decision for couples and families to deliver away from the clinic. Most women find themselves staying further away from the clinic and to get there would need to book for transport. Limited financial resources compel women deliver at home when pregnancy is due. Attitude has been another element leading women deliver at home. Elderly women have negative sentiments towards delivering in a labour ward alongside young women. Furthermore, being attended to by male midwives discourages traditional elderly women from prioritizing facility delivery. Similarly, traditions have contributed to home deliveries as women hold on to cultural beliefs regarding practices conducted for safe delivery and health of the baby. The other factor which has led women deliver at home is unawareness on the risks involved in delivering at home. Majority of women lacked knowledge on the importance of delivering at the clinic, and this could be attributed to none attendance of full ANC sessions.

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